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Decluttering Safety:
A Multistakeholder Approach to Enhancing
Safety Management in Construction

Position Paper

May 2025

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Introduction

The construction industry continues to face significant safety challenges despite decades of safety management efforts. While accounting for only 9% of the Australian workforce, construction accounted for 23% of work-related fatalities in 2023 (Safe Work Australia, 2024). This trend persists despite extensive implementation of safety management systems, procedures, and compliance requirements, suggesting fundamental issues with how construction organisations currently approach safety management.

Contemporary safety management systems have been criticised for being impractical, duplicative, ill-fitting, excessive, wasteful, and ineffective (Bieder & Bourrier, 2013; Dekker, 2017; Rae et al., 2018). Scholars have noted that safety management systems are often characterised by excessive rules, procedures, bureaucracy, and obligations that may not always contribute to improved operational safety outcomes (Grytnes et al., 2020). Dekker (2017) argues that, despite the proliferation of safety procedures and compliance requirements, safety outcomes have not correspondingly improved in many contexts.

Among emerging concepts in safety research, 'safety clutter' has gained recognition as a potential barrier to effective safety outcomes. Defined by Rae et al. as the "accumulation of safety procedures, documents, roles and activities performed in the name of safety, but do not contribute to the safety of operational work" (2018, p.195), safety clutter represents the possibility that not all safety practices add value in, and some may actually impede safety performance. Examples include rules created after incidents without connection to law or regulation, completing irrelevant or excessive paperwork, duplicated activities, and terminal activities where the output (e.g., a completed form) is never reviewed or used (Rae et al., 2018).

Building on the concept of safety clutter, Rae and Provan (2019) drew an important conceptual distinction between 'safety work' and 'the safety of work'. While 'safety work' involves activities aimed at managing and demonstrating safety compliance, 'the safety of work' concerns the actual prevention of harm during day-to-day operations. Recognising this distinction helps explain why organisations may continue to implement and maintain safety processes that consume resources without improving safety outcomes. Safety clutter emerges when 'safety work' becomes disconnected

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from 'the safety of work', resulting in processes that serve symbolic or bureaucratic functions rather than addressing real operational risks. This disconnect is particularly evident in construction settings, where administrative safety requirements remain extensive despite consistently high rates of injury.

Recent research has begun to identify safety clutter in various contexts. In healthcare, Halligan et al. (2023) found that frontline healthcare staff identified low-value safety practices related to tick-box exercises, poor policy communication, duplication of activities, and inappropriate task allocation. Within construction settings, Havinga et al. (2022) argued that written pre-task risk assessment processes, such as "Take 5" assessments, may constitute safety clutter when ineffectively implemented. Looking more broadly at organisational systems, Rae et al. (2018) identified that safety clutter can emerge when the same activities are performed repeatedly using different formats or systems. Across these contexts, safety clutter is believed to contribute to job dissatisfaction, as well as stifling innovation, and leading to substandard safety performance (Dekker, 2014; Halligan et al., 2023; Størkersen et al., 2020).

However, these studies have typically focused on isolated aspects of specific safety management activities – albeit those in widespread use. For example, Havinga et al. (2022) focused solely on Take 5 risk assessments, Hutchinson et al. (2024) examined the extent to which "audit masquerade" gives a false sense of safety security in organisations, and Rydenfält et al. (2014) concentrated on the effectiveness of safety checklists. Others have emphasised particular sources of safety clutter, such as deregulation, overregulation, and/or bureaucracy (Dekker, 2014; Rae et al., 2018).

Importantly, many studies have adopted a 'bottom-up' approach by consulting frontline workers or limiting their investigations to single organisations when attempting to identify ineffective safety practices (Havinga et al., 2021; Havinga et al., 2022; Rae et al., 2018). While the experience of frontline workers, as the 'end users' of safety clutter is important, this potentially does not give the full picture of what constitutes safety clutter, how it is created and what are its consequences. In fact, safety practices vary significantly across different contexts and thus contextual differences need to be considered in identifying what is and what isn't safety clutter (Bieder & Bourrier, 2013). Additionally, input from multiple stakeholders, operating at different levels in an

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industrial system is required when considering de-implementing any safety practices deemed to be clutter (Grytnes et al., 2020).

