

WORK PLACE SAFETY: IS IT A HABIT?

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Prelude

Anup Goswami, Vice President (Human Resources) at Eastern India Shipyard Limited sat at his table staring into space, numb with shock. He tried to gather his thoughts and do his job. His hand trembled as he reached out to his phone to call the wife of his colleague, Nitya Natarajan. At times like this, he wondered, why ever he had chosen Human Resource Management as a career.

It's not a normal day

Sudip Guha looked up at the slate gray sky

dotted with specks of angry cumulonimbus cloud as he made his way to punch in his attendance at the Eastern India Shipyard, Kolkata. He was pleased that the weather looked reasonably fine and that there was only a gentle breeze, considering that it was July. Normally he would have expected steady rain and a stiff breeze blowing across the river Hooghly, on the banks of which the yard was located.

The shipyard established in 1950 catered to building small boats, tugs, and fishing trawlers

and a repair yard and had seen better days. Hugely successful at its genesis, the yard had fallen prey to militant labor unions, the ship construction industry moving to cheaper locations in South East Asia and a general apathy in adopting modern work practices. EISL has modern infrastructure like floating dry dock of 50000 DWT, three wet repair jetties of 200 meters, two outfitting berths. It had a water area of 40000 sqm. on the river front and 20000 sqm. of land area housing its office blocks and heavy workshops, paint shops and fabrication yards, DG sets and other allied plant and equipment. Its material handling arrangements include 2 heavy portal rail cranes of 35T and 50T, 4 dock cranes & a 30 T-mobile crane.

From 2005 to 2010, the yard had to lay off about 200 workers and its strength had seen a manpower dip from 500 to 300 workers as orders for new constructions stopped coming in and the order book for ship repairs also dried up. Worse the workers had split between supporting rival trade unions with major ideological differences. The downsizing inevitably had brought the labor unions and the management to a face off, which further caused the situation to deteriorate leading to a tense climate.

Guha was worried about the weather because as the Crane Operator for the shipyards thirty ton (30 T) Mobile Crane he knew that adverse weather conditions would make operation both dangerous and could delay the progress of work. His shift supervisor Prafulla Kumar Dey, a huge lumbering veteran at the yard had already told him that they were way behind schedule on the new construction, a fishing trawler, with a

refrigerated plant on board and that they would have to get a pre-fabricated unit in place immediately. For this to happen, Guha and the crane were needed. The construction was very important because the yard was not in the best of health and the grapevine indicated that the owners were threatening to sell the yard to a foreign shipping firm. It was feared that this would mean further job cuts and most employees were afraid for their jobs.

Guha changed into his orange overalls and caught up with Dey, who would instruct him on the job at hand. Dey a normally jovial man angrily sucked at a cigarette with a scowl on his face as he conversed with the supervisor of the rigging shop, Ranjan Roy. There were reports that some of the equipment was not being maintained properly and he was upset as his team was the end users of the equipment. The rigging shop was expected to maintain all lifting equipment, cranes, blocks and tackles.

As Guha arrived, Dey turned his attention to him and told him that a twenty-ton prefabricated unit would have to be put into place, starting in the next hour or so. Dey also said that they should get the job completed as soon as possible as he expected the weather to worsen as the day wore on. Dey was also a little worried as he had had a few arguments with Guha about the latter's drinking. While Guha had not been caught drinking within the yard premises, he had on occasion come in looking disheveled, uncoordinated and had spoken in a slurred voice. He was also known to get aggressive when under the influence of alcohol.

Dey was well aware of Guha's love for liquor as

about ten of the workers frequently met at weekends for some serious drinking and on many occasions, Guha would pick a fight with his colleagues on trivial issues. He had once told Dey that he was a poor supervisor and did not know his job. The following day Guha would arrive for work as if nothing had happened and all would be forgotten. They had met the previous day and Guha had had his usual fill, before staggering off home supported by two other colleagues. Now as he talked to Guha he noticed his bloodshot eyes and a faint smell of liquor. He received a curt nod from Guha when he asked him if he was in good health and fit to operate the crane. Dey swore under his breath and flung the still lighted cigarette into a nearby trash can. He knew it was a fire hazard, but then he did not care?

