



### INJURY IN THE WILD: UNDERSTANDING AND PREVENTING OUTDOOR EDUCATION INJURY INCIDENTS

Clare Dallat & Paul Salmon Wilderness Risk Management Conference Portland, Maine, November1-3, 2017

# CONTENT

- Background
- Systems thinking in accident and injury prevention
- Incident reporting and learning: UPLOADS
- Risk assessment: NET-HARMS
- Key take home messages

# GOALS

- Develop critical reflection skills for better understanding why systems fail
- Accidents are more than just "people, equipment, environment"
- Understand the causes of outdoor education injury incidents
- Understand the system of risks faced when delivering outdoor education programs
- The power of partnerships

# BACKGROUND

- Acknowledged risk of severe and frequent injury in active pursuits (Finch et al, 2007)
- Accidents & injuries occur in led outdoor industry domain
- Industry desire to better understand injury and injury causation
- Systems required to enhance understanding do not exist (best data available was coroners reports and the media)

#### **Herald Sun**







Victoria, says coroner

#### MONASH University Accident Research Centre

#### THE ROLE OF HUMAN FACTORS IN LED OUTDOOR ACTIVITY INCIDENTS: LITERATURE REVIEW AND EXPLORATORY ANALYSIS

Dr Paul Salmon Ms Amy Williamson Ms Eve Mitsopoulos-Rubens Dr Christina (Missy) Rudin-Brown Dr Michael Lenné

October, 2009

#### Report made the following recommendations:

1. Development of a unified, theoretically underpinned accident and incident reporting system;

2. Development of a National led outdoor activity accident and incident database;

3. Development and application of a theoretically underpinned, systems-based accident analysis method;

4. In-depth analysis of led outdoor activity accident and incidents; and

5. Development of a led outdoor activity accident causation model and associated failure taxonomies.

# THE UPLOADS PROJECT



**Goal:** develop a standardised, national approach to incident reporting and learning for the outdoor education sector in Australia, and a corresponding national incident dataset

### Support:

- Organisations to learn from incidents; and
- The sector to understand the risks it faces, and take appropriate action.

### The systems approach to accident analysis and prevention

### THE HISTORY OF ACCIDENTS

#### Unsafe acts (errors and violations

System and cultural issues

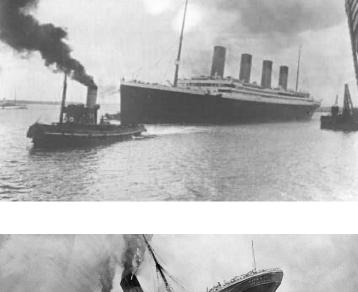
Equipment failures (hardware - software)

#### 1955

Practice

stayed here

1960s	1970s	1980s	1990s	2000s		
Aberfan	Flixborough	Chernobyl	Paddington	Linate		
Ibrox	Seveso	Zeebrugge	Long Island	Uberlingen		
	Tenerife	Bhopal	Alabama	Columbia		
	TMI	Piper Alpha	Estonia			
	MT Erebus	Dryden	Eschede			





Reason (2008)

2005

Research

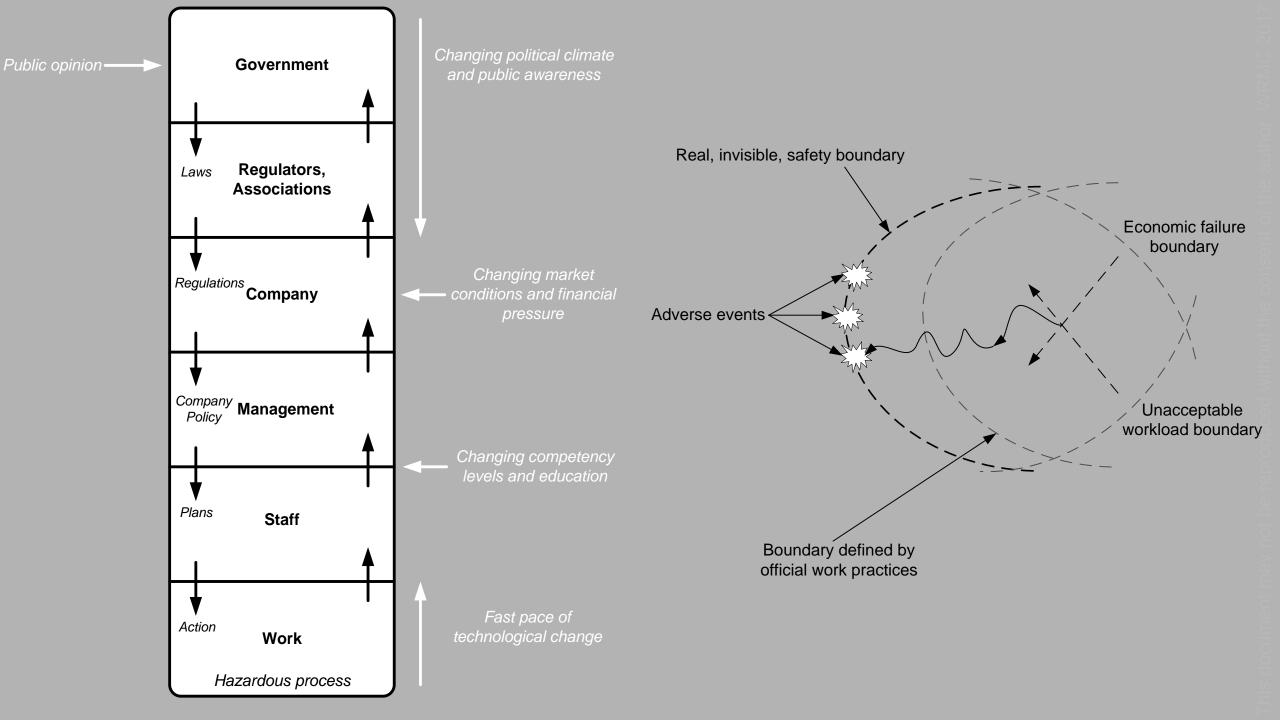
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### ACCIDENT CAUSATION – OLD AND NEW VIEWS

- Human error is the cause of incidents
- To understand failure, you must examine failures only
- Systems are safe
- Unreliable and erratic humans make them unsafe
- Systems can be made safer by restricting humans

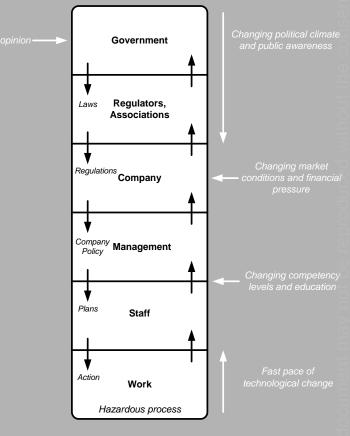


- Human error is a symptom of problems across the system (it is a consequence not a cause)
- Incidents caused by multiple
   interacting factors
- To understand 'failure' look at why people's actions made sense at the time
- Systems are unsafe
- Humans create safety through practices at all levels of the system



# **SYSTEMS THINKING**

- Safety impacted by the decisions and actions of all actors across the sports system, not just front line workers;
- Accidents are caused by multiple contributing factors, not just a single poor decision or action;
- Accidents result from a lack of poor communication and feedback across levels of the system, not just from deficiencies at one level alone;
- Behaviours are not static, they migrate over time and under the influence of various pressures;
- Migration occurs at multiple levels of the system;
- Migration of practices cause defences to degrade and erode gradually over time, not all at once. Accidents are caused by a combination of this migration and a triggering event(s).





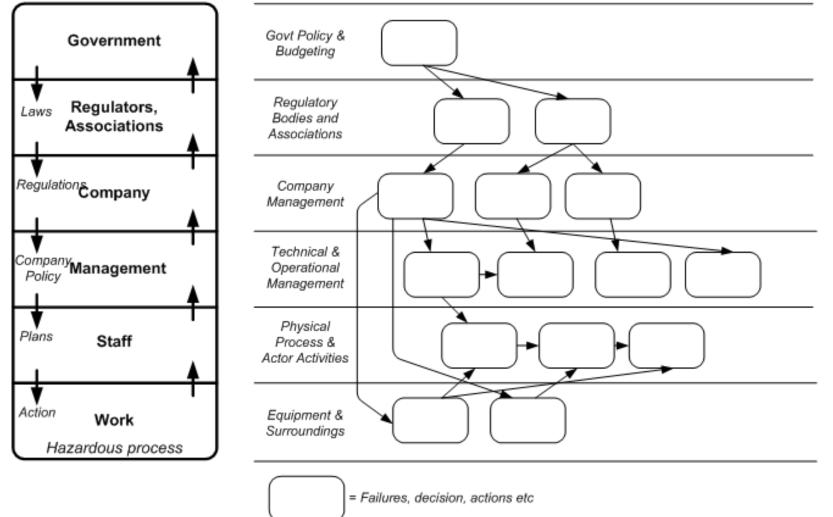
### FIXING BROKEN COMPONENTS



### IMPLICATIONS FOR SAFETY MANAGEMENT

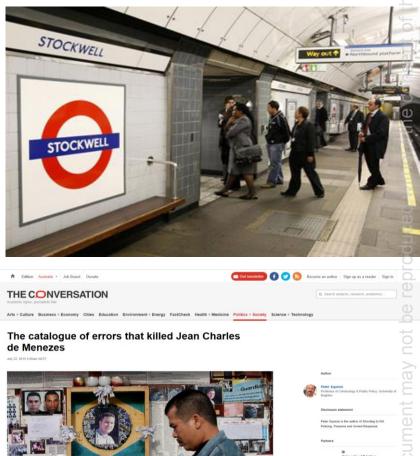
- Little point in attempting to optimise parts in isolation from each other
- Strategies should impact all levels of the system and should comprise 'webs' of interacting interventions
- Interactions between components should be the key focus (rather than the components themselves)
- "Hard fixes change something fundamental about the organisation. This is what makes them hard. But it is also what makes them real fixes" (Dekker, 2006, pg. 190)

