Oh !@#$: Where'd that come from?

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Ladies and Gentlemen:

I would like to begin by acknowledging the support of the Safety Institute of Australia and for providing this opportunity to share some of my thinking about workplace safety with you all this morning.

I would also like to acknowledge each and every one of you here as well. Your presence here is a testament to your commitment to the workplace health and safety of those around you. That is NO SMALL THING. A little later I hope to draw your attention to the "ripple effect" within workplace safety.

Before we begin though I would like to spend a few moments just engaging with the safety side of our brains.

What we are going to do now is just play a little reductionist game for a few moments. So, bear with me, there is a purpose here.

OK…… Now how many of the movers and shakers in the room, travel in the course of their work……..That's a fair proportion of the room…… Now lets see how many of us have been known to stay above the 10th floor……Numbers haven't shrunk much have they…….By the way did I mention that the ladder on the fire engine generally does not reach above the 4th Floor……..OK now don't go putting those arms down yet. Of those of us who stay above the 4th floor how many check the emergency evacuation routes/assembly points on the back of the door? Feeling pretty good I wonder.

Lets just have quick look at a recent Hotel fire. This one occurred across the road from where I stayed recently.

Anywhere here is the Tester…….. How many of you check that the emergency exit doors on your floor and the ground floor access point are unlocked and reasonably accessible……Oops that just shrunk the room. Finally, do we have anyone in the room who "walks" the emergency egress route prior to putting the head on the pillow?

Now let's think about what this all means. One thing it may mean is that of those of us who don't check the doors for function, well we just might cook. There might be a few more people checking the doors before they hit the pillows tonight. Oh, and by the way, this is a room full of people with a keen interest in safety. Imagine what happens in the general population.

OK, so I am hoping that now we are truly thinking about our own safety.

The title of my presentation this morning by the way is: -

Oh Shit! Where did that come from?

The significance of the Title I shall share with you very soon. Before I get there though I should maybe share with you a little of my background. Why? Because we are about to go on a journey together and my own reactions to this "Stuff", both the rational and otherwise, shall be heavily influenced by that background.

Anyway, I have to admit to being a Psychologist by profession. I have been that type of animal for a little over twenty years. For the first ten I worked exclusively in the area of vocational rehabilitation and applied injury management. In the region that I operated I designed and conducted the first out-patient chronic pain management program, which proved to be highly successful. I was also instrumental in the development of a national management plan towards the management of workplace stress. That was about the time of the 1st National Conference on Occupational Stress, held on the Gold Coast here is Queensland. What was interesting was, at that time, Queensland had the lowest frequency of workplace stress in the Country; arguably in the World. There were all sorts of explanations. The most common was the weather (sunny one day – perfect the next) and, of course, the laid-back lifestyle of Queenslanders. In truth, all you had to do was look at the workers compensation claim form. Guess what! No box for Stress. So, the Psychologist shows the ugly side. We need to be sure "apples" are "apples". By the way Queensland exceeded other States, at the time, on a number of other injury classifications. Make of that what you will?

Having become frustrated with the industry that I found myself within, I resigned and became a self-employed psychologist specialising in all aspects of workplace health and safety. Over the years this has resulted in supporting small and multinational businesses with the full range of safety exposures; from direct injury management, to policy development, and strategic advice on organisational processes. In the last five years or so the culmination of much of that experience has resulted in my developing a range of interventions focussed upon the analysis and development of optimal safety cultures and the creation, in many cases, of effective safety leadership. This work I apply in a number of locations around the Globe. In July I shall be again visiting India for the purposes of integrating the Safety-Net Technologies within a major manufacturing facility – this shall be an integration of Quality, Environment and Safety standards. September shall see a return to South Africa conducting a number of Transformational Safety Leadership Symposia in Johannesburg, Capetown and Durban. There shall also be some time with the leadership team of Murray & Roberts – one of South Africa's foremost industrial organisations.

My belief, when I started in this "safety world", a little over twenty years ago; was that many of the challenges that are confronted around workplace safety have their aetiology in the deep-seated practices etc that occur in, and around workplaces. In a micro sense we might consider these to be termed "psycho-behavioural". In a more macro sense we might refer to them as "cultural", or Safety Culture.

So, there is the briefest synopsis of a Career, coming from a guy who talks for a living.

We are now going on a bit of a journey. For me this is a very personal journey. So, allow me to set some expectations. How my own psyche responds to the story I am going to share, often has a mind of its own. It is just possible that there may be a level of emotion that expresses itself in the form of tears. Please do not allow that to concern you too much…. I am reminded of a guy I met in Melbourne a few years ago now. His name was George Mitchell. For those of you educated in traumatology, George is Jeff Mitchell's brother…Anyway, George was speaking about the after effects of September 11, 2001 when the buildings came down. He was a senior fire-fighter. He described his "tears" as one of respecting the value of the events that have occurred, and respecting the value of the impacts those events have had on all those people around him. Now I'm often defined as the "Corporate Head-Guy" – so I can come up with a whole lot of science to explain the uninvited presence of emotion. At the end of the day. I have never forgotten Georges' words, and that is why I share them with you. By the way; he lost over 45 friends that day.

Allow me to move on…….

