

SAFETY SUPERVISION

Making Defensible Decisions at the Front Line

8 Modules · Online Self-Paced · 2-3 Hours

tombourne.website

About This Course

Who this is for

- Frontline supervisors in high-risk industries
- Team leaders carrying safety accountability
- Anyone who makes decisions under pressure that affect worker safety

What you will be able to do

- Make and document defensible safety decisions
- Understand the legal standard that applies to your role
- Recognise when systems are drifting toward failure
- Hold yourself and others accountable fairly

Course Structure

- 01 The Reality of Safety at the Front Line
- 02 What Reasonably Practicable Actually Means
- 03 Decision Making Under Pressure
- 04 The Human Side of Supervision
- 05 Conversations That Change Behaviour
- 06 When Things Start Going Wrong
- 07 Balancing Accountability and Fairness
- 08 Applying It All — Integration Scenarios

How This Course Works

1

Read

Each module opens with the core concept — the theory and framework you need to understand your situation.

2

Case Study

Real incidents. Real decisions. Examine what happened, why, and what a different path looked like.

3

Reflect

Key questions you can't fake. These are the conversations that matter — with yourself first.

4

Test

80% pass mark per module. Closed without passing. Certificate on completion of all eight.

The Reality of Safety at the Front Line

The gap between what management thinks is happening and what actually is.

20 minutes

Work-as-Imagined

- Procedures followed to the letter
- Full staffing, right materials, ideal conditions
- Workers act exactly as trained
- Risk is static and predictable

Work-as-Done

- Constant adaptation to real conditions
- Short-staffed, late materials, conflicting instructions
- Workers solving problems management doesn't see
- The gap is invisible to anyone not present

Safety-II (Hollnagel): most work goes right because workers compensate — not because procedures are followed.

Not just a senior worker — the collision point between organisational expectation and operational reality.

Production Pressure

vs

Stopping Work

Regulatory Requirements

vs

Practical Feasibility

Team Loyalty

vs

Reporting Problems Upward

Individual Accountability

vs

Systemic Causes

Understanding these tensions is not about excusing poor decisions — it's the prerequisite for making defensible ones.

They're not the ones with the best rulebooks.

- 01** They understand the gap between policy and reality
- 02** They know when to close the gap themselves — and when to escalate it
- 03** They document their reasoning in real time
- 04** They can explain their decisions to a regulator, an investigator, or a coroner

Kalidonis NT

The Death of Paul Leach

What to look for:

- The sequence of decisions — not just the final one
- Where work-as-imagined diverged from work-as-done on the day
- What information supervisors had — and what they did with it
- How accountability was assigned, and whether it reflected the evidence

"The supervisors who navigate this well understand the gap, know when to close it and when to escalate, and can explain their reasoning afterwards — to a regulator, to an investigator, to a coroner if necessary."

Before the next module, ask yourself:

In the last week — which decisions would you struggle to explain to an investigator?

What Reasonably Practicable Actually Means

The legal standard that defines what duty-holders must do — and how it applies to your role.

20 minutes

What is reasonably able to be done, having regard to and giving appropriate weight to:

- The likelihood of the hazard or risk occurring
- The degree of harm that might result
- What a person knows or ought to know about the hazard and controls
- The availability and suitability of ways to eliminate or minimise risk
- The cost — only if grossly disproportionate to the risk

The key question

Would a reasonable person with your knowledge, in your position, with the information available, have done what you did?

Critical point

"It would be expensive" is not a defence. "It would cost ten times more than the risk it addresses" might be.

ELIMINATE — Remove the hazard entirely

SUBSTITUTE — Replace with something less hazardous

ISOLATE — Separate the hazard from people

ENGINEER — Physical controls — guards, barriers, interlocks

ADMINISTER — Procedures, training, supervision — human-dependent

PPE — Last resort — relies entirely on behaviour

Procedures and PPE sit at the bottom because they depend entirely on human behaviour, which varies.

WASS

A Death at the Salt Pit Conveyor

What to look for:

- What controls were in place — and where they sat in the hierarchy
- Evidence that higher-order controls were technically feasible before the incident
- How the reasonably practicable argument was framed in prosecution
- What documentation existed — and what didn't

*The question is not whether you followed the procedure.
It's whether a reasonable person with your knowledge, in your position, would have done what you did.*

The test runs both ways:

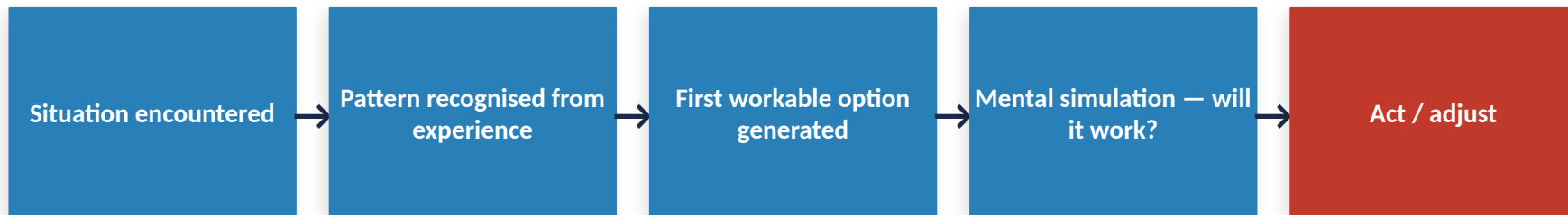
- Doing too little exposes you. But so does failing to document why a higher-order control was not reasonably practicable.

Decision Making Under Pressure

Why experienced people make bad calls — and what defensible decision making actually looks like.

25 minutes

Gary Klein: experienced workers don't evaluate multiple options — they pattern-match and act.



Why it usually works

Fast, efficient, built on genuine expertise. Correct most of the time — because experience is real.

When it fails

When the situation looks familiar but isn't. Experience is contextual — it fails at the edges of what you've seen before.

The gradual process by which a group accepts risk-taking as normal because the adverse outcome hasn't happened yet.

1 Task done the 'wrong' way once — no consequence

2 Same shortcut taken again — still no incident

3 Behaviour becomes routine — the new normal

4 The boundary has moved — risk is now invisible

! Incident occurs — looks like a 'sudden' failure

Mastermyne

The Death of Graham Dawson

What to look for:

- The production pressures operating that day — how they were communicated
- What pattern the supervisor likely recognised — and where that recognition failed
- Whether normalisation of deviance was present — and how long the drift had been occurring
- The proximate cause vs the contributing conditions — which one actually mattered most

A defensible decision is one you can explain.

What you knew

Articulate what information was available at the time of the decision

Your controls

Demonstrate the controls you had in place, and their adequacy

Your reasoning

Show that you genuinely weighed the risk — not just followed routine

Your escalation

Show that gaps were either addressed or escalated, in writing

The Human Side of Supervision

Workers are not interchangeable units. What they bring to work shapes what happens at work.

20 minutes

Fatigue

Day-to-day sleep variation — not just chronic tiredness

Psychological State

Anxiety, distraction, stress from outside work

Physical State

Pain, illness, medication effects, heat stress

Social Dynamics

Team conflict, peer pressure, cohesion

Organisational Trust

Whether the worker believes safety is genuinely valued

The belief that you will not be punished for speaking up — the strongest predictor of team safety performance.

High Psychological Safety

- Problems surface earlier
- Near-misses are reported
- Errors are recovered faster
- Concerns reach the supervisor

Low Psychological Safety

- Problems stay hidden
- Near-misses go unreported
- Errors compound
- Silence before incidents

Supervisors create or destroy psychological safety through daily behaviour — not annual safety talks.

Workers look to supervisors for signals about what's actually acceptable — not just what's written in the procedure.

When a supervisor bypasses safety steps under pressure, workers learn that lesson too.

The question to carry:

What safety behaviours are workers learning by watching you?

Conversations That Change Behaviour

Telling workers to be safe doesn't make them safe. Here's what does.

25 minutes

Why Instruction Alone Doesn't Work

M05

Workers process instructions through their existing understanding of the work, the risk, and the relationship.

Instruction

"Make sure you wear your PPE today."

What the worker hears

"The supervisor is covering themselves, this isn't actually dangerous."

What actually works

A conversation that surfaces the worker's own reasons for safe behaviour.

Workers follow instructions because they trust the person giving them or agree with the reasoning — not simply because they were told to.

The single most useful safety conversation is the one before the task starts.

Not the formal risk assessment — the real conversation.

- Does the team understand what they're doing today?
- Does anyone have a concern about this task?
- Is there anything about conditions today that changes the plan?
- What's the stop-work trigger for this job?

Done well: three minutes. Returns: catches a meaningful proportion of the problems that otherwise surface mid-task.

The commitment made in a safety conversation is worth nothing without follow-through.

- Check in during the task — not just before it
- Acknowledge what you see — the worker who is noticed doing it right does it right again
- Motivational interviewing: help them surface their own reasons — don't impose yours

When Things Start Going Wrong

Incidents don't announce themselves. Recognising the pattern early is the whole game.

20 minutes

Near-miss frequency rising

Often under-reported or dismissed as trivial

Communication breakdown

Problems reported upward less frequently

Shortcuts becoming standard

Steps that used to be done are now routinely skipped

Fatigue accumulation

Long rotations, end of shift, high-heat environments

Growing reliance on PPE

For hazards that could and should be engineered out

Normalised time pressure

Jobs consistently taking longer than planned

Stopping work is structurally difficult — but a documented stop is always defensible. An undocumented one often isn't.