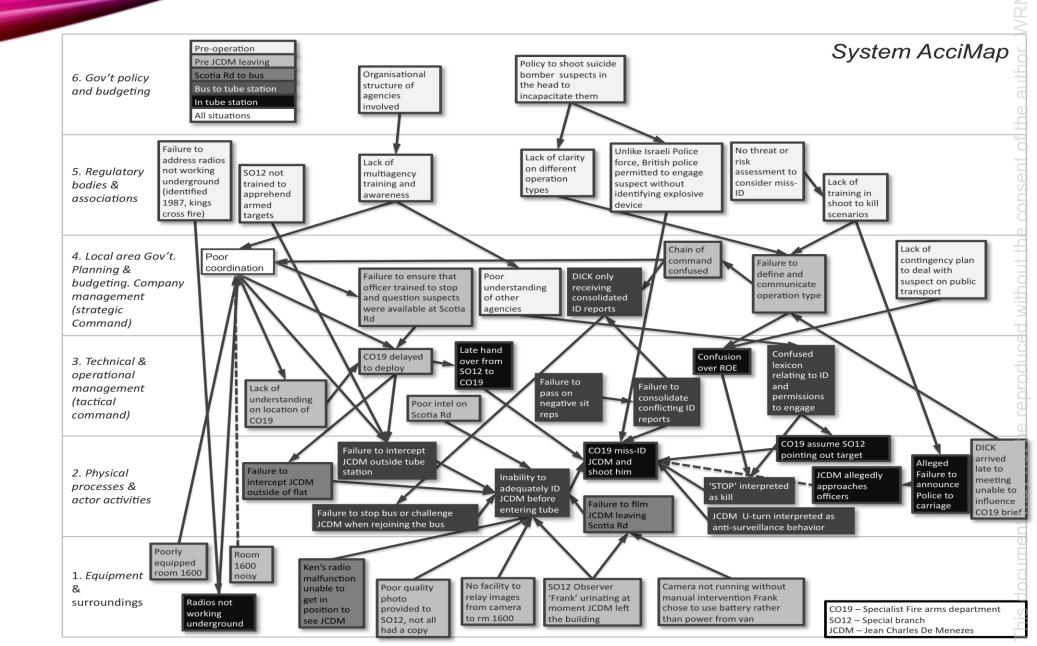




### ACCIMAP APPLIED

- 22nd July 2005, Stockwell tube station, London, UK
- Jean Charles de Menezes
- Misidentified as one of the fugitives involved in previous days failed bombing attempts

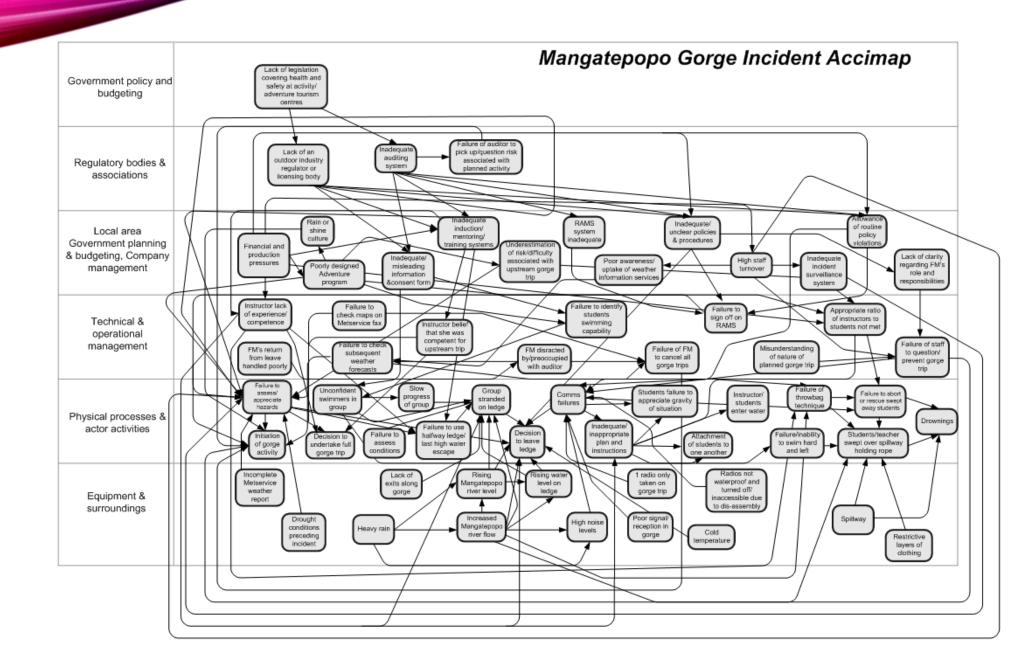




### **ACCIMAP APPLIED**

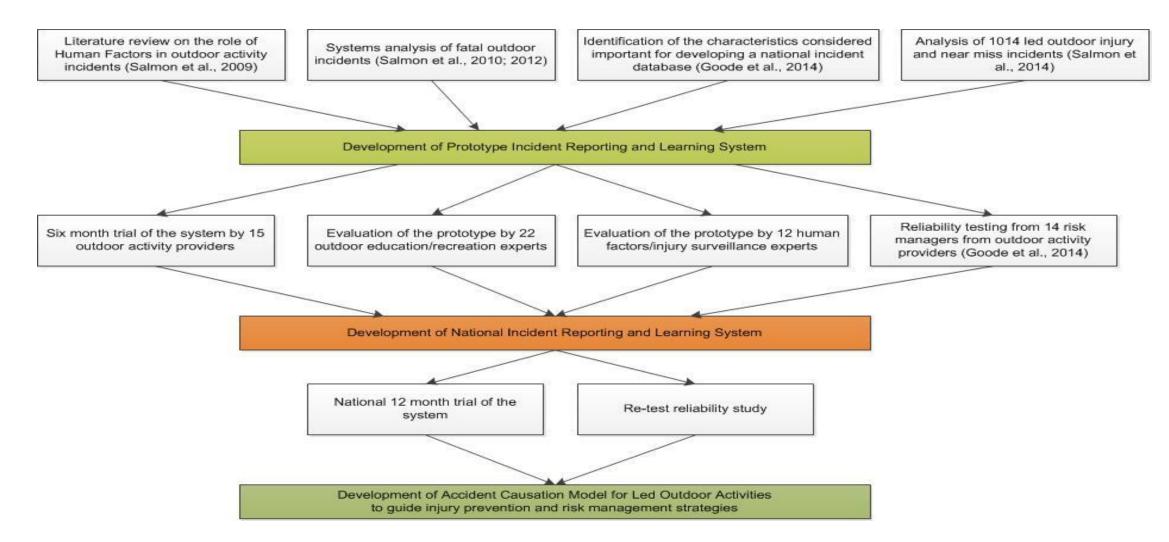
- Mangatepopo Gorge tragedy, 15th April 2008
- Gorge walking activity
- Group became trapped on ledge in flash flood
- Teacher and six year 12 students drowned





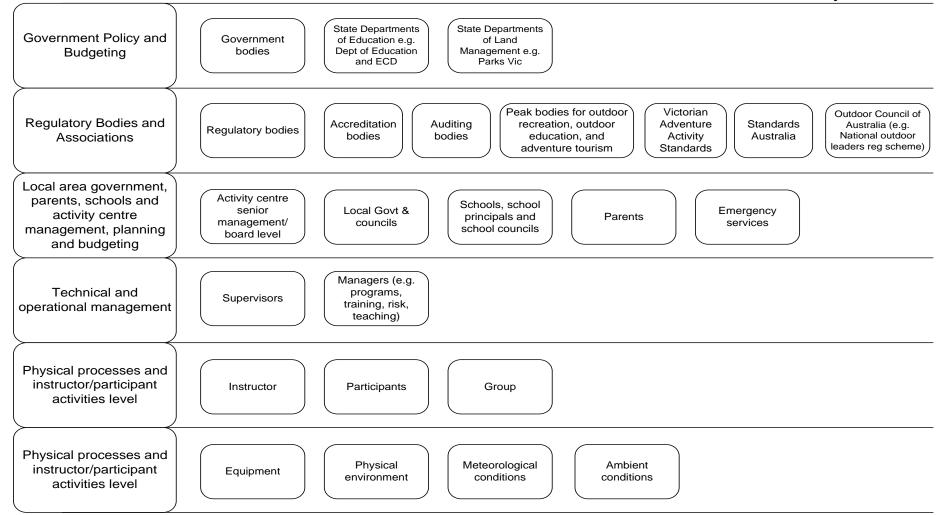
### Understanding and Preventing Led Outdoor Accident Data System (UPLOADS)