On Friday October 31st 2008, I was participating in my regular morning exercise program. As a very keen cyclist I would regularly get up early, dress up in the yellow lycra, jump on the Shogun Team Issue road bike and pump out a few K's. Generally, I would do at least 30-40 although on some occasions, if I was really keen, I'd kick out somewhere around the hundred. For the trivia buffs amongst you there is a term in Cycling called a Centurion. When you are a Centurion that means you have ridden 100 Km's. This is quite an achievement in cycling circles and I was really quite chuffed the first time I achieved this milestone…. until someone told me that it is a term which originated from the US. Are you ahead of me? Yep….. It is actually 100 miles. Don't know what the term is for "not quite a Centurion". Someone told me it's the "Metric Centurion". Does not have the same "ring" to it, does it?

Anyway, on this particular morning I had arranged to pick up some monogrammed shirts to be used in a Conference I was conducting the following week in Jo'berg. At the last minute I decided I would incorporate a 90K bike ride into the pick-up.

At around 7:20 am I was happily cycling toward Newcastle, about 25k's from home, and decided it might be good to just call into Macca's for a skim milk cappuccino. Whilst moving toward a right hand turn I heard a "skid". That is ALL I heard! My mind had time to construct only one thought!

Oh Shit! Where did that come from?

How long does it take to say that silently in your head? Literally a second. Go on, have a go……Maybe two at the very most. So, what is the timeframe between becoming aware that something bad is about to happen, and potentially not being here any more. Not long is it? Anyway, as soon as my mind hit the question mark, the car hit me! I am, as I stand here speaking to you, fully aware of pretty much all that happened that morning.

At the literal point of impact, I was unconscious for a second or two. I say that because I still actually recall being struck, though my next memory is of being airborne. I was looking toward my left arm and instinctively knew that some significant damage had been done. The arm was in a very unnatural state and I knew it was broken. The only conscious thought, was more of a lament. One word. "Anne" – the name of my much-loved wife. At some point I would have obviously hit the ground. Clearly that knocked all the wind out of me.

I recall laying on the roadway, flat on my stomach, with my left arm out in front of my body. My head was laying on the road looking also toward the left-hand side. There was no real pain which I found curious, as part of me somewhere knew "things are not good". I found myself staring at my left-hand fingers, as they were only about six inches from my face. I just kept "wiggling" the fingers and was experiencing a profound level of confusion. "How could my fingers be working on command, when my left arm is stuffed – I think I used a different word"? I recall actually working through the fingers, one by one, just watching them do as they were told. At around this time I became aware I was a bit short of breath?

The curiosities came to an end when I started to hear quite loud voices around me. The most intruding was some guy, in what seemed like quite a frantic voice at the time, saying "hurry, we have to get him off the road". There then began a bit of a debate as to this; with the majority seeming to side with "removal".

By the way I suppose I should show you where this happened. It just so happens that at this time of the day there are lots and lots of commuters doing the run between Maitland and Newcastle. We would be talking tens of thousands. It is actually the most direct route between these two centres. Even today, six months down the track, when local people become aware of the accident, there are exclamations of "was that you". It seems everybody was complaining about it. They were all late for work! The number of people I know who actually "saw" me laying on the road, without knowing who it was, at the time, is staggering. My wife's hairdresser was visibly upset when he found out it was me; he had seen me laying there. Another example was when I had to instruct a Solicitor, as is want to happen in situations like this. The Solicitor came to our home and after introductions were made began to ask a few questions about the accident. Quite micro stuff, such as which way I was laying on the road etc. As it turned out, I had also delayed his trip to work that morning, although in this case he actually drove past quite slowly and managed to have quite a "good look".

Anyway, these bods are chatting about getting me to the side of the road. I have worked in the health system long enough to know DON'T MOVE. Somehow, I managed to find enough breath to express firmly "don't move me and wait for the ambulance!" Had to say this a few times and it seemed the message got through as that discussion seemed to cease. All sorts of things are being said around me and I have "zoned out". Staring at, and wiggling, my fingers again and knowing that there is something seriously wrong with the chest. At this stage not enough insight to put that bit together. That came later.

Again, I was drawn out of my Zone by hearing one word "Anne". It seems that somebody on the side of the road had decided to take a look at my bicycle. Clearly on the frame is the image (ICE 0411-252534 – Anne). For those of you who are unfamiliar with this, it means; In Case of Emergency. Somebody on the side of the road was about to use my ICE number. All I could think of was I did not want Anne getting this sort of news from a stranger on the side of the road. I pretty much thought there was no "good news" here. Again, I managed to puff out an instruction not to ring Anne; but to ring my sister-in-law, Cheryl (who just happens to be a Nurse). This was done and the Nephew – Tyson, answered the phone. It seemed Cheryl; was having a shower. Tyson knocked on the door and said to his mother "Uncle David's on the Phone". Apparently, the response was something like "Is it important, I'm having a Shower". Tyson came back and told me this (remember I'm lying on the side of the road with some guy holding the phone to my head – that head is filling up with endorphins). I told him something like "It is pretty f…ing important and give her the phone". Tyson (who is about 16) marched straight into the bathroom, pulled back the shower curtain, and said "He said its f…ing important". Mission accomplished – and I was stuffed. By now at least one penny had dropped – there was something very seriously wrong with my lungs – finding it increasingly difficult to breathe.