Safety as a culture

As profits dipped at the Eastern India Shipyard, so did safety. Over the next five years, there were at least three major safety incidents and over a dozen minor ones. Just a month earlier a welder had been electrocuted, when he had not earthed his equipment properly and was welding in a damp area. Fortunately, the welder was young and healthy and had survived the electric shock. However, he had been advised two months of rest and was away from work, causing a temporary welder to be hired at a fair cost to the company. An inquiry had shown that many of the welders did not follow safety regulations or even wear adequate Personnel Protective Equipment (PPE). Safety shoes issued to workers were sold outside to the plant to the general public at a discount and the yards safety

manager turned a blind eye as he feared the workers and their unions.

The safety culture at the yard was poor and safety incidents were neither reported nor documented by supervisors. Workers who ignored safety were neither warned or even cautioned causing the safety standards to be very low and a general feeling of neglect towards safety prevailed. Deepak Das, the Manager (Safety), reported to the General Manager (Operations) and his views were not taken seriously, so much so, that he rarely had an opinion on anything. Das rarely left his office and was the butt of many a joke in the yard.

The management had "Safety Committee's" in place as specified by the Factories Act 1948, but these committees rarely met or deliberated safety issues. The Safety Committee and the Human Resources Department were to draw up a training calendar in consultation with each other catering to safety training. However as the management did not want to spend money on training, safety training was not carried out for any of the workers, though many of them were carrying out jobs that included dealing with hazardous chemicals and noxious gasses. Neither, the management, the workers nor the union were really concerned about safety and a safety as a culture was not in place or were attempts made to put it in place. (See Table 1/2/)

Safety Audits were rarely held on site at the yard and safety issues were not discussed. This reluctance to audit the safety system in place served to increase the gaps in safety. Minor accidents or 'near misses' which were to be reported were ignored or laughed away.

Housekeeping was extremely poor, tools were not maintained and workers did not receive training in the proper use of equipment and safety practices.

When things go wrong

Sudip Guha took a deep breath and commenced his steady climb, up the 30-ton crane ladder. He would have to climb about twenty meters vertically after which he would reach his operating cabin at the top of the crane. As he climbed he felt a gust of wind tug at his overalls. He was concerned. Was the wind picking up, if so, that was not good news? Lifting heavy loads in strong and gusting winds was ill-advised and dangerous not only for the crane but a safety hazard for those working below.

On reaching his cabin, Guha was upset to see that the earlier operator had not closed a window properly and overnight rain had entered the cabin leaving wet patches all over the cabin. He cleaned up the cabin as best as he could and tried out the crane controls. He found them fine and signaled to his supervisor Dey below that he was ready to go. This was another issue that he and Dey had argued about over the last few months. Guha found communicating by hand signals tiresome and difficult and had requested Dey to get a Walkie Talkie set, where they could communicate one on one with greater clarity. Dey had taken this up with the management but the suggestion had been shot down as too expensive and unnecessary.

After checking with the rigging supervisor, if the unit to be lifted was ready, Dey whistled to catch the attention of Guha and signaled for him to start rolling. Guha slewed the jib of his crane

around, flipped the klaxon switch on and gently eased the crane along the tracks. To his chagrin, he noticed, that the klaxon did not work. This was serious and anybody on the crane tracks would receive no warning and be caught unawares by the moving crane. Safety regulations clearly stipulated that a crane was not to be moved without a working audible alarm (klaxon). Guha was agitated and stopped the crane in its tracks, signaling to Dey below that he would not be able to operate until the klaxon was repaired.

Dey was perturbed by this new development. Guha was right, but he needed this lift to be completed at the earliest as he felt the weather conditions were worsening and there were reports that they would have rain and strong wind for the next two days. Dey cursed and looked up at Guha. He would have to meet Guha in his cabin to have this sorted out. Dey got the on shift electrician and made the climb to the top of the crane with the electrician.