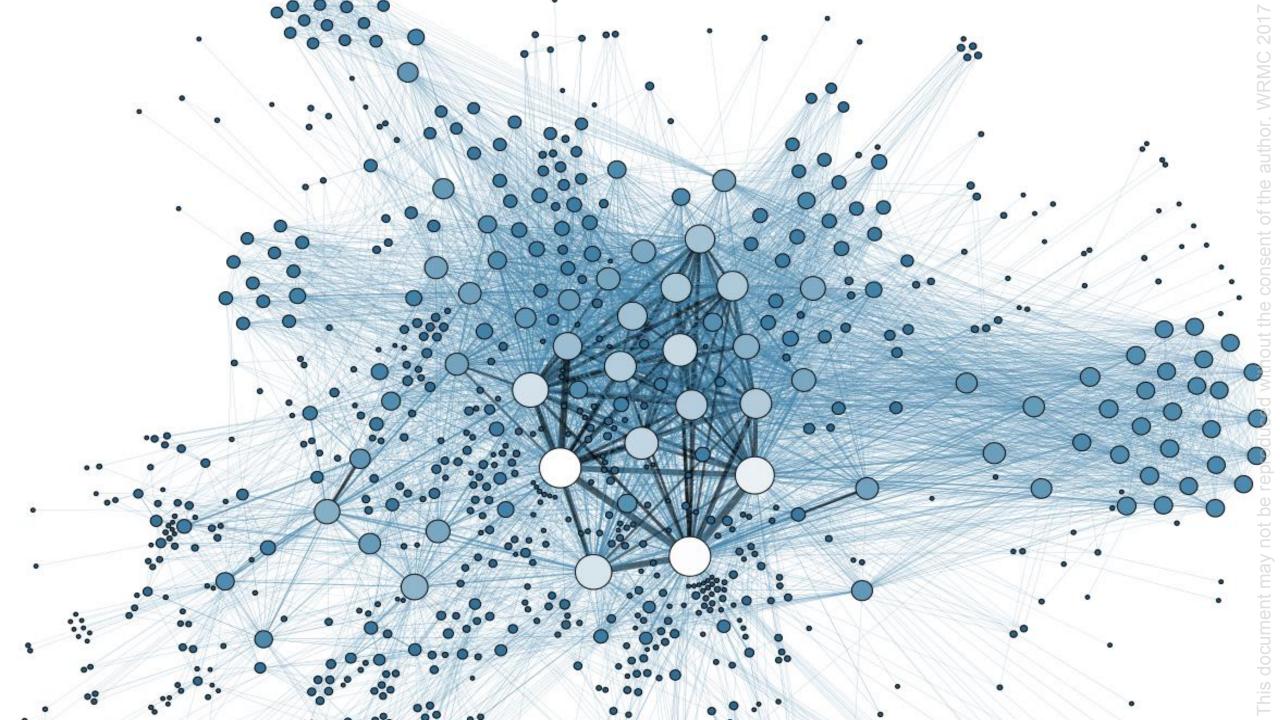
### **DEVELOPMENT OF UPLOADS**



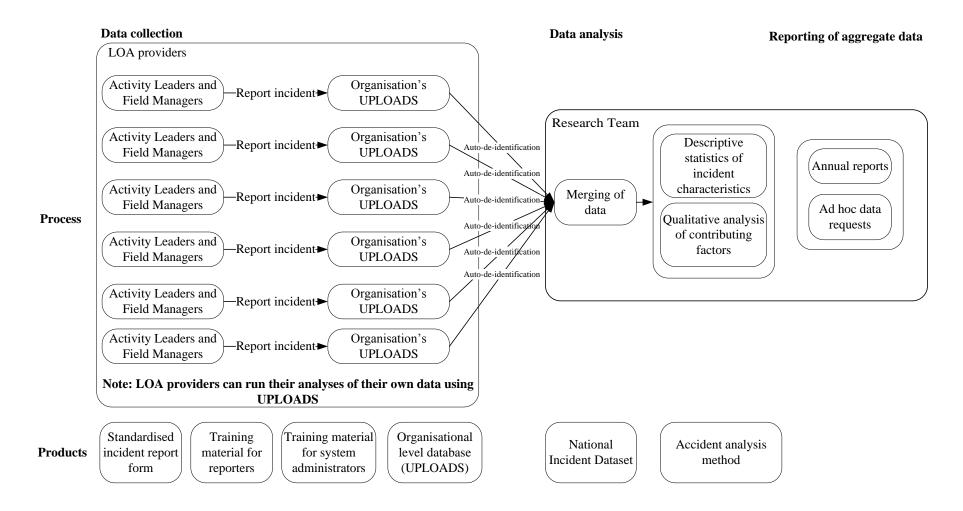
### THE OUTDOOR EDUCATION 'SYSTEM'

Led outdoor activity ACTOR-MAP



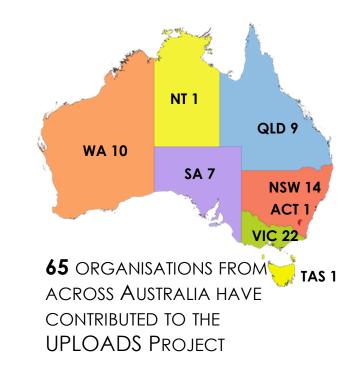


# UPLOADS



# THE FIRST 3 YEARS (2014 – 2017)

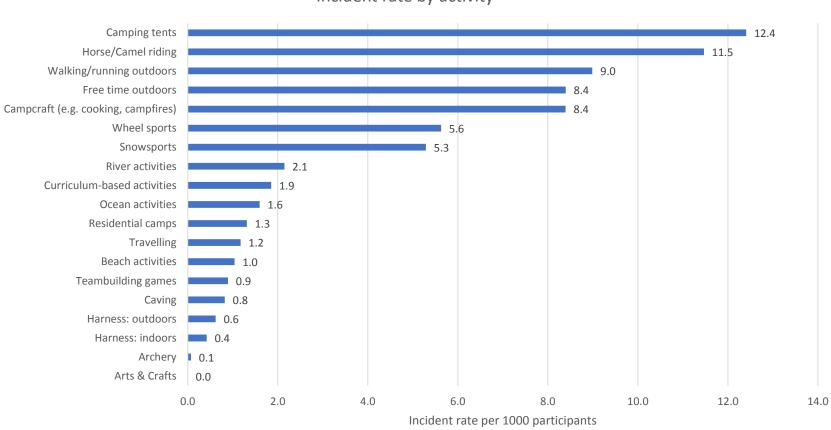
- 2037 incidents have been reported via UPLOADS
  - 1367 injuries
  - 454 illnesses
  - 131 near miss incidents
  - 65 social/psychological incidents, and
  - 20 incidents involving equipment damage
- 3086 Contributory factors



## **INCIDENT RATE**



- Cricket 242/1000
- Horse riding 122/1000
- Soccer 107/1000
- Netball 51/1000



Incident rate by activity

#### • Dislocation sprain and strain (4) Injury to nerves or spinal cord (3) Superficial injury(3)

- Injury to muscle, fascia and tendon (2)
- Fracture (1)
- . .

Neck 0.7% (n = 14)

.

Other / unspecified effects of external causes (1)

#### Shoulder and upper arm 2.8% (n = 38)

- Dislocation, sprain and strain (21)
- Superficial injury(11)
- Injury to muscle, fascia and tendon (3) • Other / unspecified effects of external causes (2)
- Open wound (1)

#### Abdomen, lower back, lumbar spine and pelvis 3.3% (n = 45)

- Superficial injury(19)
- Dislocation sprain and strain (11)
- Injury to muscle fascia and tendon (7)
- Injury to nerves or spinal cord (3) • Other / unspecified effects of external causes (3)
- Crushing injury(2)

#### Wrist and hand 18.1% (n = 247)

- Superficial injury(122)
- Burns and corrosions(36)
- Open wound (33)
- Dislocation sprain and strain (29) Fracture (10) .
- Crushing in jury(6)
- Injury to muscle, fascia and tendon (5)
- Other / unspecified effects of external causes (6)

#### Ankle and foot 27.9% (n = 381)

- Superficial injury(201)
- Dislocation, sprain and strain (138)
- Other / unspecified effects of external causes (13)
- Open wound (11)
- Injury to muscle, fascia and tendon (6)
- Fracture (4)
- Burns and corrosions(4)
- Crushing injury(4)

#### Multiple body regions3.4% (n = 46)

- Superficial injury(27)
- Other / unspecified effects of external causes (8)
- Open wound (4) •
- Dislocation sprain and strain (3)
- Burns and corrosions(2)
- In jury to muscle, fascia and tendon (1)
- Injury to nerves or spinal cord(1)

#### Head 8.0% (n = 109)

- Superficial injury(47)
- Other / unspecified effects of external causes (33)
- Open wound (10)
- Effects of foreign body entering through natural orifice(8)
- Injury to muscle, fascia and tendon (4) Burns & corrosions(4)
- Crushing injury(3)

#### Chest/Thorax 0.4% (n = 5)

- Other / unspecified effects of external causes (2)
- Dislocation sprain and strain (1)
- Crushing injury(1)
- Superficial injury(1)

#### Elbow and forearm 3.4% (n = 46)

- Superficial in jury(27)
- Dislocation sprain and strain (9)
- Fracture (4)
- Injury to muscle, fascia and tendon (3)
- Burns and corrosions(2) Other / unspecified effects of external causes (1)

#### Hip and thigh 4.5% (n = 62)

- Superficial injury(41)
- Dislocation sprain and strain (8)
- Injury to muscle fascia and tendon (6)
- Burns and corrosions(3)
- Crushing injury(1)
- Open wound (1)

#### Knee and lower leg 17.3% (n = 237)

- Superficial injury(124)
- Dislocation sprain and strain (41)
- Open wound (27)
- Injury to muscle fascia and tendon (16)
- Other / unspecified effects of external causes (14)
- Burns and corrosions(11)
- consequences of external causes (2)

#### Unspecified part of trunk, limb or body region 4.5% (n = 61)

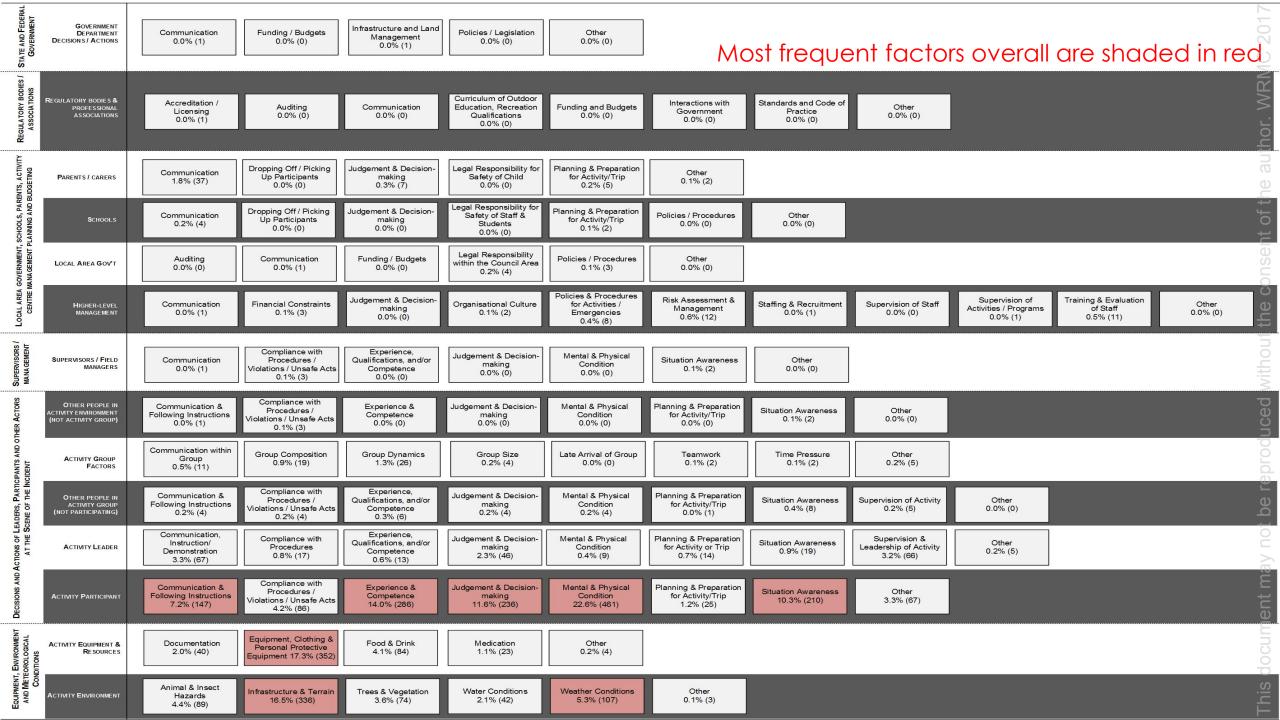
- Other / unspecified effects of external causes (31)
- Superficial injury(20)
- Burns and corrosions(3) • Dislocation, sprain and strain (3)
- Injury to muscle, fascia and tendon (1)
- Effects of foreign body entering through natural orifice (1)
- Injury to internal organs(1)
- Open wound (1)