Who knows how much time has passed. I am back in the Zone – wiggling the fingers. Ambo's have arrived and the helmet comes off, the mobile phone is located etc. There are some chats amongst the Ambo's about getting the Chopper. Clearly, they are in a hurry to get me off their hands. It is decided that "lights and sirens" could do the job in ten minutes or so. Somewhere during this confab there is the usual chat about drugs. It seems the drug of choice is Medazolan. Known to be a quality muscle relaxant/analgesic and also have an amnesic effect. A pretty good combination given these circumstances. There is though a small group of patients who have an opposite effect. It improves memory and increases vigilance. Guess which prize I won!

For me that is about the time I was transferred to the Gurney and the lights went out.

So far, my friends you have, at least to some small degree, vicariously experienced some of what was happening to me as I lay on the side of the road, knowing I had been seriously injured. At this point unsure how much?

The next memory though is one that shall be with me forever. Not because it was particularly good or bad, or even painful (though is most certainly was!). More to the point it demonstrated a level of compassion that was exceptional beyond my experience. With all that is going on in a major trauma centre, the fact that a medical doctor bothered, shall forever touch my Heart. Oh, and I should mention by this time I am unconscious (or am I). I was still aware, and could hear, what was happening around me. Despite the eyes being closed, not talking or moving. You hear about those awful situations where patients say they were awake during operations. That's all I was thinking about. I was wanting to tell the attending's, "Hey, I'm here". I could not even blink an eyelid!

Anyway, I clearly recall a youngish male doctor lean down beside my head and whisper something to me. What he said was "I have no idea whether you can hear me or not. What I have to do now is going to hurt a bit. I'm sorry but we have to do this now and can't wait for the drugs to kick in". Well, he was sure right about that. I then experienced the most intense pain of my life, and I could not even blink an eyelid! What was happening? It may be that some of you might be ahead of the Story. The attending was cutting into my chest wall, and then with his fingers separating the muscles, and finally inserting a tube all the way though to the bottom of the left lung. Boy, did it hurt! That young guy did not have to say what he said. To all intensive purposes I was way past caring. Seemingly unconscious. At about that time the "fog" began to envelope me; that fog being pharmaceutically induced. The fog five-ten minutes earlier would have been helpful.

The remainder of the day is pretty much lost. It is interrupted by visits from my wife, and other members of the family. Apart from Anne, everybody else is lost in the fog somewhere. At this point I have no real awareness of how bad things are, or are yet to become.

Having been directly involved in the applied injury management field for much of my clinical career, I did have an awareness that things were "bad". One of my first conscious fears was that I was going to become a "rehab client" or a "pain client". That fear remains today. I am the first to admit that may not necessarily be highly rational; nonetheless very "real". Fortunately, or maybe unfortunately, for me, as an accredited injury management provider, I have sustained the highest successful RTW rates of any jurisdiction around the world. So, I suppose I know how this world spins. When in a situation like this though, the rational does not always defeat the irrational. The key is to acknowledge these sorts of situations with injured workers, and the "reality" of them, when operating inside injury management systems. Unfortunately, most workplaces, and insurers for that matter, invest their time in

trying to have injured workers' "fit" the System – rather than the other way around. Such an approach significantly impacts the success of the injury management program.

Anyway, let us move on! Some time early Saturday morning I became aware of someone leaning over the bed talking to me. As it turned out, this was an Orthopaedic Surgeon (Dr Smith) whose first words to me were "look at what you've done to yourself now". Oh……..., the power of first impressions. This guy had some ground to make up – I had not done this to myself! It had been done by a car travelling at over 70km/hr. This orthopod then went on to say that the damage was significant, and whilst he would try to save the shoulder, he may have to replace it. As far gone as I might have been, I knew that this was an outcome that would not be great.

Here's where things got really interesting. I asked him if he could get a hold of Dr Jones for me. He looked surprised and asked how I knew Dr Jones? The response I gave was that we shared patients in the past. Dr Jones is a highly regarded orthopaedic surgeon – mainly does backs though. This guy then went on to tell me that he'd trained Dr Jones. Bit of a mistake. My understanding, be it right or wrong, was that Dr Jones had received much of his training in some of the large US teaching hospitals. At about this point I was getting quite concerned about this guy, and asked for a phone. I am told I was quite adamant on this point. I proceeded to ring Anne at home and ask her to open my database and supply two phone numbers. These were for a couple of emergency service workers who were known to me. One of these (Fred), had recovered from shoulder surgery himself. Anyway, I rang Fred and before I'd said a dozen words he was on his way to the Hospital. I like to think under "lights and sirens", but I suspect not. Fred stands at about 6'5'' and can be a little imposing. In an emergency services uniform, with all the bells and whistles, the effect is even greater. I am told that Fred walked in to the cubicle, took one look at my inflated left shoulder, and then looked at Dr Smith and said "...and who might you be". Response was "I'm the Orthopaedic Surgeon". Apparently, a bit of a chat ensued which culminated in a question of sorts. "Are you a shoulder specialist". Response: "No, I'm a general orthopaedic specialist". "This guy clearly needs a Shoulder Specialist. Can you arrange that?" Conversation over.

Despite all that had happened in the previous twenty-four hours this was when the Good Lord decided to smile. It just so happened at that time there was a regional orthopaedics specialist conference occurring somewhere in the Hospital. Apparently, Dr Smith entered the Conference and offered me up on a Plate. A quick glance at the X-Rays and the queue quickly shrunk. That is how I became introduced to an exceptional orthopaedic shoulder specialist, Dr Ed Bateman.

I suppose now might be the best time, there is never a good time by the way, to share with you the extent of the injuries.