Apparently, rain water had short-circuited the klaxon system and it would take at least another two hours before it could be repaired. This delay was unaffordable as far as Dey was concerned. He had to persuade Guha to get moving. Dey told Guha that he too was concerned with safety but they needed the job to be completed in the next one hour and they just could not wait. He went as far as to say that as Guha's supervisor he was responsible and Guha should just go ahead. Guha was unhappy but felt obliged to Dey, for bailing him out of sticky disciplinary situations. He reluctantly agreed. Dey silently sighed and descended the crane. At last, they were

underway.

The crane silently rolled over the tracks, a short distance of about three hundred meters and the load hooked on to the lowered hook of the crane. The weight of the piece at twenty tons did not worry Guha. The wind was freshening and getting stronger and he was apprehensive but decided not to voice his fears. He felt that there was no tangible use in doing so, as Dey would not listen to him. Guha waited for the signal from Dey and on receiving the lift signal, he operated the appropriate lever and soon got the load in the air, waiting for Dey to give him clearance to move.

Dey signaled his assent and the crane began to roll gently. Guha noticed the load swinging in the breeze and he prayed nothing would go wrong. After they had moved ten meters or so, the swing was more violent as the wind gusted and suddenly with a sharp crack and violent heaving of the crane the load fell. Apparently, the wire rope sling lifting the unit had sheared and broken. In his panic, Guha moved the crane away from the crash. It was a tragedy all around. The broken sling had severely injured the Vice President (Repairs) Natarajan who was walking by and as Guha had moved the crane, he had run over a worker on the tracks, injuring him seriously. Natarajan had recently joined EISL as Vice President after a successful tenure on board ships as a Chief Engineer and then worked as General Manager in a repair yard in Singapore. Forty-Six year old Natarajan had a young wife and two small daughters.

Those involved were shell shocked. Dey was speechless and Guha was shivering with fright.

How had this happened? Dey looked around at the carnage. How would they explain the possible death of the Vice President? Whose fault was it? What were they supposed to do now? The sound of the crash had attracted enough of attention and a crowd was beginning to gather at the site. The Vice President, Human Resources, Anup Goswami and the Safety Manager, Deepak Das soon arrived as did representatives of the unions. Somebody realized that Guha was still up in the crane, and had to be brought down. The Vice President (HR), called the in - house doctor down to the site even while he requested a local hospital for an ambulance and medical help. The doctor arrived almost immediately and declared Natarajan dead from his severe head injury.

Goswami asked his Deputy Manager to take care of the situation, while he returned to his office and immediately called the Superintendent of Police for the area. There was an emergency and he needed a police force to reach the yard immediately. Goswami placed Dey, Guha and Ranjan Roy under suspension, pending inquiry and asked the yards security to escort them to his office and give them protection till the police arrived. The unstated fact was that the suspended men and the injured worker belonged to rival unions and he feared for their safety. They could be lynched in this volatile situation. Goswami then picked up the phone to call Nitya, Natarajan's wife to convey the sad news. He had debated driving down himself to Natarajan's house, but the volatile situation at the yard precluded him from doing so. He had called his wife and had asked her to

visit Nitya immediately and provide immediate help. His wife and Nitya were good acquaintances having met at office functions.

He had also placed a call to the family of the injured worker – Sumeet Pal and told them the nature of the accident and that Pal was being shifted to the nearby Port Hospital for immediate treatment. He assured them that EISL would take full responsibility for the treatment of Pal.

The aftermath

A full-scale domestic inquiry into the incident revealed that the lifting sling that had given, was not load tested or maintained and was unsuitable for the given task. The rigging supervisor and his team had been negligent, in maintaining the equipment.

Prafulla Kumar Dey, who should have checked the equipment, was also found guilty of negligence.

Sudip Guha was accused of being under the influence of alcohol and not taking a firm stand on issues of safety. The charge that he was drunk could not be proved but was found guilty of committing unsafe acts.

The Manager (Safety) was found to be inefficient.