Despite being references in academic and industry-based conversations, safety clutter remains an under-theorised concept with currently no consensus on what constitutes clutter in the construction industry context. Practitioners hold diverse opinions about what should be considered clutter, and the effects of safety clutter on safety performance. Moreover, the consequences of removing supposedly cluttered practices remain empirically untested (Rasmussen, 1997). Without a robust understanding of its attributes, causes, and consequences, organisations risk either maintaining ineffective practices or removing elements of safety management practice that serve an important protective function.

To address these gaps, we conducted a multi-stakeholder study exploring perceptions of safety clutter across the Australian construction industry. By capturing diverse perspectives from contractors, clients, regulators, unions, and consultants, our study provides a comprehensive understanding of what constitutes safety clutter in construction and how it might be effectively addressed.

Methods

We employed a qualitative research approach using semi-structured interviews with 18 stakeholders representing diverse perspectives within the construction industry. Participants included representatives from nine contractor organisations, two client organisations, two work health and safety regulators, three construction trades unions, one employer association, and one independent consultancy. This diverse sample enabled the capture of perspectives from people engaged in multiple levels of safety management and who play different roles in implementation of safety management practices.

Interviews were conducted either in person or via video conferencing, lasting 60-90 minutes each. Participants were asked about their conceptualisation of safety clutter, specific attributes they identified as clutter within safety management systems, as well as their perspectives on the underlying causes, and perceived consequences of safety clutter. All interviews were audio-recorded with participant consent and transcribed verbatim for analysis.

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Interview transcripts were analysed using thematic analysis. The analysis process involved familiarisation with the data, generation of initial codes, searching for themes, and refining those themes to produce the final analysis.

Findings

Our research into safety clutter in the construction industry reveals a complex phenomenon that undermines effective safety management, while consuming significant organisational resources. Through in-depth interviews with industry practitioners, we identified three key dimensions of safety clutter: its attributes (what it looks like), its sources (where it comes from), and its consequences (why it matters).

Our findings show that safety clutter manifests through nine distinct attributes, categorised as misintended, excessive, or irrelevant practices. These attributes emerge from ten identifiable causes that operate at contextual, system-response, and implementation levels (See Figure 1). The resulting consequences affect organisations across four critical domains: operational effectiveness, worker engagement, business performance, and safety culture. This section presents a narrative analysis of these findings, illustrating how safety clutter persists through interconnected factors that require collaborative, multi-stakeholder approaches to address effectively.
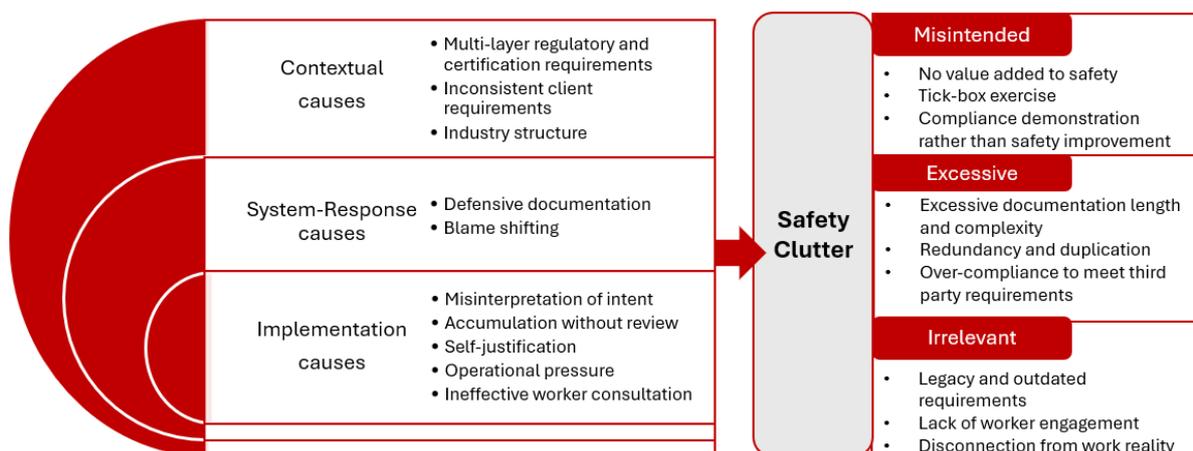

Figure 1: Sources and Attributes of Safety Clutter

This figure illustrates the three levels of causes —contextual, system-response, and implementation—that contribute to safety clutter, which is defined by the attributes of being misintended, excessive, or irrelevant.