# **INJURIES**

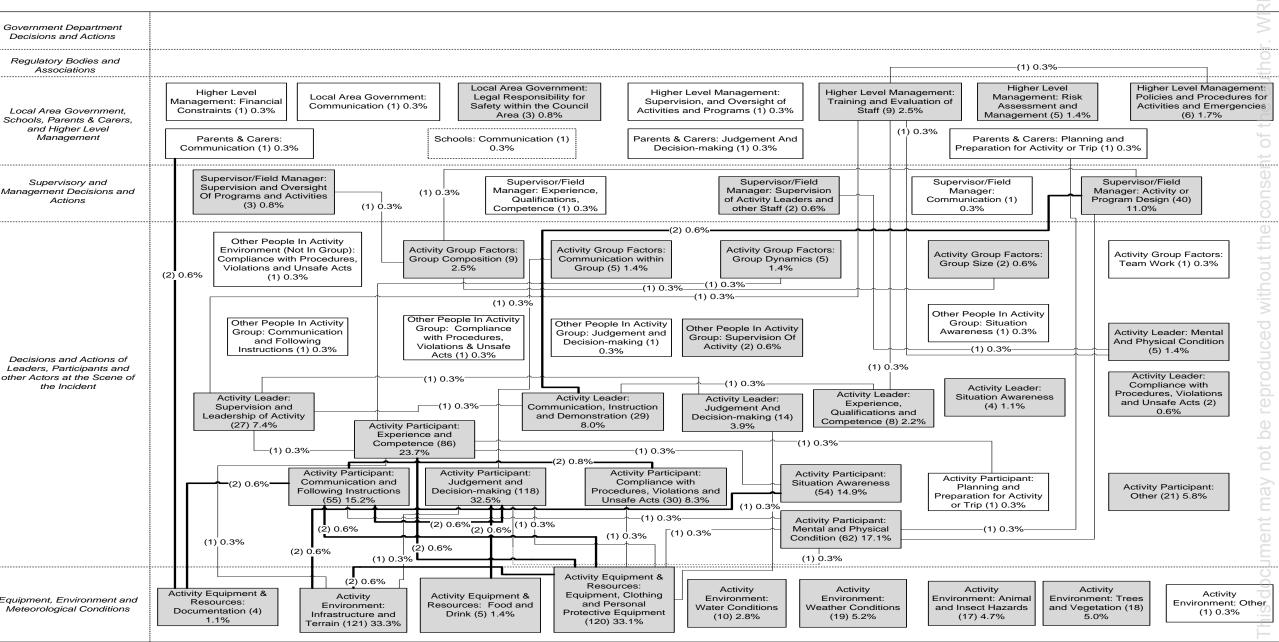
- Sequelae of injuries, of poisoning and of other

- Injury to nerves or spinal cord (1)
- Crushing in jury(1)

STATE AND FEDERAL GOVERNMENT	Government Department Decisions / Actions	Communication 0.0% (1)	Funding / Budgets 0.0% (0)	Infrastructure and Land Management 0.0% (1)	Policies / Legislation 0.0% (0)	Other 0.0% (0)	Most	frequent fo	actors at e	each leve	are shade	d in grey	
REGULATORY BODIES / ASSOCIATIONS	REGULATORY BODIES & PROFESSIONAL ASSOCIATIONS	Accreditation / Licensing 0.0% (1)	Auditing 0.0% (0)	Communication 0.0% (0)	Curriculum of Outdoor Education, Recreation Qualifications 0.0% (0)	Funding and Budgets 0.0% (0)	Interactions with Government 0.0% (0)	Standards and Code of Practice 0.0% (0)	Other 0.0% (0)				thor. WRN
LOCAL AREA GOVERNMENT, SCHOOLS, PARENTS, ACTIVITY CENTRE MANA GEMENT PLANNING AND BUDGETING	Parents / carers	Communication 1.8% (37)	Dropping Off / Picking Up Participants 0.0% (0)	Judgement & Decision- making 0.3% (7)	Legal Responsibility for Safety of Child 0.0% (0)	Planning & Preparation for Activity/Trip 0.2% (5)	Other 0.1% (2)						ne au
	<b>S</b> CHOOLS	Communication 0.2% (4)	Dropping Off / Picking Up Participants 0.0% (0)	Judgement & Decision- making 0.0% (0)	Legal Responsibility for Safety of Staff & Students 0.0% (0)	Planning & Preparation for Activity/Trip 0.1% (2)	Policies / Procedures 0.0% (0)	Other 0.0% (0)					nt of t
	Local Area Gov't	Auditing 0.0% (0)	Communication 0.0% (1)	Funding / Budgets 0.0% (0)	Legal Responsibility within the Council Area 0.2% (4)	Policies / Procedures 0.1% (3)	Other 0.0% (0)						onser
	HIGHER-LEVEL MANAGEMENT	Communication 0.0% (1)	Financial Constraints 0.1% (3)	Judgement & Decision- making 0.0% (0)	Organisational Culture 0.1% (2)	Policies & Procedures for Activities / Emergencies 0.4% (8)	Risk Assessment & Management 0.6% (12)	Staffing & Recruitment 0.0% (1)	Supervision of Staff 0.0% (0)	Supervision of Activities / Programs 0.0% (1)	Training & Evaluation of Staff 0.5% (11)	Other 0.0% (0)	the c
SUPERVISORS / MANA GEMENT	SUPERVISORS / FIELD MANAGERS	Communication 0.0% (1)	Compliance with Procedures / Violations / Unsafe Acts 0.1% (3)	Experience, Qualifications, and/or Competence 0.0% (0)	Judgement & Decision- making 0.0% (0)	Mental & Physical Condition 0.0% (0)	Situation Awareness 0.1% (2)	Other 0.0% (0)					without
DECISIONS AND ACTIONS OF LEADERS, PARTICIPANTS AND OTHER ACTORS AT THE SCENE OF THE INCIDENT	OTHER PEOPLE IN ACTIVITY ENVIRONMENT (NOT ACTIVITY GROUP)	Communication & Following Instructions 0.0% (1)	Compliance with Procedures / Violations / Unsafe Acts 0.1% (3)	Experience & Competence 0.0% (0)	Judgement & Decision- making 0.0% (0)	Mental & Physical Condition 0.0% (0)	Planning & Preparation for Activity/Trip 0.0% (0)	Situation Awareness 0.1% (2)	Other 0.0% (0)				uced
	ACTIVITY GROUP FACTORS	Communication within Group 0.5% (11)	Group Composition 0.9% (19)	Group Dynamics 1.3% (26)	Group Size 0.2% (4)	Late Arrival of Group 0.0% (0)	Teamwork 0.1% (2)	Time Pressure 0.1% (2)	Other 0.2% (5)				reprod
	OTHER PEOPLE IN ACTIVITY GROUP (NOT PARTICIPATING)	Communication & Following Instructions 0.2% (4)	Compliance with Procedures / Violations / Unsafe Acts 0.2% (4)	Experience, Qualifications, and/or Competence 0.3% (6)	Judgement & Decision- making 0.2% (4)	Mental & Physical Condition 0.2% (4)	Planning & Preparation for Activity/Trip 0.0% (1)	Situation Awareness 0.4% (8)	Supervision of Activity 0.2% (5)	Other 0.0% (0)			: be re
	ACTIVITY LEADER	Communication, Instruction/ Demonstration 3.3% (67)	Compliance with Procedures 0.8% (17)	Experience, Qualifications, and/or Competence 0.6% (13)	Judgement & Decision- making 2.3% (46)	Mental & Physical Condition 0.4% (9)	Planning & Preparation for Activity or Trip 0.7% (14)	Situation Awareness 0.9% (19)	Supervision & Leadership of Activity 3.2% (66)	Other 0.2% (5)			ion Ve
	ACTIVITY PARTICIPANT	Communication & Following Instructions 7.2% (147)	Compliance with Procedures / Violations / Unsafe Acts 4.2% (86)	Experience & Competence 14.0% (286)	Judgement & Decision- making 11.6% (236)	Mental & Physical Condition 22.6% (461)	Planning & Preparation for Activity/Trip 1.2% (25)	Situation Awareness 10.3% (210)	Other 3.3% (67)				ient may
MENT, ENVIRO METEOROLOG CONDITIONS	ACTIVITY EQUIPMENT & Resources	Documentation 2.0% (40)	Equipment, Clothing & Personal Protective Equipment 17.3% (352)	Food & Drink 4.1% (84)	Medication 1.1% (23)	Other 0.2% (4)							docum
	ACTIVITY ENVIRONMENT	Animal & Insect Hazards 4.4% (89)	Infrastructure & Terrain 16.5% (336)	Trees & Vegetation 3.6% (74)	Water Conditions 2.1% (42)	Weather Conditions 5.3% (107)	Other 0.1% (3)						This



#### Contributory factors 2015/2016 - Injury-causing incidents (n=363)



### SUMMARY OF CONTRIBUTORY FACTORS

### Local area government, schools, parents, activity centre management planning and budgeting

- Inadequate risk assessments
- Policies and procedures for activities and emergencies (e.g. management procedures for designing activities)
- Interactions between activity center, schools and parents