The four employees were dismissed and the dead Vice President compensated as per the Workmen's Compensation Act 1923. It was on the grapevine that one of the trade unions wanted to take the CEO to court over poor safety conditions and lack of proper maintenance of lifts and hoists. This was avoided by Goswami

negotiating an out of court settlement with the union and the family of the injured employee. The out of court settlement was in addition to the compensation that he had received. The inquiry committee made some caustic comments on the lack of safety in the yard and the need to establish a safety culture. The management's role in this endeavor was stressed. The management for their part brought in an experienced Safety Manager, who had completed a five-year stint at a shipyard in the Middle East and was known to be a stickler for safety practice. It was hoped he would turn safety at Eastern India Shipyard around and workers would return home safe at the end of the day. The position was upgraded to Chief Manager – Safety and reported directly to the CEO.

Safety Manager: Change in the air

The new safety manager changed the yards culture towards safety with a new initiative which was a scientific behavior-based approach. In essence, the new approach proactively focused people's attention on sets of unsafe behaviors that are commonly associated with an organization's historical accident record. This was achieved by examining the organization's fatal accident records, near-miss reports, and risk assessments, to develop a measure of safety behaviors for each work area involved in the initiative. This measure was then used by workgroup based observers as a means of monitoring ongoing safety performance. The first few weeks of data were used to discover each workgroup's current levels of safety performance, to enable a baseline to be

established, which was then used as a comparison point for future ongoing safety performance. The baseline was also used as the basis by which safety performance targets are set by each workgroup. The results of ongoing monitoring were then feedback on a regular basis to the workgroup so that remedial and corrective actions could be taken. Although it was felt that long-term changes in behavior take time to achieve, it is possible to raise standards of expected behavior in the short-term, and achieve that standard. To do this, however, requires an intense and highly visible safety presence on the plant which the new safety culture sought to achieve. The new safety manager constituted safety committees and scheduled safety meetings to discuss safety issues and action plans. Safety Committees were constituted by employees from across the hierarchy and were expected to address safety issues in a systematic and planned manner. Loss of work-days due to accidents was proactively targeted. The safety manager set a baseline benchmark of 2.0 accidents for every 200,000 working hours which while ambitious, set the stage for lifting safety standards.

The new safety policy focused on the following areas in trying to alter the culture at EIS:

Workmen were to be properly trained in having a proper understanding of all equipment that they

were to use. The training extended to safety measures associated with the equipment, which included all machinery, cranes. Welding and cutting gear as well as lifting gear like slings and hoists.

Supervisors were expected to improve housekeeping and take good care in disposing waste material from bins, which included oily rags and other inflammable material, at regular intervals. Supervisors were also advised to ensure a strict compliance in use of Personal Protective Equipment which extended to the use of hard-hats, safety shoes, overall's, and safety harnesses. Those working in noisy areas were to wear ear defenders. A zero tolerance policy was enunciated towards non-compliance in this regard.

With this proactive approach safety figures improved substantially at the shipyard and a safety culture was established which had a multiplier effect in terms of productivity as worker morale rose substantially.

Eventually, it was understood that there is no one magic bullet to take care of all safety issues and it required a calibrated and well-planned safety strategy with strong management support to improve the situation at the shipyard. Safety is indeed a necessary habit and is a major component of organization culture.