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Attributes of Safety Clutter

Safety clutter can be defined as safety processes, documentation, and activities that consume organisational resources without contributing to improved safety outcomes. Through in-depth participant interviews, our research identified nine key attributes of safety clutter, which naturally grouped into three overarching categories: misintended, excessive, and irrelevant safety practices. These categories represent different ways that well-intentioned safety initiatives can become counterproductive in practice.

Misintended Practices as Clutter

At its core, misintended safety clutter consists of safety activities that provide no value to improving safety outcomes. These are safety activities that do not meaningfully reduce risk or enhance protection but persist in practice, nonetheless. As one participant explained, "*There's a lot of paperwork that often doesn't really serve a purpose. It's there, we do it, it doesn't really change safety outcomes, doesn't improve site safety*" (Employer representative). In such cases, the effort invested in maintaining these activities far outweighs their benefit – in other words, "*the juice isn't worth the squeeze*" (Regulator 2).

The disconnect between safety efforts and safety outcomes also creates what participants described as *"tick-box exercises"* that focus on formality rather than substance. One participant observed that "*safety is viewed as a compliance measure rather than something that can actually prevent someone's life from being lost... safety is then viewed as some sort of compliance tick and flick. We've got to do it. A chore almost... It's just surface level stuff*" (Regulator 2). The emphasis shifts from preventing harm to demonstrating compliance, undermining the true purpose of safety systems.

This shift toward compliance demonstration safety is often driven by external regulatory pressures. As another participant noted, "*sometimes you look at it and you think it's just a case of creating paperwork for the sake of having paperwork... it's completely out of your control but you've got to make sure you comply*" (Contractor 4). The regulatory focus on documentation can inadvertently push organisations toward creating safety processes that serve bureaucratic purposes rather than genuinely protective ones.

These three attributes of misintended safety clutter—no value added, tick-box exercises, and compliance demonstration—collectively reveal a fundamental

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disconnection between safety activities and their intended purpose of preventing harm. Workers engage with these processes superficially because they recognise them as bureaucratic exercises rather than meaningful safety measures.

Excessive Practices as Clutter

Beyond purely misintended practices, our research identified a second category of safety clutter that stems from potentially valuable safety activities implemented to such an extreme degree that they become counterproductive. This excessive safety clutter overwhelms workers and safety professionals alike with too much information, too much repetition, and too many requirements.

Documentation length and complexity emerged as a particular concern for participants. One participant described the practical impossibility of effective implementation: "*Safe work method statements (SWMSs) being 32 pages... I find it difficult to remember what I've read after three or four, five pages, let alone 30 pages... it just cannot work in theory. And in practice, it doesn't work*" (Union representative 1). When safety documentation grows to such lengths, its utility for guiding safe work becomes questionable.

This problem is compounded by redundancy and duplication across safety requirements. When existing safety tools become too lengthy or disconnected from frontline work, new processes are added on top rather than replacing or refining what's already there. As one participant reflected, "*SWMSs had become so bloated and disconnected from the work group, we now have to implement this stop card, Take 5 card… 'Isn't this just hazard risk controls, the same as SWMSs?' 'Yes, it is. But we know that no one's reading the 60 to 90 long page SWMSs, so we now have to do this and do this dynamic risk assessment'*" (Employer representative). The result is a layering of redundant processes that duplicate effort without enhancing safety.

The over-compliance to third party requirements drives organisations to implement excessive measures beyond what's necessary for actual safety. One participant lamented: "*There's also a number of scenarios over the past probably four to five years, just about every client now has an external auditor who audits your system. So at the moment, we're dealing with... four or five external auditors reviewing our system over a 12-month period. It's fair to say that everybody's got a different view of the world of what should be in your system. One auditor may think it's okay, another external*"

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auditor may have a different view of the world. So you're constantly changing, reviewing and updating your system to comply with an external body" (Contractor 4). This excessive focus on meeting external requirements often comes at the expense of developing more effective safety processes.

These three attributes of excessive safety clutter—documentation length and complexity, redundancy and duplication, and over-compliance to meet third party requirements—reveal how safety systems can grow beyond their useful scope. Rather than enhancing safety, these practices create information overload, duplicate efforts, and divert resources away from activities that could more directly impact safety outcomes.