### Supervisory & management decisions and actions

- Lack of supervision of staff in the field
- Issues relating to activity/program design
- Group with variable abilities requiring higher levels of supervision

### Decisions and actions of leaders, participants, and other actors at the scene of the incident

- Communication & following instructions
- Symptoms related to pre-existing injury (e.g. knee injury, wrist injury)
- Supervision & leadership of activity
- More instruction or briefing required for activity
- Mental and physical condition (leaders not fit for work)

#### **Equipment & Environment**

- Lack of appropriate equipment (i.e. participants not bringing equipment)
- Documentation
- Activity Environment: Infrastructure & terrain

# WHAT DO WE KNOW BECAUSE OF UPLOADS?

- Most LOA injuries are minor
- Incidents have multiple contributory factors spanning multiple actors
- Minor incidents have similar contributory patterns to the big ones
- Outside of usual suspects, key areas for improvements include risk assessment, interactions between parents, centres, schools, documentation, pre-existing injuries, fit between participants and activities, policy and procedures
- LOAs have a low injury incident rate compared to other sports (2.1 per 1000 participants)
- LOA sector is good at managing overtly risky activities e.g. high ropes courses
- Most injuries occur in less overtly risky activities e.g. free time, campcraft, walking/running

# **UPLOADS 2**

- Redevelopment of new UPLOADS tool
- Develop a structured process for translating systems-based accident data into appropriate and effective prevention strategies (UPLOADS-PrIMe)
- Assess the effectiveness of the UPLOADS learning cycle (reporting, analysis, decisions, implementation, follow-up)
- Testing the effectiveness of UPLOADS by comparing the incident and safety records of organisations using UPLOADS versus organisations not using UPLOADS

### BROADER UPLOADS RESEARCH PROGRAM

- A systems approach to risk assessment (Dallat et al., 2017)
- Analysis and design of outdoor education regulatory systems (Carden et al., 2017)
- Near miss incident reporting and learning
- Instructor/Leader Improvisation (Trotter et al, 2017)
- Multi-national injury incident analysis

### A systems approach to risk assessment NET-HARMS

### THE RESEARCH PROBLEM

- Inadequate risk assessment highlighted as contributing factor in injuries and deaths on led outdoor activities (LOA)
- Systems approach to accident causation in LOA sector (and safety critical domains generally) is now prevalent
- The extent to which schools/organizations consider the overall LOA system during risk assessment was not clear.

In short – are we predicting potential accidents with the same underpinning perspective as when we investigate them?



## EXAMPLE 1

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general agreement (     emergency contact a     name and contact of	nd phone number for that day				
Risk Assessment					
Explain all requirements ex	pected from parent helpers				
Determine the number of st excursion	aff required to adequately supervise the chi	ldren (Ideally 1 adult to every 2 child	dren, or 1 adult to every 4 children) this	depends on the destination of the	
Are any other adults require	ed to supervise the children that need to hav	ve specialised skills such as first aid,	anaphylaxis or asthma training		
The transport to and from t	he proposed destination for the excursion (b	us over 12 seats do not require boos	ster seats)		
The proposed route and des	stination for the excursion				

### EXAMPLE 1 CONT'D.

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× Google one world for children risk assessment • 5 Search • 5 Share More >		Sign In 🖇
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Will there be any water based activities/risks		
The proposed activities at the excursion		
Proposed duration of the excursion		
Date Risk Assessment completed:		
Staff member completing the Risk Assessment:		
Team Leader to evaluate the excursion and supervisory practices after the excursion		
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	Sue Natoli is online	

## EXAMPLE 2

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Sample Risk Management Plan: Excursion										
Name of school: Excursion	Number in group/class: 55									
Name of principal: J Citizen				Name of excursion coordinator: K Citizen						
Description and location of	excursion: Bushwalk in National Park			Contact number: XXXX						
Date of excursion: 18 Octo	ber			Accompanying staff, parents, caregivers, volunteers: 2 class tead	hers and 4 pare	ent/carer				
Group/class: 6S and 6G				volunteers						
Task/Activity	Hazard Identification & Associated Risk Type/Cause	Assess Risk* use matrix		Elimination or Control Measures	Who	When				
Bushwalking in national park	<ul> <li>uneven ground surfaces, bites and stings, exposure to sun, wind, rain</li> </ul>	4		al park staff of expected arrival and departure times, location of ticipants, students with medical conditions	Excursion Coordinator	Prior to wa				
	and dehydration.  - allergies to insects, reptiles and	- allergies to insects, reptiles and	- allergies to insects, reptiles and	3	<ul> <li>National Pari group togeth</li> </ul>	Supervisors	On walk			
	plants. - becoming lost or isolated from the			sion participants of National Park safety instructions.						
	group	group	-			ed footwear suitable for walking, clothing to protect arms and legs for changing weather conditions	All			
	- change in weather conditions		- Wearhats, sl	hirts with sleeves and sunscreen while outdoors.						
			- Ensure partic	cipants carry water bottles						
			<ul> <li>Staff carry in: taken in the s</li> </ul>	sect repellent, additional sunscreen and ensure rest breaks are shade	Teachers					
				<ul> <li>Identify participants with known medical conditions and ensure appropriate medication/treatment is available</li> </ul>		Prior to wa				
		implementa	cipation of students with known allergies has been considered, ppropriate risk controls, e.g. a trained staff member is available to opriate first aid (e.g. epipen for student with anaphylaxis)	Coordinator Teachers						
			- Ensure staff	and students are aware of emergency response procedures.						
			- Checkweath	erforecaston day of excursion						
			- Carry maps a	and compass	a					
			<ul> <li>Emergency p</li> </ul>	plans communicated for dealing with potential incidents						
			- Carry first aid	1 kit						

## EXAMPLE 3

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-	Identified Risks							5						9
	Event	Inherent Risk Level (Circle)	Hazard Details (Tour leader to complete)	Require	d Manageme	ent Strategie	s	Details o	to be in	Manageme nplemented er to complet		5		
	Communication													
	Lack of mobile phone contact between staff	Low Medium High Extreme	Inability for staff to communicate while participating in activities.	Arrangements s All staff to carry access. Share contact o	/ mobile phor	ies with appr								
	Lack of mobile contact between staff and students	Low Medium High Extreme	Inability for staff to communicate with students while participating in different group activities.	All staff to have the duration of t All students to h the duration of t Student phones whilst sleeping.	the tour. nave all staff the tour. s to be turned	contact num	bers for							
	Poor E-mail connection	Low Medium High Extreme	Difficult for parents to contact staff in emergency at home.	Staff to regularly from parents or		s for commur	nication							
	Poor availability of mobile contact between staff and xxxxx contact person(s)	Low Medium High Extreme	Inability to ask for guidance for behavioural issues, accidents or change of plans	Two xxxxxxxx Use email for n Regular reportir prearranged.	on urgent cor	ntact.								

## RISK ASSESSMENT USING A SYSTEMS APPROACH

**Outcome:** Hazards across the entire system would be identified, and consequent risks to participant (s) harm assessed and managed.



## STUDY 1 – HOW ARE WE CONDUCTING RISK ASSESSMENTS?

- Four outdoor education program risk assessments analysed to assess the extent to which they were underpinned by contemporary systems thinking.
- UPLOADS Accident Analysis Framework and Accimap used to analyse and map hazards and actors.

- 77 Hazards identified
- 8 Actors
- 3 States
- Multiple activities (n=21)
- Camp and Journey Based Programs represented



#### ACCIMAP DISPLAYING THE HAZARDS IDENTIFIED IN THE FOUR RISK ASSESSMENTS

Government department decisions and actions													
Regulatory bodies and associations													
Local area government, schools and parents Activity centre management planning and budgeting													
Supervisory and management decisions and actions	Student numbers												
	Limited skill (1)	Medical conditions (3)	Exhaustion (1)	Special needs group (1)	Abrasions (1)	Lost student (1)							
Decisions and actions of leaders, participants	Dehydration (1)	Burns (3)	Fatigue (1)	High risk behaviour (1)	Fractures (3)	Infection (1)							
and other actors at the scene of the incident	Chafing (1)	Slips and trips (1)	Strains and sprains (2)	Abduction (1)	Injury from arrow (1)	Negative impact with another group (1)							
	Trailer reversing (1)	Jumping (1)	Diving (1)	Falls (3)	Allergic reaction (3)								
Equipment,	Steep terrain (1)	Sloping ground (1)	Tree fall (1)	Temperature hot/cold (3)	Falling objects (1)	Sharks (1)	Bike failure (1)	Vehicles (1)					
environment and meteorological conditions	Unknown site (1)	Environment being harmed by human (1)	Road hazards (1)	Weather conditions (2)	Heights (1)	Exposure (1)	Communication device failure (1)	Jewellery (1)					
	Treed campsite (1)	Wild animals (1)	Lightning (2)	Water visibility (1)	Drowning (3)	Fire (1)	Clothing entangled in bike (1)	Arts and crafts material (allergic reaction to) (1)					
	Exposed ridges/hollows (1)	Cattle grids (1)	Animal bites/stings (3)	Rips (2)	Water quality (2)	Sunburn (1)	Trailer decoupling (1)	Equipment failure (1)					

# **STUDY 2 - PRACTITIONER SURVEY**

- Online and voluntary
- Aims:
  - 1) determine which risk assessment methods and policy guidance are currently used in practice (if any);
  - 2) understand practitioner perspectives around the utility of risk assessments; and,
  - 3) identify perceived challenges and barriers in applying these methods to the LOA context.
- Total sample (n=97)
- All states and territories represented in findings



# FINDINGS

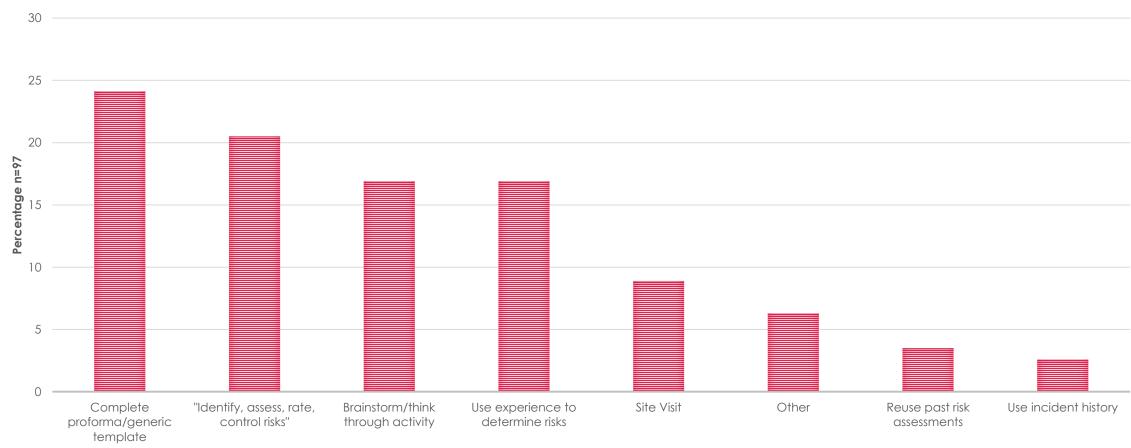
In general, a picture of <u>confusion and uncertainty in</u> relation to conducting risk assessments, as well as a <u>lack of policy guidance and</u> <u>formal training</u>, was observed.