11 Manufacture of Beverages	6	31	-	1
12 Manufacture of Tobacco Products	1	7	-	-
13 Manufacture of Textiles	35	1003	2	9
14 Manufacture of Wearing Apparel	7	7	-	-
15 Manufacture of Leather and Related Products	3	14	-	6
16 Manufacture of Wood and Products of Wood and Cork, Except Furniture; Manufacture of Articles of Straw and Plaiting Materials	3	36	-	-
17 Manufacture of Paper and Paper Products	21	139	-	6
18 Printing and Reproduction of Recorded Media	1	11	-	-
19 Manufacture of Coke and Refined Petroleum Products	6	33	-	-
20 Manufacture of Chemicals and Chemical Products	86	461	8	6
21 Manufacture of Pharmaceuticals, Medicinal Chemical and Botanical Products	19	110	-	1
22 Manufacture of Rubber and Plastics Products	13	176	-	5
23 Manufacture of Other Non - Metallic Mineral Products	35	115	4	-
24 Manufacture of Basic Metals	129	372	1	1
25 Manufacture of Fabricated Metal Products, Except Machinery and Equipment	51	248	1	-
26 Manufacture of Computer, Electronic and Optical Products	5	41	-	-
27 Manufacture of Electrical Equipment	7	112	-	2
28 Manufacture of Machinery and Equipment N.E.C.	8	281	-	4
29 Manufacture of Motor Vehicles, Trailers, and Semi-Trailers	6	44	-	1
30 Manufacture of Other Transport Equipment	17	217	-	2
32 Other Manufacturing	17	221	-	2
33 Repair and Installation of Machinery and Equipment	1	305	-	5
35 Electricity, Gas, Steam and Air Conditioning Supply	50	246	4	11
36 Water Collection, Treatment and Supply	-	1	-	-
45 Wholesale and Retail Trade and Repair of Motor Vehicles and Motorcycles	7	190	-	1
46 Wholesale Trade, Except Motor Vehicles and Motorcycles	5	22	-	1
47 Retail Trade, Except Motor Vehicles and Motorcycles	1	2	-	-
52 Warehousing and Support Activities For Transportation	-	3	-	-
58 Publishing Activities	-	1	-	-
59 Motion Picture, Video, and Television Programme Production, Sound Recording and Music Publishing Activities	-	3	-	-
84 Public Administration and Defense; Compulsory Social Security	3	50	-	1
94 Activities of Membership Organizations	8	13	-	-
Total	653	4996	29	84

Source: Ministry of Labor & Employment – Govt. of India (ON677 - 2012)

Table 1: Fatal Accidents

Causewise Number of Fatal Accidents in Non-Coal Mines in India(2002 to 2010)									
Causes	2002	2003	2004	2005	2006	2007	2008*	2009*	2010*
Fall of Roof	1	1	2	1	0	1	2	4	0
Fall of Sides	10	7	12	5	9	8	12	11	11
Other Ground Movements	0	0	0	0	0	0	0	0	0
Winding in Shafts	0	0	0	0	0	0	0	0	0
Rope Haulage	0	0	0	0	0	0	0	0	0
Dumpers, Trucks, etc.	10	13	18	12	17	19	13	10	5
Other Transportation Machinery	3	2	3	1	2	6	3	1	3
Non Transportation Machinery	6	6	6	9	5	7	5	5	6
Explosives	8	5	3	4	3	2	2	2	2
Electricity	1	3	2	0	0	0	2	0	0
Gas, Dust, Fire, etc.	0	1	0	0	0	0	2	1	0
Fall of Persons	10	11	6	13	15	8	10	3	4
Fall of Objects	2	3	3	2	7	3	2	5	10
Other Causes	1	0	2	1	1	2	9	2	4
Total	52	52	57	48	58	56	62	44	45

Note: *: Data for the year 2008 to 2009 are provisional and data for 2010 are up to 30.09.2010.

Source: Ministry of Labour & Employment, Govt. of India (10889), (11536) & (12510)