A defensible stop-work sequence:

- 1 I identified [specific hazard X]
- 2 The control for X was [Y]
- 3 Y was absent / inadequate
- 4 I stopped the task and reported it to [named person]
- 5 I documented the decision and time

"I wasn't comfortable" doesn't hold up. "I identified X, Y was absent, I stopped and reported it" does.

RPC

The Death of Hamiora Sharland

What to look for:

- Warning signals present before the incident — and where in the organisation they were received
- What information supervisors had vs what was known at other levels
- The distinction between information that was available and information that was acted on
- Where intervention was possible — and why it didn't happen

*The supervisor who recognises the early pattern has the chance to intervene.
The one who doesn't is managing consequences instead of causes.*

None of the warning signals automatically produce an incident. But each one reduces the margin for error — and when they accumulate, the probability of a serious outcome rises steeply.

Balancing Accountability and Fairness

Who gets blamed after a serious incident — and whether that reflects what actually happened.

20 minutes

Human Error	Inadvertent. Predictable. Produced by the system.	Response: Redesign the system — not discipline.
At-Risk Behaviour	Choosing a behaviour that carries unjustified risk, usually because the risk isn't seen or the safer choice is less accessible.	Response: Coaching and system change.
Reckless Behaviour	Conscious disregard for a substantial and unjustifiable risk a reasonable person would not accept.	Response: Accountability.

Most serious incidents involve human error and at-risk behaviour — not recklessness.

Supervisors are proximate enough to the work that there's always something they could have done differently.

The predictable patterns:

Failure to enforce a procedure

Failure to identify a hazard

Failure to stop work

Defence starts before the incident:

- Document decisions in real time
- Escalate concerns in writing — to a named person, with a specific request

Genuine accountability requires a genuine investigation of what actually happened — not an assignment of blame to the most visible person available.

Supervisors who understand this are better positioned to do their job well — and to protect themselves if things go wrong.

Applying It All — Integration Scenarios

Bringing the eight frameworks together into structured, defensible reasoning.

25 minutes

It's 3pm Friday. Two hours behind. Late material delivery. One worker visibly fatigued (started 5am). Final stage: working at height. Client calling every 30 minutes.

The five questions you must work through:

- 1 What hazards are present, and what is the current state of controls?
- 2 What has changed from the original task plan?
- 3 What does the reasonably practicable standard require given current conditions?
- 4 What decision authority do you have — and who needs to be informed?
- 5 If you proceed and something goes wrong, what would you need to be able to say?

M01

Work-as-Imagined vs Work-as-Done

Safety-II, Hollnagel

M02

Reasonably Practicable Standard

WHS legislation hierarchy of controls

M03

Recognition-Primed Decision Making

Klein; Normalisation of Deviance, Vaughan

M04

Psychological Safety

Edmondson — team safety performance predictor

M05

Motivational Interviewing & Pre-Task

Collaborative conversations that change behaviour

M06

Warning Signals & Stop-Work

Pattern recognition before incident emergence

M07

Just Culture

Marx taxonomy: error, at-risk, reckless

M08

The Defensibility Test

Structured reasoning for every high-stakes call

A decision you could clearly explain to a regulator, an investigator, or a coroner is generally a decision made for the right reasons.

What hazards were present?

Specific, named — not generic

What controls did I have in place?

And where did they sit in the hierarchy?

Did I genuinely weigh the risk?

Or did I default to routine?

Did I document my decision?

In writing, in real time, to a named person

If I identified a gap — did I close it or escalate it?

Both are defensible. Neither is not.



Which decisions in the last month would you struggle to explain to an investigator?



What is the highest-order control in place for your most significant hazard? Is it reasonably practicable to go higher?

Reasonably Practicable



Where has pattern recognition led you to treat a new situation as familiar? Where has normalisation of deviance taken root in your team?



In the last week — did any worker show signs you noticed but didn't act on? What would you do differently?



*Think of the last safety conversation you had. Was it instruction delivery — or genuine dialogue?
What would the other version have looked like?*



List three warning signals present in your workplace right now. What would acting on each one look like — practically?

When Things Start Going Wrong



In your team — are near-misses reported? If not: is that because there are none, or because something makes reporting feel unsafe?



Write down the last high-stakes decision you made. Apply the five-question framework. Does it hold up?

SAFETY SUPERVISION

The supervisors who navigate this well aren't the ones with the best rulebooks.

They're the ones who understand the gap, know when to close it and when to escalate, and can explain their reasoning afterwards.

Complete the final assessment to receive your certificate.