Business Leaders' Health & Safety Forum

ZERO HARM WORKPLACES

February 2015

Leading through a tragedy

Cos Bruyn — Downer NZ

On October 19, 2012 one of my employees, Graham Brown, was killed at work.

Without a doubt, Graham's death is one of the hardest things I've had to deal with as a chief executive. It has made me even more determined to make sure we manage our critical risks at Downer NZ, and to do everything I can to prevent another event like this in future.

"My first duty of care is always to my employees. My duty to protect the company's reputation comes second to that."

Cos Bruyn

Chief Executive
Downer NZ

Graham Brown was 67 years old when he was killed while working as part of a team clearing a rockfall from Milford Sound road. He was our most experienced driller and had worked for Downer for nearly 40 years. Graham was struck by a metal hose clamp when a high pressure hose flew off a compressor. The blow was strong enough to crush his hard hat, and he died despite heroic efforts by his workmates to keep him alive until emergency services arrived.

I still remember the shock I felt when I got the call about the accident. It was like being hit with a broadside. As a chief executive you are used to fixing things. But when someone dies at work there's no way you can fix that.

I learned a lot about leadership from this experience. But there are three things I think a chief executive really needs to focus on:

1. Being present and showing sustained support for the victim's family and workmates
2. Ensuring the lessons from the tragedy are identified, quickly shared and acted on
3. Putting moral obligations to protect your people ahead of your duty to protect your company's legal position.

Supporting family and workmates

Straight after the accident one of my locally based managers went to see Graham's wife, Elizabeth, and I took the first plane down the next day. It was really important to me to be there personally. The welfare of Graham's family, his workmates and the local Downer team were the most important things to me at that time.

I spent the next three days talking to them, making sure we had good support services in place, and assuring them I'd do everything I could to find out what went wrong. This support included financial help for Graham's family and professional counsellors for the workmates who'd tried to keep him alive. Being Kiwi blokes we had to really encourage them and others to accept this counselling. But in the end they did and the feedback was, it had been really helpful.

It's really important to not forget about the family and workmates after a few months. Keep up the contact and communication, particularly as you go through the investigation process and Coroner's hearing. One thing we did, to show we hadn't forgotten Graham, was to unveil a memorial on Milford Road on the first anniversary of his death. I attended that event with Graham's family and friends, and I think it really helped in the healing process for all involved. We've also created a scholarship in his name at Canterbury University's Engineering School, in partnership with our client for the Milford Road, The NZ Transport Agency. These have helped create a fitting and lasting legacy for him.

When our internal investigation was completed we shared the findings with the family. I was open and honest about what happened, what we'd learned, and what we were doing to make sure nothing like this ever happened again in our business, or elsewhere in the industry.

> "The chief executive has to drive the investigation and take personal responsibility for making sure the lessons are acted on."

> "It's really important to not forget about the family and workmates after a few months."

Learning and sharing the lessons

I believe that when something as serious as this happens at work, the chief executive has to drive the investigation and take personal responsibility for making sure the lessons are acted on – and quickly. You need the right people involved from the start so the investigation can be done quickly and thoroughly. It's a no-brainer that it has to look at the root causes.

Like most fatal accidents, Graham's involved multiple contributing factors. It happened on a Friday before a long weekend. An equipment failure led to an unplanned change in machinery. The hazard ID focused on the obvious and serious risk of further rockfalls, not the less obvious dangers like equipment failures. Most importantly – as the investigation uncovered – there was a lack of best practice information available to the industry on compressors and ancillary equipment.

The investigation led to a number of changes at Downer, including how we use high pressure equipment. We developed our own "best practice" guide, which we shared with our parent company in Australia, Roading NZ and the NZ Contractors' Federation in New Zealand – who circulated it around the industry. It was really important to me that the lessons we'd learned were shared as widely as possible. We also changed the way we do site safety plans.

To make sure Graham's accident wasn't forgotten we held safety stop-work meetings across the Downer business in Australia and New Zealand on the anniversary of his death. This was a powerful opportunity to remind ourselves of the lessons learned, and to ensure they were still being applied.

Moral before legal

Probably the biggest lesson for me from this experience is how quickly things go awry if you let legal concerns dictate how you interact with the family, the regulator and people in your business. My gut instinct was to speak openly and honestly about what happened and what we're doing about it, as soon as the facts were known.

The initial legal advice didn't support that approach because of concerns that being open and honest might make us more exposed to prosecution. I disagreed with that advice for two reasons.

First, I believed I had a moral obligation to share the lessons from our internal investigation as quickly and widely as possible to keep Graham's family informed and to prevent the same thing happening to someone else. We couldn't wait until the regulator's investigation was over to do that. What if someone else had got hurt in the meantime? I couldn't have lived with myself. This experience really impressed on me that my first duty of care is always to my employees, and others who could be victims of a future accident. My duty to protect the company's reputation comes second to that.

Also, I drew a line in the sand about pleading guilty to charges initially laid by the regulator against Downer NZ when, deep down, I knew we weren't guilty. Had we done so, we would have been saying we could have done significantly more to prevent the incident. How would that have made Graham's team feel, when really, it had been a freak accident?

Second, my experience was that when the inspectors investigating Graham's death couldn't get all the information they needed, they began to draw the wrong conclusions. When we were open and provided them with what we knew, they were in a much stronger position to make the right decisions. I believe this openness was material in the regulator eventually deciding to withdraw the charges against us.

More determined

This experience has made me even more determined to manage our critical risks.

I know we can never rest on our laurels. We've got to keep searching for improvements in our processes and better ways of engaging our people on safety. We owe it to Graham to never forget the lessons from his accident.

Advice from other chief executives

Chief executives who attended a peer learning event with Cos Bruyn in October 2014 shared their insight on leading after a serious injury or fatality at work:

- Act fast to inform the family, your staff and the media. If you don't, they'll likely hear about it first from somewhere else, like social media.
- Keep talking and be open or rumours will run rife.
- Interview witnesses quickly while memories are fresh.
- Be sensitive to cultural and religious beliefs, consider protocols and find out who to involve ahead of time.
- Keep the family informed as you go through the internal investigation and talk them through the findings, particularly:
  - Accountability – tell them what went wrong and what parties were involved
  - Support – provide support early and regardless of whether some form of court reparations is likely
  - Change – tell them what changes are being made as a result of their loved one's death.
- Consider how you manage the potential conflict between your moral and legal obligations. Plan ahead – talk with your lawyers about this and develop an approach.
- Lawyers have an important role to play during an investigation by the regulator but it's important you use them in the right way.
  - Have senior staff prepare information for investigators and ask your lawyers to review it (not write it).
  - Senior staff should also lead interviews with investigators. Have lawyers present to advise them and record what's said.
- Keep a record of all conversations with the investigators so any misinterpretations or inaccuracies can be challenged.
- Keep supporting and talking to the family regardless of the outcome of the investigation. If you end up sitting across from them in a court room, the experience will be less traumatic if you've treated them with respect.
- Talk to clients and contractors about the event.
- Look after yourself and ask someone to keep an eye on you to ensure you're coping. Lead by example and participate in any counselling set up for others.

Leaders make a difference

The Business Leaders' Health and Safety Forum inspires and supports its members to become more effective leaders on health and safety. The Forum has more than 200 members, who are CEOs or Managing Directors of significant New Zealand companies.

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