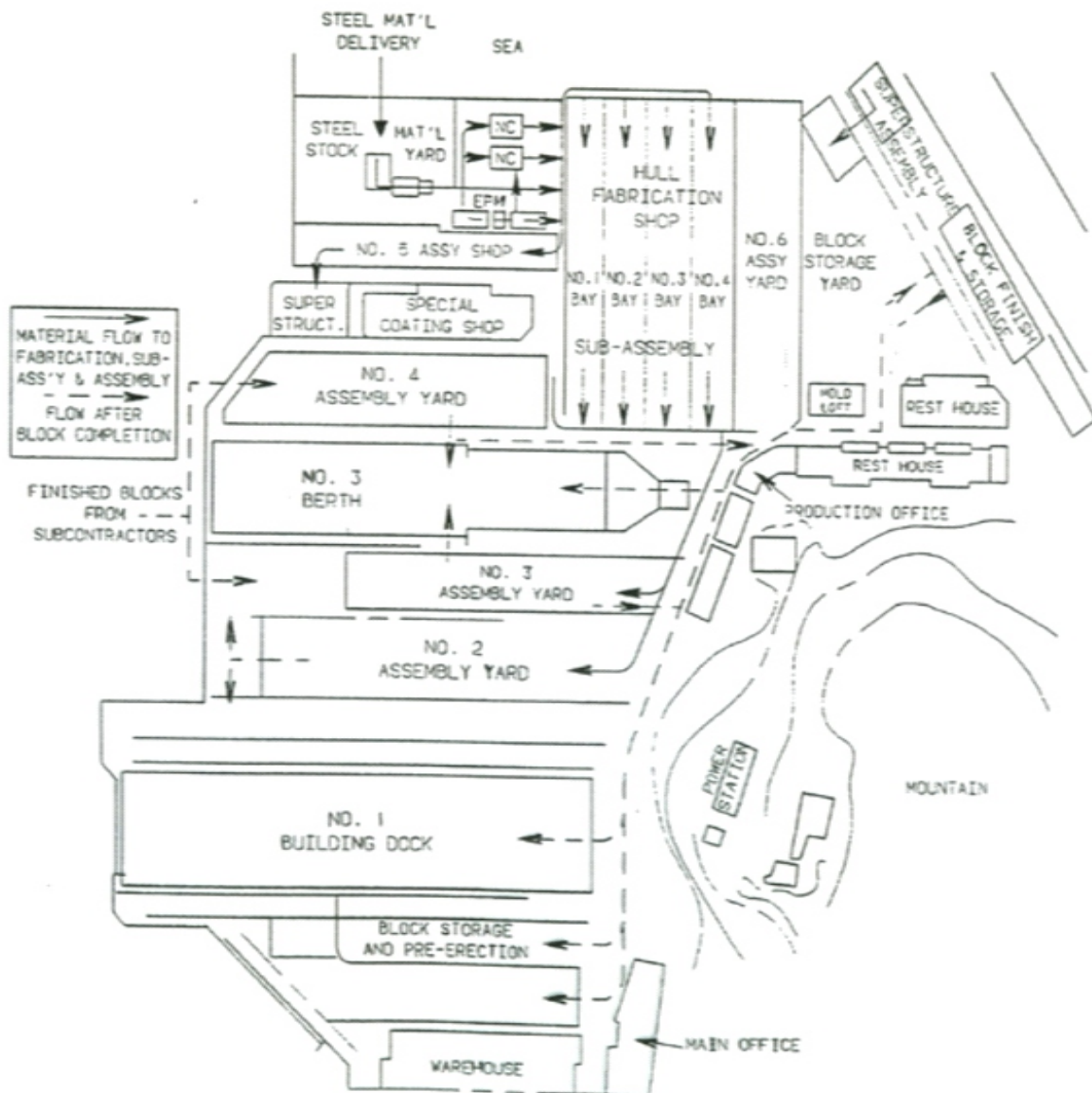
Table 2: Industry Wise Accidents 2012

2012	Adult			
	Men		Women	
	Fatal	Non-Fatal	Fatal	Non-Fatal
01 Crop and Animal Production, Hunting and Related Service Activities	2	5	1	1
02 Forestry and Logging	1	-	-	-
05 Mining of Coal and Lignite	2	3	-	-
07 Mining of Metal Ores	-	1	-	-
08 Other Mining and Quarrying	5	1	1	-
10 Manufacture of Food Products	92	471	7	18

A small shipyard would necessarily constitute the following units in the building yard:

1. A steel stockyard
2. A steelwork hall
3. An Outfitting center
4. A pipe shop
5. A general-purpose shop
6. A paint shop
7. A warehouse
8. A units and blocks storage area
9. An erection area consisting of three platforms
10. Outfitting quays
11. Lifting and handling installations
12. One building accommodating the production supporting services
13. One building accommodating the management and administrative offices
14. A health and medical service
15. A training center
16. A building accommodating the catering services
17. A transportation station
18. A parking

Table 3: A Small Shipyard Layout



4th Generation Shipyard Layout (Aalto University, School of Engineering)

Teaching Note

Abstract

Eastern India Shipyard is a ship repair facility that caters to the repair of ocean going ships and smaller craft.

The well-equipped yard suffers from a poor safety culture leading to a serious accident resulting in the death of a senior officer of the yard. The case discusses the events leading up to the accident and explains why a poor

Safety culture can lead to a loss of productivity and can cause other Human Resource Management problems.