Irrelevant Practices as Clutter

The third category of safety clutter identified in our research relates to practices that are disconnected from workplace realities. These don't reflect how work is actually performed or address genuine risks, creating a gap between formal safety systems and actual work practices.

One manifestation is the persistence of legacy and outdated requirements that no longer match current work conditions. A participant described a telling example: "*This company then moved to telematics, so in vehicle monitoring they could see in real time where vehicles were, they're in constant contact with people in those vehicles. Yet they still persisted with the journey management form... they never really stopped to think about whether that document was adding any value to the process*" (Contractor 2). Organisational inertia keeps outdated requirements in place even after their purpose has been superseded by new technologies or practices.

Irrelevance also often stems from a lack of engagement with the workers these systems are meant to protect. Safety processes created without frontline input fundamentally miss their purpose, as one participant noted: "*Something that doesn't add value or that the workforce can't fully engage with would probably be what I would describe as clutter*" (Contractor 6). This disconnect occurs when systems are developed without consultation: "*It's something which regrettably is being prepared by company safety managers… not based on the engagement and consultation with workers and trying to capture their experience, their knowledge and their capacity*" (Contractor 7). Without incorporating the expertise of those who actually perform the

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work, safety requirements fail to address actual risks and become irrelevant to daily operations.

At the most fundamental level, irrelevant safety clutter stems from a disconnection from work reality, creating a mismatch between formal safety systems and how work is actually performed. As one participant explained: "*You've heard this concept of work as done versus work as imagined, right? So sometimes there's a disconnect between what we think happens at the corporate level on site to actually what actually happens on site... A classic one is around Take 5... They're largely not used well, and they're just generally used, just filled out so the paperwork's done, as opposed to a lifeline of defence checking controls are in place before you proceed with the work.*" (Contractor 2). This fundamental disconnect limits the effectiveness of document-heavy safety systems in shaping actual work practices.

These three attributes of irrelevant safety clutter—legacy and outdated requirements, lack of worker engagement, and disconnection from work reality—create a divide between formal safety systems and the actual conditions and practices of workers. Safety requirements that don't align with how work is actually performed are unlikely to be implemented effectively, creating a gap between "work as imagined" in safety documentation and "work as done" in practice.

In summary, our analysis reveals that safety clutter manifests through distinct attributes categorised as misintended, excessive, and irrelevant practices. Each category requires a targeted approach for effective decluttering. Misintended clutter, those adding no genuine safety value but existing primarily for tick-box exercises and compliance demonstration, should be eliminated or minimised to refocus efforts on meaningful protection. Excessive clutter, potentially valuable safety activities implemented to counterproductive extremes, should be simplified to their essential components, reducing documentation length and complexity, eliminating redundancy and duplication, and streamlining compliance with varied requirements imposed by clients, auditors, and other external stakeholders. Irrelevant clutter, disconnected from workplace realities and worker expertise, require collaborative redesign with frontline input to align with how work is actually performed and address genuine risks. This framework provides organisations with a clear roadmap for working collaboratively

with stakeholders across all levels, systematically transforming safety systems from bureaucratic exercises into practical tools that genuinely protect workers.

Sources of Safety Clutter

Our research revealed that safety clutter emerges from a complex interplay of forces operating at different levels within and beyond organisations. Rather than having a single cause, safety clutter arises from the interactions between external pressures, organisational responses, and implementation practices. Understanding these sources not only helps explain why safety clutter persists despite widespread recognition of its negative impacts, but also identifies the key stakeholders—from regulatory bodies and organisational leadership to safety professionals, unions and frontline workers—who must collaborate for effective decluttering efforts. This multi-layered analysis provides the foundation for strategic partnerships essential to addressing each type of safety clutter.

The Contextual Environment: External Pressures

At the broadest level, our findings show that safety clutter stems from the challenging context in which construction organisations operate. These contextual factors create conditions where safety clutter is almost inevitable unless actively countered.

The construction industry faces a particularly complex regulatory landscape characterised by multi-layer regulatory and certification requirements. One participant clearly articulated the challenge: "*And then you've got the Federal Safety Commissioner…they have slightly different requirements than our legislative framework. So I feel sorry for the companies having to deal with both the Victorian legislative requirements and then the Federal Safety Commissioner's requirements to get registration*" (Union representative 1). The sheer volume of overlapping requirements becomes overwhelming, with another participant noting, "*In 20 days we had nine audits. All our clients have got, every site has to be audited once a month*" (Contractor 9).