First off, I suppose you already guessed I had a punctured lung.

Next were the fractured ribs – all of them by the way. Some were flailed (broken both sides) and it was one of these that decided to visit my lung.

Next was the fractured humorous. This is the big bone in your arm between the elbow and the shoulder capsule – They counted eight fractures here (whilst suspecting more).

On top of that is what is called the Upper Tuberosity. Think of this as the ball on the top that sits inside the shoulder socket. This bit had about a half dozen fractures and was sheared off.

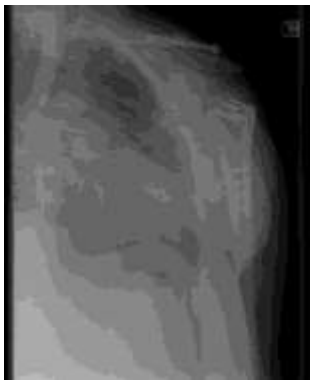
Next was the fractured clavicle (collar bone) – They counted four fractures there.

Next was the fractured scapula (shoulder) – They counted 2-3 here.

All in all, there were more than twenty-four fractures. They just said they s topped counting after that. Many of these were identified “on the table”. The surgical procedure went on for almost six (6) hours. To put that into some sort of perspective, quadruple bypass surgery often takes less!

Having done the “repairs”, Ed Bateman comes to me in recovery and explains what he has done. I retain parts of that conversation only. What stands out was his saying “you’re going to come across a lot of people telling you this is what you need to do for a shoulder; do the opposite. I had to be bit tricky in there, so it’s going to take time”. As it turned out some of the fractures had to be “sewn” in place. There was not enough stable bone to provide a platform for any hardware.

Oh !@#$!: Where’d that come from?



At this point I shall take a step back and deconstruct some of what has gone on here.

Before I do that though allow me to introduce something many of us are familiar with. The standard risk matrix. There are all sorts of permutations of this thing, but this one will do for now.

Let me go back to the accident itself, and specifically my own behaviour at that time. I was happily cycling away thinking through a whole collection of scenarios for the day and beyond. Having decided to break the trip with the Skinny Cappuccino I moved out amongst the traffic to make the right-hand turn, at the traffic lights, into the Macca’s driveway. Something I had done successfully an infinite number of times, by the way. It was during this manoeuvre that I got “squashed”.

So, lets have a look at some of this.

Before we begin, any Cyclists in the room. You might like to consider taking a short walk. Maybe we need to get the definition right first. A cyclist is somebody who has more bikes than they need. In my case I had the good road bike (that one got hit), the handmade Italian Olmo holiday bike (lovingly polished in the Shed) and the cheap Aldi mountain bike (gone to God as bits kept falling off).

OK…... Quickly let me explore with you the intricacies of cycling against a standard risk matrix.

What is the risk associated with riding a bicycle, responsibly to School (I know that can conjure up problems all by itself)? I am going to suggest to you that an accident is probably somewhere around “unlikely”. Some might say “rare”, given the number of kids riding to school each day etc. That’s one of the problems with applying a quasi statistical measure to this anyway. For the sake of the argument let us accept the “unlikely” position. For no other reason, than I’m the guy up here with the microphone. Now let’s have a look at the

Consequences. Someone on the left-hand side of the road getting "sideswiped" by a car is probably going to, at the very least, get some bark knocked off. It is not beyond the realm of possibility at all that they may experience multiple fractures, or worse. So, when we drop these on the Risk Matrix we find a Medium or High result. Depending on your personal or organisational view there shall be responses to these results, I hope.

Likelihood	Consequences				
	Insignificant	Minor	Moderate	Major	Severe
Almost certain	M	H	H	E	E
Likely	M	M	H	H	E
Possible	L	M	M	H	E
Unlikely	L	M	M	M	H
Rare	L	L	M	M	H

So now I am going to move our bicycle out across in front of the traffic. What we are doing is now placing ourselves amongst the traffic flow - in safety parlance don't we call this "line of fire". So, let us again consider the same questions. As we increase the level of exposure to the vehicles, it would be fair to suggest that we are also increasing the likelihood of something happening. So, if our previous rating here was "unlikely", we have to at least up the ante to "possible". Now if the event actually occurs, and we are now amongst traffic, the consequences too we would think are going to have to ramp up a bit. We are now almost certain to experience multiple fractures or death. I am hoping that most of us would consider this to be in the Severe category on our Risk Matrix. We are now looking at "Possible" and "Severe"; which gives us an Extreme risk. It is when we get up here we stop a process because the risk is unacceptable don't we?….. The process then is to integrate some sort of mitigation process. Now here's the rub people. Almost every road cyclist I know, including obviously myself, performs that manoeuvre a significant number of times on every ride we take. Why….when the possible outcome is so dire?

This leads me to having to further deconstruct these events. Firstly, let us talk about a construct which we shall call "risk tolerance". Now here we may be in for a bit of a surprise. Just try doing a phrase search on Google for "risk tolerance". You might be somewhat shocked to see that it's not about safety at all. We hit about 900,000 pages and they are largely concerned with the world of high finance. That, in itself, should be sending a shiver down the back of the neck. We can all see how well those guys apply the tenets of risk to their World. All of our communities, particularly our workplaces, as well as our personal superannuation, are bleeding heavily at the moment. Now if we factor into the Google search OH&S as well….oh boy … do things shrink. About two thousand (2000) – In the Google world that is a "nonsense".