It is an established fact that unsafe work conditions and poor safety habits are one of the leading causes of death and disability among India's working population. (Table 1 and 2)

Deaths due to negligence are needless and preventable. The case deals with the death of a worker due to unsafe working practices fostered by an unsafe culture. Further to this, the case goes on to examine ways and means of improving the safety culture at the workplace and how a poor safety culture effects employee performance.

While India may have laws to ensure workplace safety, implementation of these laws has always been a challenge resulting in unsafe conditions and in fatalities that lead to a fall in productivity.

A ship building and repair yard are packed with machinery and moving parts – furnaces, welding plants, lathes, cutting torches and cranes that are behemoths. The challenge of maintaining safety standards in a shipyard is critical because of the large workforce and the high stakes involved in building or repairing a ship. The case wrote out of the experience of the author (based on a true incident) in the shipping industry as well as a Human Resource practitioner, examines the safety culture at a shipbuilding yard on the eastern seaboard of India. The actual shipyard located on the west coast of India turned sick and was closed for a while. Names and locations have been changed. The author is a Master Mariner with over twenty years of shipping experience with ten years in command of state of the art ships. Presently the author is a consultant in the area of shipping and harbor construction and has been a Professor (OB & HR) for ten years.

The case examines an accident, the events that led up to the incident and the aftermath and actions that follow a work place accident and is an original piece of work. It also emphasizes the fact that change management initiatives more often than not require a top down mandate and is a deliberate attempt in making positive changes to employee welfare.

Key Words: *Safety, Safety Culture, Fatal Accidents, Safety Audit*

Objectives

The case study has multiple objectives the primary ones being:

1. To enable student to understand the implication of safety issues in large industries and its implications on industrial relations, employee engagement, and productivity. To teach students that there is no tradeoffs between productivity, performance, and safety. Students need to understand that unsafe behavior is not rational and causes much grief and in the long run can destroy an organization. To drive home the point the faculty may ask students the following questions:
 - a. How many of you wear a helmet while driving a two wheeler?
 - b. How many of you wear a seatbelt while travelling in a taxi or driving a car?
 - c. How many of you lift heavy weights from a standing position straining the back?
 - d. How many of you stand on a chair to change a light bulb or clean the ceiling fan?
2. To enable students to understand the importance of a safety mindset and safety behavior's in improving the safety culture.
3. To discuss issues related to safety culture

and the difficulty in permeating such a culture without the support of the top management.

4. Students may be encouraged to use the Ishikawa cause and effect diagram in attempting to deduce the cause of the accident in asking 5 Why's. This will allow them to improve problem solving and deductive skills.
5. To understand the changing role of operational safety in an industry in the era of globalization and worker empowerment.
6. The case can also be used as the base for domestic enquiry following an accident. Domestic Enquiry is an important part of the Human Resources Managers and Line Managers job.

Target audience

The case study is to be discussed in a MBA Class (Organization Behavior/ Human Resource Management/ Operations Management/ Change Management). The case study is particularly useful in teaching of executive management courses.

Methodology to be followed by the teacher

The case may be taught in the class room using the following approach:

1. Core analyses of safety issues and its implications of Human Resource Management
2. The interplay between safety, productivity and employee engagement.

3. The role of the top management and issues in bringing about change in an organization
4. The use of training and development in bringing about behavioral and attitudinal change in the workforces approach towards safety.
5. The case may be used by the instructor to discuss different dimensions of safety and the dangers of workplace violence with the following questions answered:
 - a. What was the real cause of the accident?
 - b. How would the new Safety Manager Plug gaps in the safety culture at EIS?
 - c. Was the action of Anup Goswami, Vice President (HR) appropriate?

The case highlights the fact that safety as a culture was nonexistent at the Eastern India Shipyard and the accidents which eventually lead to the tragic death of the Vice President was not an isolated incident in itself but probably the result of poor safety systems.

One can find a series of events which reflect poor safety, from throwing a lighted cigarette in a trash can to working a thirty-ton crane without a klaxon alarm. All these indicate that the culture which supports safety was abysmal and in this setting, it is not surprising that the accident occurs.