This regulatory complexity is further compounded by inconsistent client requirements, requiring contractors to maintain multiple parallel safety systems. As one participant noted, "*They [the client] review our management plans on a monthly basis... they're*

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continually asking for changes and amendments" (Contractor 6). These challenges are exacerbated when working with multiple clients, each with different requirements: "*By the time I went to five builders and done five things for each builder, I had another 25 things on there... my documents were 20 pages long*" (Contractor 9). These pressures are especially pronounced in joint ventures and multi-contractor situations, resulting in what one participant referred to as "*a heap of clutter that's not necessary*" (Contractor 8).

The fundamental industry structure further complicates safety management through its multi-tiered subcontractor model and transient workforce. As one participant observed, "*We work in a subcontractor workforce in Australia... In one week, they will potentially work for three separate contractors*" (Contractor 5). This fragmentation makes consistent safety systems difficult to maintain and increases the likelihood of redundant or conflicting requirements.

System-Response Interactions: Organisational Adaptations

The research indicates that organisations don't passively receive these external pressures but actively respond to them, often in ways that generate additional safety clutter. These responses represent a middle layer between purely external factors and purely internal implementation practices.

Perhaps the most significant response is defensive documentation, where organisations create extensive paperwork primarily in an attempt to protect themselves from legal liability, rather than in the interests of safety improvement. One participant bluntly described this dynamic: "*I think the clutter is coming from the litigious nature of the game. The game is, 'I own a business. The regulator says you must be safe or we're going to whack you with a stick.' Okay? So, my next logical step is I need to talk to a lawyer and make sure I never get whacked with the stick*" (Employer representative).

This defensive stance often leads to the creation and retention of excessive documentation, as another participant explained: "*People may have legacy policies and procedures that they haven't changed, for fear that if they do change and an incident happens, that they'll be held to account*" (Regulator 1). The focus shifts from preventing injuries to avoiding liability.

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Related to this defensive posture is the practice of blame shifting, where safety documentation becomes a tool for redirecting responsibility from organisations to individuals. "*It also tends to me that it's individualising the safety side of things. So if something goes wrong, oh well, you didn't sign this correctly, or this wasn't filled out correctly, or, to try to put the blame back on the individual, rather than the system of work which has allowed that error*" (Union representative 1). Another participant described how "*when things do go wrong the employer's got this kind of shield, oh, but we've got a procedure. You didn't follow the procedure. We're going to go into disciplinary*" (Union representative 2).

These system-response interactions reveal how organisations adapt to external pressures in ways that generate safety clutter. While organisations have choices in how they respond, these responses are significantly shaped by the broader context of regulatory requirements, liability concerns, and industry structure.

Implementation Practices: Internal Organisational Processes

At the most immediate level, safety clutter emerges from specific implementation practices within organisations that involve how they develop, maintain, and apply safety systems day-to-day.

One common issue is misinterpretation of intent, where the original purpose of safety regulations becomes distorted through excessive implementation. "*I think the application of how the legislation, the requirements and how that's interpreted, I think, is sometimes misinterpreted and applied not in the true sense of how it was first, and originally, imagined*" (Union representative 1). This often results in extending documentation requirements beyond their intended scope, as illustrated by the same participant: "*Under our construction regulation, you only need a safe work method statement for high-risk work. You don't need the safe work method statement to go through parking your car on the side, walking from the carpark to the front gate...*"

Even more pervasive is the problem of accumulation without review, where safety requirements continually grow but are rarely pruned. "*Every time we start off with a small document and then every time there's an incident or a near miss people add to the document... But nobody ever takes anything out. So a few years down the track, you've got a 20 or a 30 or a 50 page SWMS that we're trying to cover everything. But by trying to cover everything, we cover nothing*" (Consultant). Another participant

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described this as "*a vicious circle... We've had an incident. We build upon that. We introduce new processes, documents, checklists, what have you. Another incident happens, well guess what? We then go through and add more stuff*" (Regulator 2).