Anyway, the idea of "risk tolerance" is roughly about how much uncertainly an investor can handle. There are a whole lot of factors that feed into that scenario and I suggest you hit Google if you want to dig deeper.

I want us to spend some time though considering this issue of "risk tolerance" from a personal safety perspective. My cycling example demonstrates, only too painfully, the outcomes that can occur through becoming too tolerant of the risks around us. As I have said, those of us in the cycling community tolerate this risk several times every time we take to the road. Our only protection is a piece of plastic we wear on our head. I shall show you what's left of my piece of plastic a little later.

So where does this "tolerance" come from. I suggest largely from our personal experience. We really do need to remember that we function within a community that measures its success so much differently than the rest of the World. Our success is measured by the

absence of events. That is critical, so allow me to try and say it in a different way. When something has NOT happened, then we are doing well. Try watching any sporting event and feeling that something really fantastic has been achieved when there has not been a result. I don't know about you…. I always feel a bit disappointed when I have watched a game of football and at the end of the 90 minutes we have a draw. In Rugby League, they even came up with a "Golden Point" rule; just to make sure "something happened".

So, when so much "stuff" is not happening, we very quickly become tolerant of all those risks that we "know" are there, but are not happening. After a while we may not even "know" they are there. They have been absent from our experiential frame for so long that they are filed in the "rainy day" category.

Now here's something a little scary! How do we know what is happening or not happening? Well yes, there is that thing about our personal experience. I had been riding a pushbike a few thousand K's for a number of years and never been "hit" before. The fact that I had never been "hit" before has absolutely nothing to do with the consequences that would occur should the "event" occur. My shoulder tells me that every day!

We are severely restricted in our ability to make informed decisions because of this question of "knowledge". I have lost count of the number of health professionals at John Hunter Hospital, who when advised what had happened to me, responded with "not another one". Does that place a whole new emphasis upon our Risk Matrix exercise earlier? It certainly did for me. We have to be careful though we don't "jump" the other way. The staff at John Hunter Hospital also have a biased frame of reference – they see the banged-up cyclists (or the outcome). They have no real understanding of "frequency" or "likelihood".

So, not only does the issue of "likelihood" bare no relationship to "outcome", our ability to make appropriate decisions about "likelihood" is significantly compromised. I refer to this as "Inadvertent Ignorance"; make no mistake there is nothing deliberate about this! The consequences though I shall carry for all time.

Allow me to take this position a few steps further……Where does our knowledge about "likelihood" come from. I have already suggested a large measure comes from this whole area of "personal experience". It also comes from, by the way, other sources. Again, cyclists chat amongst themselves. I have people pedal past my house, who I don't know, and wave. Maybe their seeming knowledge of my impact, impacts their knowledge to some degree, and just maybe one or two may modify their own behaviour due to what they know about me. I believe not, though. They are too often being reinforced by all that "stuff"; not happening. That is the more immediate reward. Here we might be thinking about some of the behavioural psychology literature about the impacts of immediate verses delayed rewards. Remember, when we get home in one piece, we do NOT see the absence of a system failure as a reward. The reward is we just did 87 km at an average speed of 34 km/h with our heart rate in the aerobic zone for 80%. If we are really keen we shall also take note of the cadence as well. Those are the "rewards"; those are the "outcomes". We do not even give a scintilla of thought to the "what might have beens". For a more thorough analysis of some of this "stuff" send me an email request and I shall forward the relevant documents to you.

We also develop this "knowledge", most unfortunately, from the media. Now that should scare us more than anything. Anybody who truly believes that the media provides unbiased reporting of news events etc has been living in a different world than I. Whether a "story" even makes the News is an issue. There are so many factors that impact this outcome as well. A couple of examples. Recently a young man of twenty-eight was killed when he was buried alive in East Maitland, NSW. He was apparently plastering the sides of a four-metre

hole which was to be used for horses to swim in – a plunge pool I understand. Hole collapses, he dies. I am not going to go near all the breaches that might exist around the failure to comply with trenching procedures etc within the process. Others shall pursue that course I am sure. What I am going to say, is that of the four (4) news networks that transmit into that area, only one even referenced this terrible fatality. If you had been watching the other three (3) you have no idea. No knowledge!

Another example would be the current issues around Swine Flu. How many days did it take to stop being the lead news story? What about the Networks who showed images of people wearing face masks as a barrier to being infected by Swine Flu. We could argue the pros and cons of that approach I am sure. My point is that some of that footage was a couple of years old. It was actually part of their "Bird Flu" archive. This is not a case of not reporting. It is clearly a case of fabricating aspects of the "story" to maximise the preferred impact of the piece. Our knowledge here is clearly compromised.

Now a defence that some people shall put up, quite reasonably I would suggest, is that as we gain more experience, and maybe "buy in" technical competence, our ability to make a more informed decision around these factors increases. That argument makes every bit of sense. Indeed, I travel the world based upon this quite reasonable belief. I am left pondering though,….. what type of risk-based decision making occurred when the Egyptian government decided it no longer required a pork industry, and ordered the complete destruction of all the pigs in the land. There was no evidence at all linking your common garden everyday porker with the transmission of Swine Flu. Despite that, a Meat Supplier in Sydney, during the same week, reported that they would normally deliver upwards of 80 dressed porkers per day. Their order book shrank to 4! We also now hear about H1N1 Influenza. Why, because the US Gov't expressed concern that continued reference to this form of Influenza as "Swine Flu" was affecting pork sales within the retail meat market. So even the name of this thing is politically influenced. I make these points to demonstrate, I hope, that much of the "knowledge" that we access as key components of our decision-making processes around risk, is potentially so compromised as to make any decisions emanating from those processes quite problematic; and prone to failure.