Do you believe there are any issues regarding the application of risk assessments to the outdoor activity/program context?

- Yes 79%
- No-21%



## **RISK ASSESSMENT METHODS**



Methods used for risk assessment

## WHAT RISKS ARE YOU ASSESSING?

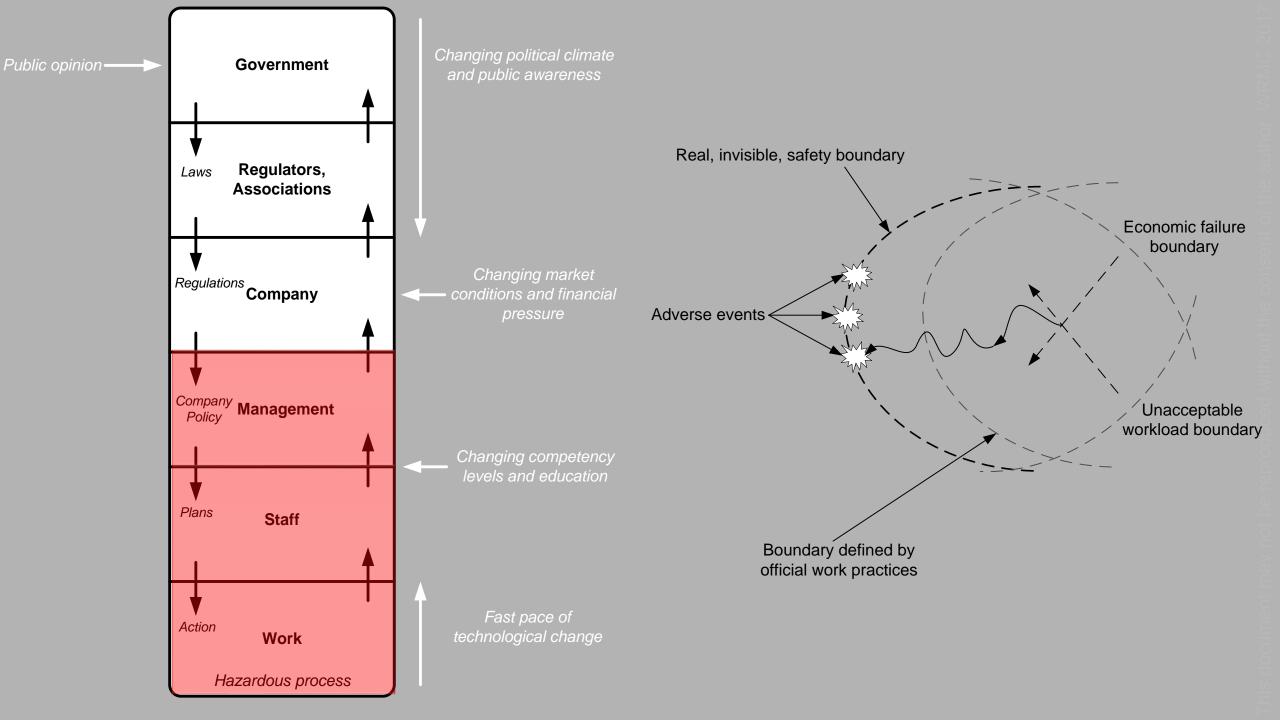
Figure 5 Accimap re	presenting the LOA system level where the risks identified for assessment reside (adapted from Salmon et al, 2010)
Government Departments	
Regulatory Bodies and Associations	
Local area government parents and schools	
Activity Centre Management, planning and budgeting	
Supervisory and management decisions and actions	Program (9%)
Decisions and actions of leaders, participants and other actors at the scene of the incident	Activity (40%) Group (10%) Staff (6%) "Participant, equipment
Equipment, environment and meteorological conditions	Venue (20%) (9%) Weather/ Geography (9%) Equipment (3%) (3%)

# **KEY FINDINGS**

ng the LOA system level where the risks identified for assessment reside (adapted from Salmon et al. 20

- Accident causation research demonstrates that factors also related to schools/centers/orgs, organization management, parents, activity leader supervision, risk assessment, and program design.
  - On
     Image: construction of the constructi
- 57% of respondents learned organisational risk assessment 'on the job';
- 35% use brainstorming or thinking up risks as a method of risk assessment;
- 70% of respondents currently 'confused' in relation to organizational risk assessment.

Only a small proportion of the potential risks around LOA program development and delivery are currently being assessed.



### DOMINANT MODEL OF RISK ASSESSMENT IN THE LED OUTDOOR CONTEXT

- The "People, Equipment and Environment" approach.
- Focuses predominantly at risks/actions at the immediate context of, and within, the confines of the activity.



## STUDY 3 – A REVIEW OF THE RISK ASSESSMENT LITERATURE

- 342 methods reviewed
- Multiple 'safety-critical' domains healthcare, nuclear, construction, process
- Some RA underpinned by systems approach (e.g. FRAM, STPA)
- Most RA methods adopt linear, chain-of event perspective
- Conclusion risk prediction methods are not aligned with current understanding on accident causation

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Systems thinking; risk

decision-making; risk

KEYWORDS

practitioner

Accepted 13 September 2017

assessment; emergence; risk

#### Check for updates

#### Identifying risks and emergent risks across sociotechnical systems: the NETworked hazard analysis and risk management system (NET-HARMS)

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#### ABSTRACT

Accidents are a systems phenomenon and multiple methods are available to enable retrospective analysis of accidents through this lens. However, the same cannot be said for the methods available for forecasting risk and accidents. This paper describes a new systems-based risk assessment method, the NETworked hazard analysis and risk management system (NET-HARMS), that was designed to support practitioners in identifying (1) risks across overall work systems, and (2) emergent risks that are created when risks across the system interact with one another. An overview of NET-HARMS is provided and demonstrated through a case study application. An initial test of the method is provided by comparing case study outcomes (i.e. predicted risks) with accident data (i.e. actual risks) from the domain in question. Findings show that NET-HARMS is capable of forecasting systemic and emergent risks and that it could identify almost all risks that featured in the accidents in the comparison data-set.

#### Relevance to human factors/ergonomics theory

Methods which both support and enable application of a systems theoretical perspective to risk assessment are extremely limited. This paper outlines the development of a risk assessment method both underpinned by systems thinking and that was consciously designed to facilitate ease of use and application by the risk management practitioner.

# **AN OBVIOUS DISCONNECT**

#### Systems approach to Accident Causation

- Accidents caused by interacting factors across 'systems'
- Error as a consequence of factors residing throughout the system
- Systems-based strategies and countermeasures
- Multiple methods to view and analyse accidents through this lens

#### Systems approaches to Risk Assessment

- The same factors that are present in accidents must also be present in the system prior
- Not many methods available to predict and analyse what may occur as a result of multiple, interacting risks
- Most risk assessment methods are linear, chain-of-event and focus largely on the sharp end of operation (Dallat, Salmon and Goode, 2017a).



# **NET-HARMS' DESIGN PRINCIPLES**

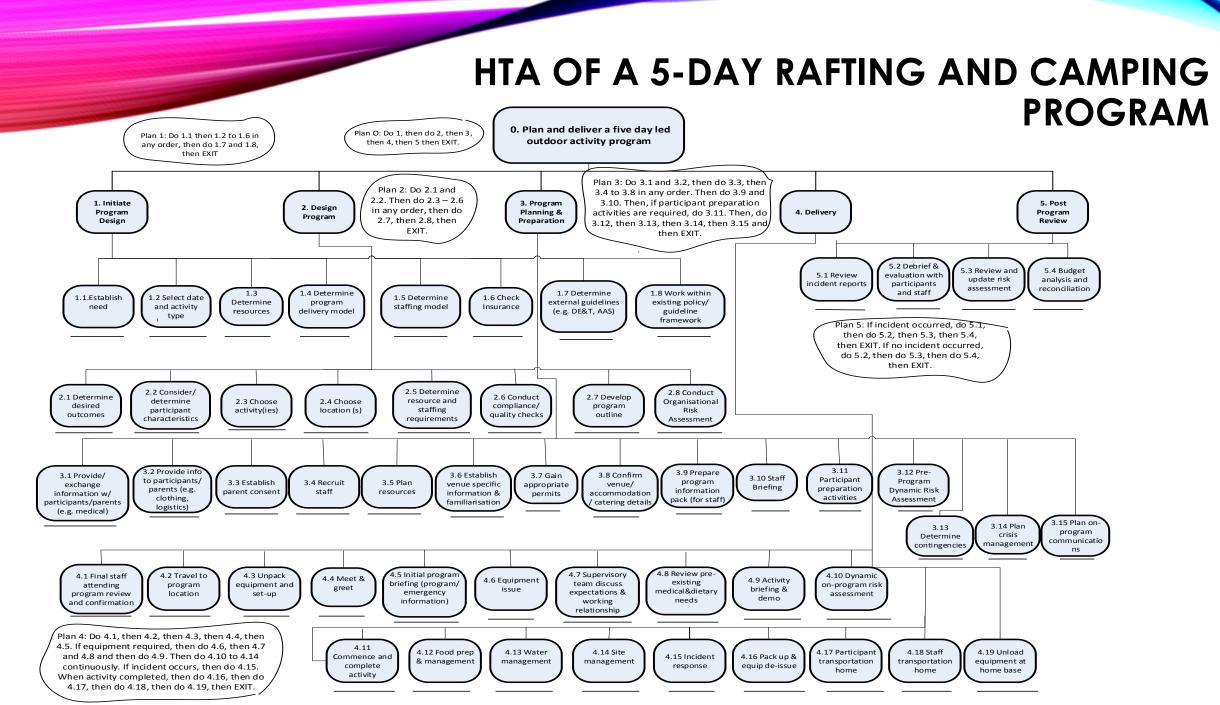
- Organisational RA Tool
- Can predict emergent risks (the risks that arise when risks interact with each other).
- Used by teachers/planners
- Planning tool ('Proceed or Not')
- WHS Compliant
- Time efficient
- Range of experience levels