Safety clutter can also emerge from self-justification processes, where safety professionals and departments develop complex systems partly to demonstrate their value to the organisation. One participant observed that "*OHS/HR (occupational health and safety and human resource) departments just trying to justify their existence and produce these glossy procedures and protocols to show this is the work we're doing, this is our workload. This is why you pay for an OHS team*" (Union representative 2). This rationale for safety work shifts the focus from safety outcomes to compliance, as another participant noted: "*Safety is viewed as a compliance measure rather than something that can actually prevent someone's life from being lost... It's we've got to do this because this boss is going to get checked*" (Regulator 2).

Day-to-day operational pressures further contribute to the gap between formal safety systems and actual practices. "*The people that are filling out the permit, they want to get the work done, they're under time pressure so they don't fill it out correctly or they don't fully understand the content*" (Contractor 6). These pressures reflect competing priorities that reshape how safety systems function in practice, with one participant noting that "*the one thing that the site managers judged on is not lost time injuries, it's productivity*" (Union representative 2).

Finally, ineffective worker consultation undermines the relevance and practicality of safety systems. One participant asked rhetorically, "*How many SWMSs are actually developed in consultation with the work group? It's typically them often searching compliance codes, adding in detail*" (Employer representative). Even when consultation opportunities exist, barriers remain: "*We open the floor for feedback... but usually the guys don't like speaking in a public situation... so therefore they don't communicate it back to us and then therefore we're left with a system which isn't maybe broken but it needs work*" (Contractor 6).

The Interconnected Nature of Safety Clutter Sources

The results also indicate that these sources of safety clutter do not operate in isolation but instead they interact and reinforce each other across levels. Regulatory complexity at the industry level drives defensive documentation at the system-response level,

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which in turn leads to accumulation without review at the implementation level. Similarly, inconsistent client requirements contribute to operational pressures, while industry structure impacts worker consultation practices.

This multi-layered, interconnected nature of safety clutter sources helps explain why it's so persistent despite widespread recognition of its negative impacts. Addressing safety clutter effectively requires interventions at all three levels—industry contextual, system-response, and implementation—with particular attention to the connections between them.

For example, reducing documentation length and complexity within an organisation would have minimal benefit if client auditing expectations still require exhaustive evidence, exacerbated by the inconsistent client requirements across projects. Similarly, a builder might develop streamlined safety processes, but if principal contractors impose their own extensive requirements as defensive and blame shifting documentation against potential liability, the decluttering effort potentially becomes ineffective in practice.

Importantly, these sources reflect the multiple stakeholders involved in creating and maintaining safety clutter. Regulators, clients, industry associations, organisational leaders and safety professionals all contribute to the problem in different ways. Consequently, effective decluttering requires collaborative actions from these diverse stakeholders rather than isolated efforts from any single group.

Understanding these interconnections provides a foundation for more effective approaches to reducing safety clutter and focusing safety efforts on what truly prevents harm. By recognising how external contexts shape organisational responses, and how those responses in turn influence implementation practices, we can develop more integrated strategies that address safety clutter at its multiple roots rather than just treating its symptoms. This multi-stakeholder approach to decluttering safety systems will be the focus of the next phase of our research.

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Consequences of Safety Clutter

While understanding the sources of safety clutter reveals with whom to intervene, failing to address these accumulated practices leads to far-reaching consequences that can undermine an organisation's entire safety approach. Our research identified significant consequences of safety clutter that extend beyond mere inefficiency. These impacts can be grouped into four major categories: operational consequences, worker-related consequences, business consequences, and safety culture consequences. Together, they reveal how safety clutter can paradoxically undermine the very safety outcomes it aims to improve.

Operational Consequences

Safety clutter significantly impairs operational effectiveness in three key ways:

Safety clutter causes resource misallocation by diverting safety professionals from field activities to administrative tasks. As one participant noted, "*I have to pull four safety people off site, sit them in a room and say, go and make this go away. I lose all the influence on the behaviours of people out on site, because I'm doing administrative controls*" (Contractor 9). This misallocation creates a substantial resource burden, reducing safety professionals' time for direct safety oversight, with another participant noting, "*There's weeks where I might spend, say, over five days I might spend maybe 70% of my time just doing administrative things and maybe only 30% actually out on the ground having a look at what's going on*" (Contractor 6).