Now… I have given the example around cycling and my own accident, and more laterally looked at some associated factors which may well have contributed to my decision to perform an action that clearly had the potential to kill me, and nearly did. Allow me to suggest to you that we are at equal risk of these things happening in our workplaces, and they are happening. I only spoke to a National Safety Manager last week who was at a loss to understand why a well-regarded employee, was seen to be performing work at heights wearing all the appropriate fall protection devices. He just had not bothered fixing them to anything. The more we do something the more tolerant we become of the potential hazards associated with that "something". Do not make the mistake of believing that the more you do a thing, the better you are at doing a thing. If you are fortunate that might be true. It might be equally likely you just have not been bitten yet. You are prone to over-rate your competence which also feeds into this whole question of Risk Tolerance.

Now I shall return to the situation that has brought us together this morning. The fact that I was bitten so badly by the car that collided with me. When we were last here I was describing the Surgery. As a result, my left arm and shoulder are now heavily reinforced by surgical Titanium. There is also a bolt that was inserted into the Collar Bone to literally hold it together. If you take a closer look at the bolt you shall see that it seems a little larger than life. When I awoke from the operation and was attempting to review the changes, I did notice that I seemed to have a bit of hardware that actually appeared to protrude somewhat beyond

the skin. My suspicion had been a piece of metal, and the later X-Rays confirmed that. I remained curious as to why it was so long, and left it at that.

I also happened to be hooked up to all sorts of machines and had cables and tubes running all over the place. That, in itself, is quite distressing. Probably the most important tube at that time was the one leading to my right foot. It was hooked up to a Patient Controlled Analgesia (PCA) Unit and was feeding me straight morphine. This little beast was designed to allow me to choose to top up the "juice" every six (6) minutes. There was a countdown timer on the screen. I can tell you I spent a lot of time learning to count backwards. Now you are not supposed to OD using a properly calibrated PCA device. There is one particular day I recall where Anne visited, and all I did was sit in chair……. tubes everywhere….and rock myself gently in the chair…. counting backwards from 360.

The next ten days or so were a mixture of pain, awareness, fears, and questions. In the first week the highlight of my existence was being provided with a bed that was remotely adjustable, by me. Prior to that every time that Anne left, she would have to wind the bed in much the same way as you started a Model T Ford.

When you are laying in a bed, unable to do almost anything... the ability to raise or lower your pillow actually becomes a benchmark on the road to recovery. I am sure in times of difficulty you may heard someone say something like "don't sweat the small stuff". The meaning being that the little things are not worth getting upset about; it's almost like having to wait for the big things. Well I am here to tell you that I have experienced the "big things" – and was right in the middle of them. There was very little I could do about it. What I had some control over was the little things. So, an applied reality is, that in situations where the majority of our "control" has been removed, and I certainly was in that category, it is the "small stuff" that might show the way toward the bigger picture. So… do not automatically discard the "small stuff" …It needs to be given greater prominence in recovery. Sadly, our health systems deliberately pay scant attention to this "small stuff". In New South Wales it has recently been announced that all hospitals shall be directed toward the universal use of pre-packaged frozen foods.

This decision began ringing alarm bells for me. I am reminded of a Kitchen Overseer who was in charge of catering at the Maitland Correctional Centre quite some time ago – this was a maximum-security prison. He suggested, and this has been confirmed by every Custodial Officer I have ever met, that if the food was "ordinary", or there was not enough of it "expect a bad day". Now I am not saying that a prison and hospital are the same, although the French philosopher Michel Foucault might argue differently. They would both be defined by his nomenclature as "Total Institutions"

The NSW Minister of Health may not consider the quality and volume of food as being a high priority. Indeed, he has been quoted as saying that "the efficiencies we obtain shall release funds for other frontline health services". Now we all know "efficiencies" means "cheap" ….. and "front-line services" might translate to "operations, nurses, doctors etc". So, what we do is remove the "small stuff" to spend more on the "big stuff". Make no mistake please, I am not saying that this is not a difficult area to manage. It is……..., and because these health systems are dealing with ourselves and our families they are always amongst the most emotive in our communities.

It is often said though that you are safer at home than in Hospital. Well of course you are! When you are in Hospital your health has been compromised by some illness, disease, accident etc. Let me put this another way. You are safer at home than in Hospital. Not because you are ill…because you are there. In the United States more people die as a result

of their hospitalisation (not their illness, accident, disease, complications etc) than do from Motor Vehicle and Workplace Accidents, Suicides, Falls, Poisoning, and Drowning combined. These are what are called “preventable errors”. The Washington Post reported on April 8th last year that between 2004 and 2006 there were almost a quarter of a million people (240,000) who died as a result of errors. To put this into perspective this is around three percent (3%) of all admissions – that is a pretty big number! Remember these deaths are not the result of the illness etc that put you there. They are all determined to have been “preventable”. A smaller number are actually deemed negligent. Now if we add in those persons whose illness etc are actually made worse due to their hospitalisations, and the preventable errors that become part of their treatment, that number well exceeds the millions.