What are the critical components of a sound safety culture? Many of the following are required for establishing a credible and efficient safety system.

1. Safety must be a core value for the shipyard.
2. The top management must believe in and support the requirement of a safety system that works. Resources in terms of proper staff, equipment and training must be provided.
3. Establish and enforce high standards of safety.
4. Be vigilant to safety lapses and never grow overconfident.
5. Empower individuals to be safe and support the safety culture.
6. Establish a system where safety issues are voiced without fear of reprisal.
7. Foster mutual trust based on the knowledge that workers are safety conscious.
8. Provide timely response to safety issues and concerns.
9. Provide for continuous monitoring of safety standards by regular safety audits and arrange to plug gaps.
10. Learn about safety all the time.

The new Safety Manager has his work cut out and while there is no one way of improving safety, there are some fundamental steps that he should consider to address the safety culture issues within the shipyard.

Create safety awareness

The Safety Manager should first create an awareness of the importance of safety culture

and link it to safety performance.

The case shows what a poor culture can lead to in terms of safety performance.

Continuous safety training is the mantra for a safe organization and a proper process for training with the adequate resources must be put in place.

Perform a safety audit immediately

The Safety Manager must identify where the safety gaps are and close them immediately. This requires a close and ruthless scrutiny of the existing system.

Reward

By consistently reinforcing positive behaviors, linking them to the benefits they bring, and relating these benefits to the employees the Safety Manager should be able to gradually shift the safety values of the organization in the required direction.

- Keep the organization, at all levels, focused on “What is at stake if safety is an issue?”

Keep employees focused on the requirements of safety and the potential loss if safety is not followed. This can be done by discussing case studies and real life accidents. These discussions can serve as a deterrent to slackness and apathy.

Anup Goswami, VP (HR) has been professional and adept in handling an explosive situation. Violence could have erupted and was prevented by his action of getting the police to the workplace immediately and getting the main characters of the accident out of the system.

Goswami also handled the union well and prevented his organization from getting dragged into a legal maze.

A systematic safety database was maintained and the yards safety record was tracked particular behavior based safety.

a. What was the real cause of the accident?

A poor safety culture, unresolved conflict, poor training and a general sense of hopelessness. In dealing with accidents a discussion may be carried out on accidents caused by 'an act of God' or force majeure.

Accidents are not a one off situation but a culmination of many factors, which build up over time.

The main cause of the accident was poor training on part of the crane operator and poor supervision. It is also to be understood that workers attitude towards safety needs to be improved and this would result in better safety related behaviors.

An unsafe culture is perpetrated by a body of workers who operate with an unsafe mindset and are not ready to change. It is also important to understand the role of immediate supervisors and managers in enforcing discipline and rules in keeping a safe workplace.

b. How would the new Safety Manager plug gaps in the safety culture at EIS?

Some suggestions are mentioned in the case study. However, the new manager needs to positively motivate the workers to be cognizant of existing dangers and develop a safety

mentality. Safety Audits conducted at regular intervals serve to keep a close watch on safety issues and can prevent accidents proactively. Non-Compliances are to be recorded, communicated and acted upon to improve the safety quotient. Inspection of work areas and audits of safety programs are tools that can be used to identify problems and hazards before these conditions result in accidents or injuries. Audits also help to identify the effectiveness of safety program management and can be used as a guide to assure regulatory compliance and a safe workplace. All safety deficiencies found during audits and inspections were to be corrected as soon as possible and conditions that present hazards are to be corrected or controlled immediately. It is often said that a shock is required to bring change and the death of four workers had that effect on the shipyard workers. Safety was looked at more proactively and attempts were made to incorporate it into the work culture. The new approach to safety did have the desired effect and EIS's safety record improved over time.

c. Was the action of Anup Goswami, Vice President (HR) appropriate?

The VP (HR) took prompt and appropriate

action. The accident could have easily escalated into violence considering that rival unions were present and there was tension in the air. The action of calling the in-house security in and the police, speaks of clear and proactive action.

Violence is always in the air when an organization has a divided union and loyalties' are questioned as in the case of Eastern India Shipyard.

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