It also leads to procedural ineffectiveness as the volume of documentation creates a disconnect between paperwork and practice. "*You lose sight of the actual implementation of the controls on site... the guys maybe just click yes, yes, yes, yes, yes but have they actually implemented it on site? Nine times out of 10, maybe 50 or 60% of the time they're missing some of the controls*" (Contractor 6). This results in time spent on documentation that provides little practical value: "*I might lose a week or two weeks just putting those [management plans] together and then they might not get looked up again for three or four months*" (Contractor 6).

Perhaps most concerning, safety clutter can result in risk management degradation by obscuring critical safety information. "*It clouds the focus and stops people from having a crystal-clear understanding of the things that could kill them or change their lives*" (Contractor 1). In some cases, safety clutter creates new hazards: "*Administrative*

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controls where you need to do things in a certain way that actually add extra unnecessary steps under the banner of safety, which are far from creating a safer workplace, are probably causing frustrations, and in some ways adding to job load and increasing risk" (Union representative 2). This can lead to a false sense of security, with one participant noting, "*When you think about it, I believe that we've over systemised the workplace to such an extent that people think, 'Well, I'm safe because of all these safety systems.' It's like, no, you still have to think*" (Consultant).

Worker-Related Consequences

Beyond operational impacts, safety clutter affects workers' engagement, psychology, and the utilisation of their expertise:

Safety clutter leads to disengagement from safety processes as workers find systems overwhelming or impractical. "*People don't engage with it, and they don't understand it, and they just look at it and go, it's too much*" (Contractor 8). This disengagement manifests as workers circumventing requirements or taking shortcuts to avoid burdensome processes: "*It creates people taking shortcuts… if I know I have to fill this form out, and I know it's going to take two days to get back to me… or if I just go flat out now and do it for half an hour, it'll be done, and if I don't get caught, I don't get caught*" (Contractor 9).

Safety clutter also has psychological impacts on workers, causing frustration and job dissatisfaction. "*It's very frustrating as a worker, employee travelling from site to site doing inductions*" (Regulator 1). This frustration can contribute to broader psychosocial impacts, as noted by one participant: "*Well I think if you look at the psychosocial hazards, the burden that's being placed on the individual worker, potentially, to do all this, and really, they haven't got much autonomy...*" (Union representative 1).

Additionally, cluttered systems tend to disregard worker expertise by prioritising documentation over practical knowledge. Systems that emphasise paperwork over worker input fail to capture valuable field experience, diminishing the role of worker expertise in safety management. "*I think what we don't do well at all is really use the expertise of the people actually doing the work by having them help design the system*" (Contractor 7). This disconnect is further emphasised by another participant who observed that "*a lot of that clutter that we have in our systems has not been developed*

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by people who've done the work" (Consultant), highlighting how safety systems often become burdened with impractical requirements when created without frontline input.

Business Consequences

Safety clutter creates substantial business costs beyond safety outcomes:

The financial impact stems from increased resource requirements, productivity losses, and program delays. "*It affects the program and, as you say, your production efficiency… you lose days in program because we haven't had the meeting with the contractor or they haven't completed this checklist, when in actual fact, from a site point of view, it's safe to proceed but because we haven't got the paperwork we haven't followed the procedures therefore it can't*" (Contractor 6).

Safety clutter damages reputation of safety and relationships between stakeholders. "*If the perception from the contractor is that what they're signing up to is unreasonable, unnecessary and not a value add and then client is holding you to account on that, 100% that clutter impacts that relationship*" (Client 2). This extends to the reputation of safety itself: "*I think it impacts the brand of health and safety as well*" (Contractor 2). The disconnect between management and workers is particularly concerning: "*The paperwork in between management and the worker actually divides us, it doesn't bring us together*" (Employer representative).

Ironically, excessive documentation can create compliance issues. "*If we have a process that says you have to have a written record of this, and then the written record is not completed, but the actual physical check is done, we're non-compliant with our own system, and therefore we're at risk*" (Contractor 8). The focus shifts from genuine safety to superficial compliance: "*You end up with a bloated system, and an inefficient system. You get yourself into a mindset of safety is about compliance to the legislation, compliance to this or compliance to that, rather than safety being about actual safety*" (Contractor 8).