Unfortunately, when I return to my own experience I find that the health system generally does not like some of these questions. I am the sort of guy who likes to know what is going on around me and I certainly admit to having a very keen interest on what people are doing to my body. This is called Health Locus of Control and I have it in spades…….. So, whilst the care and compassion from the nursing staff was, for the most part, exceptional, a number of the doctoral fraternity clearly were challenged by some very basic questions. An excellent example of this was when I asked something about the oxygenation levels in my blood being a bit low and we were more than a week post surgery. It certainly seemed that this was not something that was expected from a patient, and fair enough I suppose. There was no semblance of an attempt to answer the question. The lead doctor actually ignored the question; there were a number of interns modelling their patient communications from this one.

Now amongst this little flamange of medicos there was one guy who seemed to be standing back. I had certainly seen him running around the Ward, and my observation had been that the nursing staff, as well as the other interns, seemed to treat him a little poorly. As it turned out when I had asked that question the attending, whilst ignoring me, sent the intern back to deal with it and complete a very basic psycho-social history…… I am reminded here of my early days as a Metallurgist at BHP in Newcastle, where we would send an apprentice off to the Store to locate a set of left-handed screwdrivers……. Anyway, this Intern comes in and we have a good chat and he answers my questions appropriately, and with some genuine interest. We get to chatting about a whole range of things, as I have been told I am prone to do. Anyway Jack, as I shall call him, was in his late 40’s and I was curious as to why he was an Intern. Jack went on to tell me that he had completed all his medical training within another country and to gain his medical license for Australia he had to complete twelve months in an Australian hospital. We were quite comfortable chatting away so I offered my observations about the “treatment” I had observed on the Ward. Jack was well aware of this and said it did not worry him too much. He was doing what he was doing for his family and he only had six months to go. Jack clearly did not fulfil the expected role of the sycophantic intern following the attending for any morsels of “wisdom” that might fall off the white coat during the Grand Rounds; and he was treated accordingly. By the way Jack was an Associate Professor, had actually been the administrator of a major teaching hospital, and was a leading paediatrician in his own right. Says something about the culture of vertical autocracy which is known to exist within primary health care. Also exists by the way in many of our workplaces as well.

Another example would be the night that my blood pressure started doing a few funny things and the temperature started climbing. Now one of the risks associated with my injuries, and the treatment I had received, was the likelihood of infection. As I was on hourly “Obs” one of the nurses expressed concern about the temperature rising and then the shift ceased. When the next Nurse turned up to take the “Obs” I asked about the temperature. She looked

confused. Now this is not the time when you want to have a detailed knowledge of the factors that contributed to Texas City blowing up. One of those by the way was around communication failures at shift handover. Now, whilst of course I knew I was not going to "blow up", I certainly was concerned about both infection and pneumonia. Remember I still have a tube drawing fluid out of the lungs, and pneumonia was a genuine risk. I expressed these concerns and was told "don't worry". I am in a hospital bed, unable to perform any independent functions, totally reliant upon the practices and services of somebody else (essentially helpless); well "don't worry" is not going to cut it.

The organisational response was, for the first time, to close the room door. This had not been done since I had been moved to that room! The organisational response was to ignore the call button that I pressed after ruminating for nearly an hour as to whether I should or not (I had already become conditioned about the "use" of the call button) – I think about twenty minutes later somebody stuck their head in with the "are we OK in here". Somebody different by the way; just walking past. Admitted to having no knowledge of my circumstances – that should be scary! I don't know about you, but I always find the use of the royal "we" a little patronizing. Anyway, I think I responded by saying words to the effect of "you might be well, but it appears I may not, would you mind getting the Doctor for me". Response "Now, why would we want to do that, they're very busy you know". Anyway, Dr finally arrives and we have a chat, he has a good "listen" to the lungs, and he agrees to call in again before he leaves in the morning. By the way we indirectly knew each other, more about that in a moment. Oh….. almost forgot, the next organisational response. First thing the next day I am relocated to a room that is the furthest possible from the Nurses Station…and not in the car park……. there I was to stay until discharge. How would you interpret those responses? Context is everything!

The organisational response that had the most impact, by the way, was closing the door. Now that is coming from a guy who travels extensively, deals with senior people in some very big organisations, has to adapt to both 5 star and ½ star accommodations, all sorts of working environments etc. When it comes does to it, it is being "cut off" that is truly damaging. For them it was clearly "out of sight, out of mind". I am absolutely certain that the person who made the decision to "close that door" had no intent to cause distress. It just seemed the expedient thing to do at the time. The "easy" thing is not always the "best" thing. Remember our exploration of the "small stuff". In our world of Safety, we do tend to focus upon the macro, I would suggest we need to be submitting equal attention toward the micro.

As our time together draws toward a conclusion, I shall just make a comment about an aspect of "culture" that exists within our health system, and also within our workplaces in general. That is the willingness to turn a "blind eye" to stuff that is happening around us. When I conduct safety culture analyses, of some pretty large businesses, one of the items is: -

- "when I see someone doing something unsafe I shall always step and say something to them".

Now I am sure most of us in this room would probably say yes, in an instant! My question is, would we do so if it meant our job? Would we do so if it meant we would be ostracised from our colleagues? Would we do so if it meant being a witness in a formal proceeding? Would we do so if it meant we would be labelled as a "whistle-blower".