- Incorporate existing RA's
- Identify new hazards/risks
- Identify range of controls
- Could be data-based
- All activity types
- Low cost
- Multiple end users

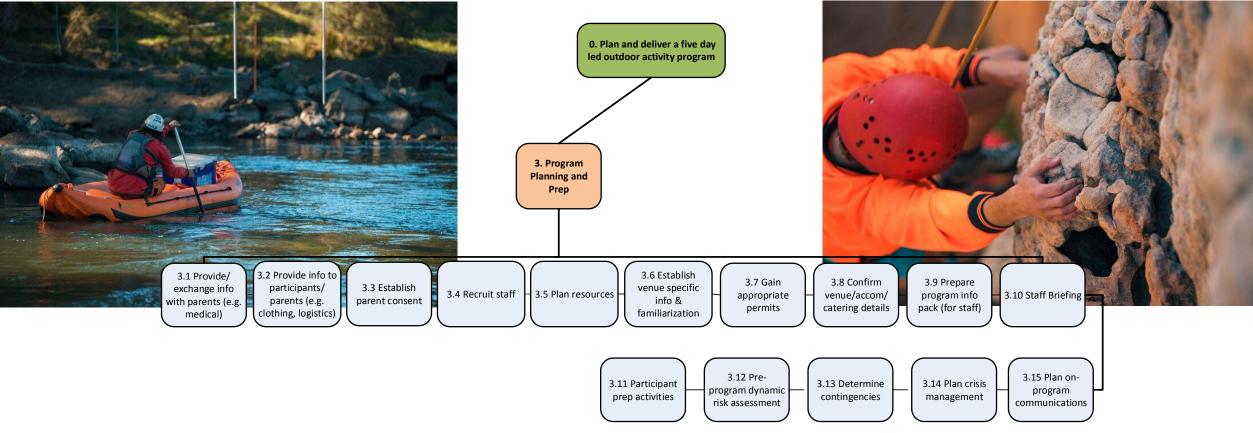
## STEP 1 - HIERARCHICAL TASK ANALYSIS

- Used to anchor identification and assessment of system risks
- A methodology for describing the goals, tasks, operations and plans associated with work systems (Stanton, 2006).
- A useful way of looking at how people interact with equipment and with various aspects of their working environment
- By work systems, we are referring to the human and non-human actors throughout the organisation who influence the design, development and delivery of the outdoor program.

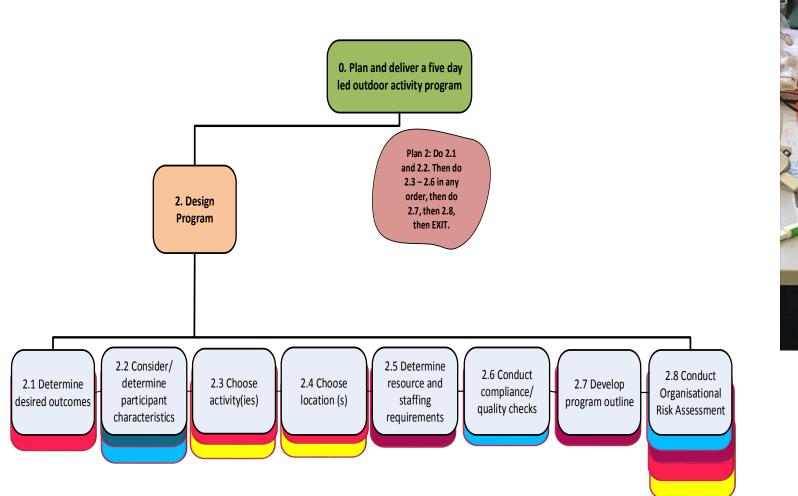




## EXCERPT - PROGRAM PLANNING AND PREPARATION



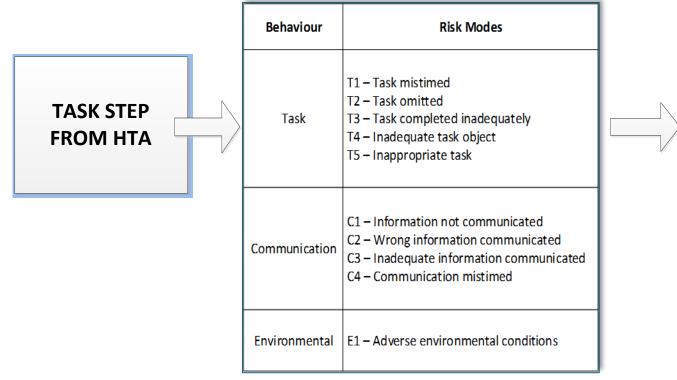
### **EXCERPT - PROGRAM DESIGN**







## **STEP 2 – NET-HARMS TAXONOMY**





- Based on SHERPA (Embrey, 1986)
- The taxonomy is the consistent filter through which we identify and assess risks

## PREDICTING TASK RISKS – EXAMPLES

HTA Task	Risk mode	Risk description	Risk consequence
1.6 check insurance	Т3	Insurance of sub-contractors not checked	inadequate/ no insurance /risk of harm/liability claim
2.3 choose activities	Т3	Activities are selected with lack of detail - eg. Distances of day/ rapid ratings etc	Injury from too high challenge level
2.3 choose activities	Т5	Coordinator chooses route due to strong personal preference	Group of students lost or injured
3.3 establish parent consent	E1	Room too noisy/ env unsuitable/ too much info/ parents busy/ distracted	Incomplete info. Not fully informed. Not understood. Not full consent.
3.10 Staff Briefing	T1	Staff briefing undertaken late (e.g. on the bus, immediately before program)	Staff member may miss important aspects of briefing relevant to management of risk Staff members do not have time to develop/evaluate appropriate risk controls
3.9. Prepare program information pack (for staff member)	Т1	Information pack prepared and delivered too late	Field program leadership does not have sufficient time to review and ensure familiarity with complete program information e.g. emergency phone no's, participant information
4.7. Supervisory team discuss expectations and working relationship	Т2	Expectations and working relationship not discussed	Potential for key information not to be communicated prior to activity (e.g. how to use satellite phone, behavior expectations, group communication methods, where first aid kit is, epi pen locations) Mismatch in expectations e.g. between provider and school

#### **'PLAN CRISIS MANAGEMENT' TASK RISKS**

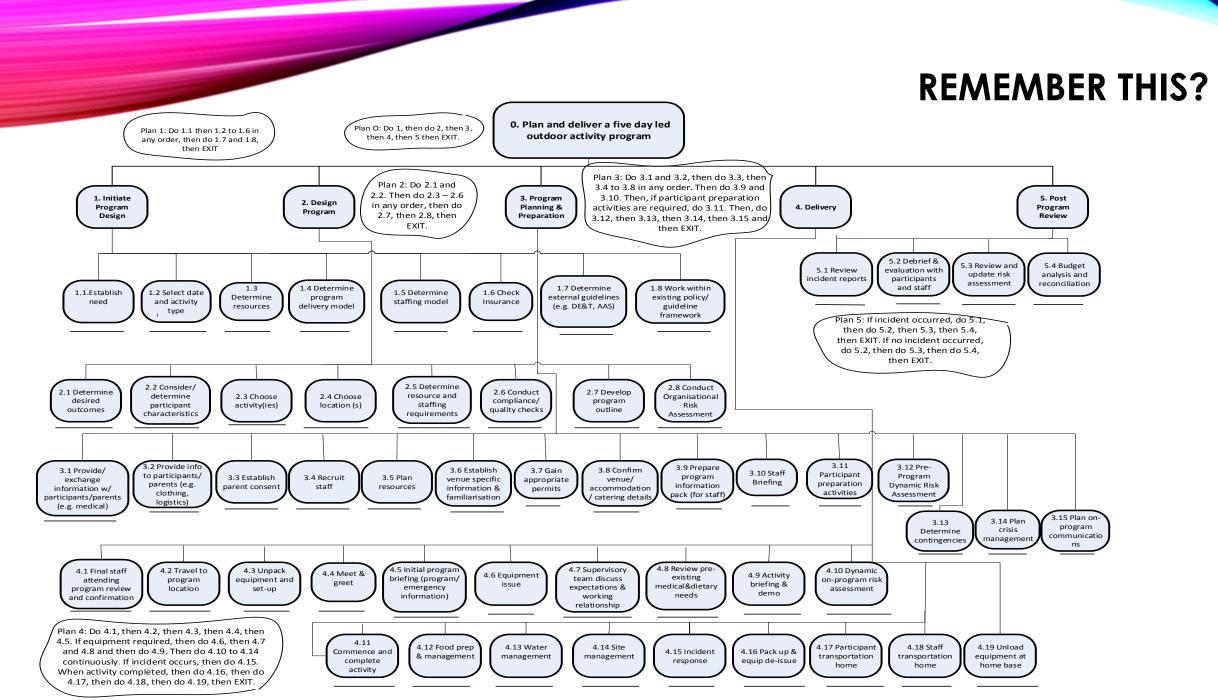
HTA Task	Risk Mode	Task Risk Description	Risk Consequence(s)
3.14. Plan crisis management	T1	Crisis management planning is conducted too late	<ul> <li>Ineffective/inappropriate crisis management plan leading to further risks/harm</li> <li>Position becomes forced and reactive</li> </ul>
	T2	Crisis management planning is not conducted	<ul> <li>No crisis management plan in place</li> <li>Staff in field are not supported leading to likely escalation of situation due to resource scarcity</li> <li>Ineffective/inappropriate crisis management plan leading to further risks/harm</li> <li>Position becomes forced and reactive</li> </ul>
	Т3	Crisis management plan is inadequate	<ul> <li>Ineffective/inappropriate crisis management plan leading to further risks/harm</li> </ul>
	Τ4	Crisis management tool is inadequate for the planned context (e.g. off the shelf, untested, administrative plan not designed for potential remote, overseas, communications- challenged environments)	<ul> <li>Ineffective/inappropriate crisis management plan leading to further risks/harm</li> </ul>
	C3	Inadequate communication of crisis management plan	<ul> <li>Not all staff aware of crisis management plan</li> <li>Sub-optimal enactment of crisis management plan</li> </ul>
	C1	Crisis management plan not communicated to all staff	<ul> <li>Not all staff aware of crisis management plan</li> <li>Sub-optimal enactment of crisis management plan</li> </ul>