Workplace Culture Consequences

Perhaps most significantly, safety clutter undermines the development of a positive workplace culture in relation to safety:

It erodes trust and credibility between workers and management. "*The biggest consequence in my opinion is the erosion of trust. It's basically saying to a group of*

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workers and companies who are specialists often in what they do that we know better than you do" (Contractor 7). This leads to cynicism about management's commitment to safety: "*I think employees tend to think, 'Let's just get this built. Let's do what we have to do to get this built.'*" (Regulator 1).

The complexity and volume of safety documentation impedes communication effectiveness. "*For example, our working at height requirements, due to the fact that we repeat it across various documents, there's a legislative change or an internal change, you have to backdate and make 20 updates across all that thing, so then what would happen is you may miss one or two and then all of a sudden you've got conflicting messages which result in people doing work differently*" (Contractor 5). Language barriers further complicate this: "*From a communication point of view, trying to get them involved in filling out the administrative side of things is a challenge because you're relying on a translator and then if the translator's not there, then it just doesn't get through and then the process doesn't get followed whatsoever*" (Contractor 6).

Safety clutter distorts leadership and accountability within organisations. "*They are second to none at cannibalising the efforts of other people and distributing work and contracting out what is a responsibility that is theirs*" (Contractor 1). This can lead to workers being blamed for system failures: "*When there's a serious incident, they will try to individualise and look at, rather than knock the system itself or what they did or didn't do, it will be trying to put the blame, which is a very human thing to do*" (Union representative 1). As safety processes become increasingly cluttered, organisations lose their ability to properly lead safety efforts, with one participant lamenting: "*We're losing our ability to influence our workers because we're getting told what to do and we are going down a path of more clutter as we go*" (Contractor 9).

Conclusion

Our research into safety clutter has revealed how well-intentioned safety requirements and practices can become counterproductive burdens on organisations. By examining the distinct attributes, sources, and consequences of safety clutter, we've developed a comprehensive understanding of this pervasive challenge.

The attributes of safety clutter fall into three distinct categories. Misintended elements provide no genuine safety benefit and exist primarily as no-value-added activities, tick-box exercises, and compliance demonstration without actually preventing injuries. Excessive elements might have some underlying value but are implemented to such an extreme degree that they diminish effectiveness through documentation length and complexity, redundancy and duplication, and over-compliance to meet third party requirements. Irrelevant elements are disconnected from workplace realities that they don't reflect how work is actually performed or address actual risks, creating a gap between formal systems and frontline practice.

Safety clutter emerges from a complex interplay of forces across multiple levels. At the industry contextual level, organisations must navigate complex regulatory environments, diverse client expectations, and industry structures that foster redundancy and complexity. At the system-response level, defensive approaches to safety driven by legal concerns and blame-shifting create documentation that serves protection rather than prevention. At the implementation level, internal organisational practices around system maintenance, professional roles, operational priorities, and worker engagement shape how safety systems develop over time.

This multi-layered analysis demonstrates why addressing safety clutter requires coordinated actions across stakeholder boundaries. Regulators, employer associations, clients, unions, and contractors all play essential roles in either creating or reducing safety clutter. Crucially, internal decluttering efforts that fail to engage external stakeholders will have limited effectiveness, as many sources of clutter originate beyond organisational boundaries.

The consequences of unaddressed safety clutter extend far beyond administrative inefficiency. Operational disruptions, worker disengagement, business costs, and impacts on the workplace culture collectively undermine the very purpose of safety systems, which is preventing harm. When safety activities become disconnected from

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their protective function, they paradoxically increased risk by diverting attention and resources from genuine hazards.

Effective decluttering strategies must target each type of safety clutter appropriately: eliminating misintended elements that serve no genuine safety purpose, simplifying excessive practices to their essential components, and redesigning irrelevant requirements with meaningful worker input. This targeted approach, implemented through collaborative stakeholder engagement, can transform safety systems from bureaucratic exercises into practical tools that genuinely protect workers.

Our findings establish a foundation for the next phase of research, which will:

- map the processes that create safety clutter
- conduct cost analysis to quantify their resource impact, and
- engage multi-stakeholders in workshops to collaboratively develop and implement decluttering approaches that address its sources while preserving the core protective function of safety systems.

Through these next steps, we aim to develop evidence-based, practical approaches that address the underlying causes of safety clutter, enabling organisations to not only declutter existing systems but also implement sustainable practices that prevent clutter from developing in the future.

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