I would suggest that at least some of us are reconsidering our position. We are now conducting our own internal risk assessments. We are deciding what level or risk we are willing to tolerate. We are potentially saying things similar to "nothings happened, no-one got

hurt, so why rock the boat"? We are possibly becoming tolerant of what we see going on around us. In all likelihood a larger number of us shall keep our tongue behind our teeth, and actually not speak up. If that all sounds a bit far fetched, let me tell you that it has been shown that over fifty percent of health care workers have admitted to not reporting errors or breaches that they know that they are obligated to report. Now, before we say how terrible these people are, let us consider their employers for a moment.

In the US, hospitals, nursing homes, and other facilities that use medical devices, are required to report to the FDA all deaths caused or even possibly caused by medical devices. Not even "people", they get to blame the tools, so to speak. Guess what? They don't report!! Susan Gardner, the Deputy Director of the Office of Surveillance and Biometrics says she receives about 4,000 of these reports a year. There are 40,000 to 50,000 facilities covered by this reporting requirement. So, I contend that much of what our operational people are doing, or more to the point not doing, is heavily influenced by what they see going on, or not going on, around them. In our world we might call that Safety Leadership.

Now it is not that difficult to focus the microscope of safety culture and leadership on the health system. My own internal participation within that System made that inevitable.

When you see these sorts of behaviours being played out daily inside organisations which aspire toward "High Reliability", you cannot help to be more than a little concerned. These are systems in which we often place our absolute trust, and certainly our families. To the credit of these Systems they do recognise many of their challenges and are exploring various interventions to try and improve performance. Unfortunately, as long as we, as a community, express greater concern about hospital waiting lists, than we do about optimal safe practice and culture then the System shall respond by doing all that it can to deliver that result. If that means they take "short-cuts", massage data – to the point of fabrication, tick and flick their process checklists, turn a "blind-eye" and eventually normalise the errors around them, and operating to excessive productivity targets (doing too much with too little); these Systems are really going to be rowing heavily against the tide.

Before I conclude this morning, please don't make the error of believing that because many of us in this room are not working within primary health care, that these factors do not apply to our own work environments. They Do!

- The Commission of Enquiry into the Nius Island Helicopter fatality identified a culture of shortcuts at HMAS Albatross. Whenever I conduct a Safety Culture review one of the factors which comes to the surface is the question of shortcuts. They continue to be more prevalent than you would imagine.
- If you use LTIFR you are using a metric with minimal value. We all know about the extreme efforts to keep people at work, "licking stamps" if necessary, to avoid lost time. We all know about some workplaces "sheltered workshops"; where the "rehab" people get to sit and play cards etc. Some companies have the injury management bod at the surgery/hospital before the patient. Let me tell you, that's not entirely care and compassion. Looks a bit like "massaging the numbers to me". Oh, and by the way, if your company kills someone, don't worry too much, the stat does not appear within LTIFR so your OK.
- Those of you who use Step-Backs, Take-5's, or other checklists…....be careful. Again, when I conduct Transformational Focus Groups we regularly find significant percentages of the workforce saying they "tick and flick" them. Why…...because they do not see any useful reason for them…they are often right…. that's a significant story for another day.

- We often see the normalisation of error when we conduct incident investigations. Apart from the employees who often comment with words to the effect of "I thought something like that might happen"; they too had chosen not to say anything. It is quite likely they have never been asked by the way.
- Finally, we have the question of resources. Right now, in the World everyone appears to be savagely cutting back their employees. In many cases they are not necessarily reducing the throughput of the process. They are trying to punch out just as much with less. The essence of improved productivity it would seem. We are also cutting back those services that are designed to support the effective operation of those employees. We are going to see injury rates and deaths increase I am sure – sadly many of the people making these decisions are unlikely to have the task of walking up a driveway to tell someone their mother, father, son, or daughter is not coming home – EVER!

I personally am observing that employee training and safety seem to be the key targets…I know many of you know that already…indeed I can see from the number of delegates here today that it is an issue many are confronting. In the last few months I had been booked to present at the World Engineering Conference Safety Stream in Bangkok and the Roundtable OH&S Forum in Dubai. Both did not happen. The Bangkok event was billed as the worlds largest single meeting of Engineers – that in itself is scary. Only one "stream", the safety stream, was cancelled. What is the take home message here…….? As for Dubai, the worlds richest petro-dollar community could not find a flight sponsor!

Now we know this is also hitting us at home. I have recently conducted an Integrated Safety Culture and Leadership Analysis for a leading business within Australia. The intervention took almost twelve months to complete (interrupted by my accident) and at the point where it was time to deliver the 200+ page review; which explored all the micro improvement opportunities for the business…the advice was that such would have to occur over the phone. The barrier reported being an airfare worth a few hundred dollars.

As long as these sorts of things are seen to be happening, at the same time that our businesses are loudly and proudly spruiking their commitment to OH&S as being the "No 1 Priority", the disconnect between word and deed stands out like a beacon. It is with the greatest of regret I see some very skilled, knowledgeable, and well remunerated business leaders not seeing the beacons so obvious to the operational workforce itself. The Iceberg of Indifference is well hidden by the fog.

It has been said "that if all you have is a hammer in your hand then every problem looks like a nail". Maybe that is what is going on here.

Or maybe, just maybe, with all these pressures embedded within our structures, coupled with the more recent "pressure to perform" to unrealistic measures of "achievement", we are just becoming more tolerant of the Risk.

THANK YOU