## **STEP 3 – EMERGENT RISK PREDICTION**

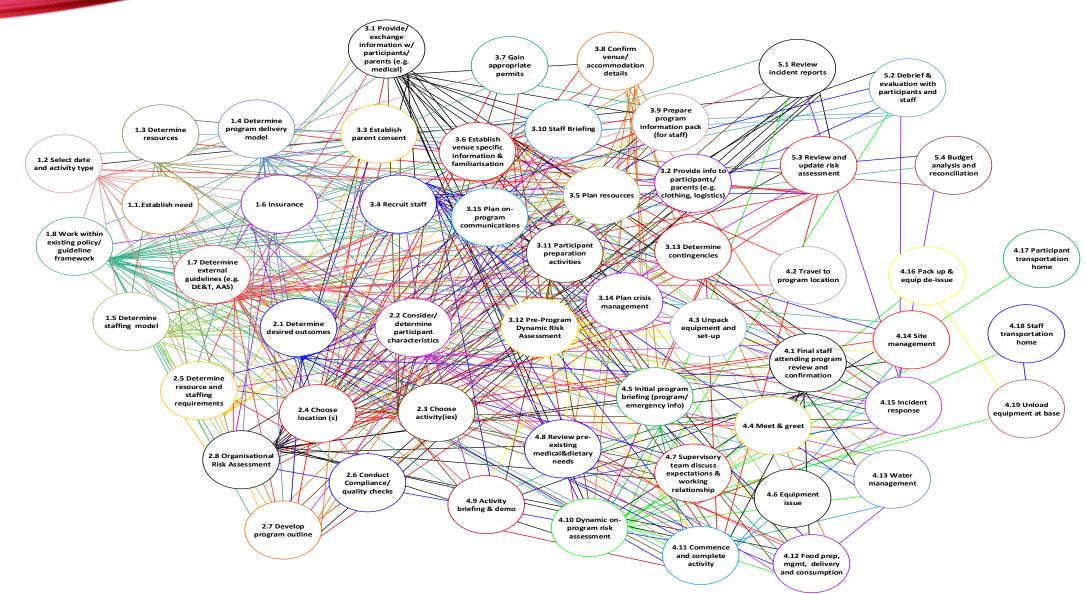
• Remember how a systems approach to accident causation considers that multiple factors and interactions are integral?

• This next step helps us identify and assess the impact of those interactions in a risk prediction context.





## **RELATIONSHIPS BETWEEN TASKS**



# PREDICTING EMERGENT RISKS

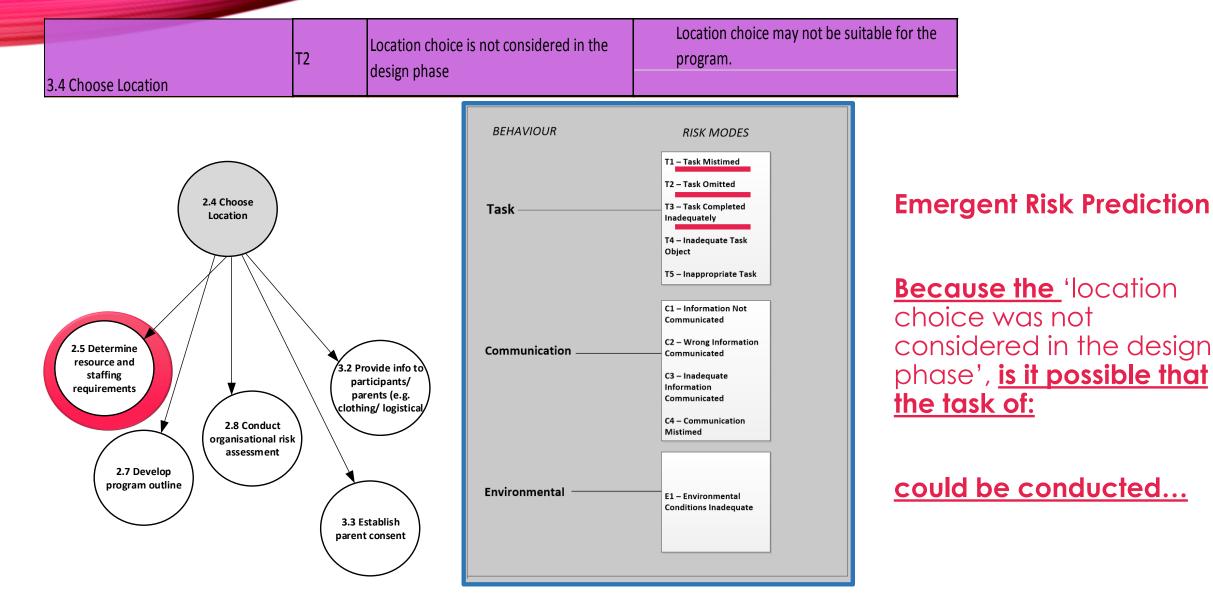
Emergent behaviours are they key to understanding accident causation

We want to identify what is the likely impact on linked tasks if the initial one is done badly, not at all, too early/too late etc.

#### Why is this important?

It helps us identify the tasks associated at all stages throughout the work system – design, development, planning and delivery – that are critical to manage risk and achieve optimal outcomes.

#### LINKED TASKS – 2.4 CHOOSE LOCATION



## **EMERGENT RISK EXAMPLES**

			Emergent		Emergent risk
HTA Task	Task risk	Linked task	risk mode	Emergent risk description	consequence
		4.12 Food		Food proparation (ordering is	Program food is
	Deserves planning is inclasure (s.s.			Food preparation/ ordering is	-
	Resource planning is inadequate (e.g.	preparation and		done poorly / inadequately as	inappropriate in
3.5 Plan resources	not enough, incorrect)	management	T3	planning was also inadequate	content/quantity
					<b>-</b>
					Student become
	Program outline communication is	4.11 commence		Poor outline information lead to	hyporthermic from
2.7 Develop program	inadequate e.g. doesn't give full	and complete		mistimed activity start - rafting	being wet on river as
outline	overview of program	activity	T1	finishes in the dark	temps drop
	Consideration of participant				
2.2.	characteristics is inadequate in the				
Consider/determine	design phase of the program (e.g. with			Activities are chosen without	Activities are
participants	no consdieration given to participants	2.3 choose		consideration of participant	inappropriate for this
characteristics	with specific needs	activities	T1	characteristics	participant cohort
					Unhealthy learning
					environment puts
					students off outdoor
					experiences in future.
	review of pre-existing dietary and				Dangerous
4.8 On program review	medical conditions is inadequate (e.g.	4.11 complete		Inadequate review leads to	environment for
	rushed, missing information, group	and commence		inadequate program environment	impacted students
and dietary needs	leadership change)	activity		being chosen	not realised

# WHAT DOES THIS TELL US?

Study showed that:

- 141 task risks were predicted in the design, planning and review stages (Sections 1, 2, 3 and 5) of the HTA. Tasks at the program delivery of the program, (Section 4 of the HTA), had 91 predicted task risks.
- NET-HARMS identified **1131 emergent risks** associated with the design, planning and review tasks (Sections 1, 2, 3 and 5 of the HTA), whereas in the program delivery tasks (Section 4 of the HTA), 232 emergent risks were predicted.
- The largest number of emergent risks reside within the tasks not associated with delivery of the activity.
- Overall, the study demonstrated the existence of 5.8 times more emergent risks in the system than task risks.

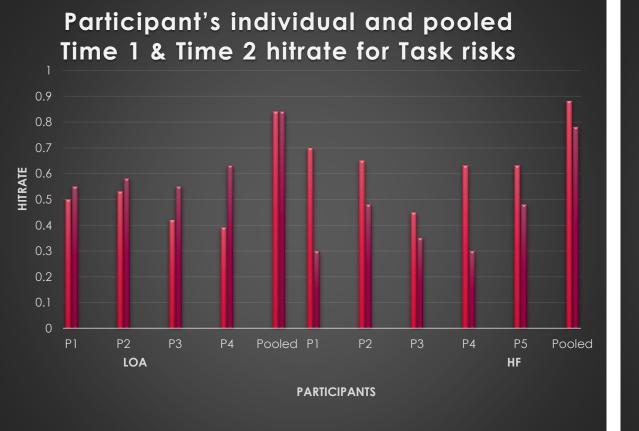


## **TRANSLATION INTO PRACTICE**



This documentme not

## **VALIDATING NET-HARMS**



■Time 1 ■Time 2

Participant's individual and pooled Time 1 & Time 2 Hitrate for Emergent risks 0.8 0.7 0.6 **HITRATE** 0.2 0.4 0.3 0.2 0.1 P2 Ρ3 P2 Ρ3 Ρ4 Ρ5 P1 Ρ4 Pooled P1 Pooled LOA HF PARTICIPANTS Time 1 Time 2

# SUMMARY

- Systems thinking approach required for safety management; anything else limits impact and learnings
- Accident analysis/investigation should always be blame free and go up and out
- Injury incidents always have multiple contributory factors spanning the entire outdoor education system
- Risk in outdoor education activities is low
- Sector good at managing overtly risky activities less overtly risky activities are an issue (e.g. free time, campcraft)
- Risk assessment needs to look at risks across the system as well as emergent risks that arise when different issues
  interact with one another
- NET-HARMS is a new risk assessment method that supports this view



#### The UPLOADS Project

UPLOADS: An incident reporting and learning system for the outdoor education, recreation and adventure sector in Australia

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#### **Upcoming Events**

No upcoming events

#### **ACKNOWLEDGEMENTS/FURTHER INFORMATION**

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