

Safe Execution of Work is an Operational Responsibility: Challenging the Misconception that Safety is the Responsibility of the HSE Function

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Abstract

A persistent organizational misconception is that occupational safety and health (OSH) is primarily the responsibility of the Health, Safety and Environment (HSE) function because HSE professionals are specifically appointed to address safety matters. This perception can obscure a fundamental feature of work: safety is not a separate activity performed alongside operations; it is an inherent requirement of how work is planned, resourced, authorized, directed, supervised, controlled, and performed. International OH&S frameworks reinforce the integration of safety into organizational management and operational processes, with ILO-OSH 2001 explicitly identifying OSH as a line-management responsibility and ISO 45001 requiring OH&S requirements to be integrated into business processes (ILO, 2001; ISO, 2018).

This article examines the relationship between responsibility for safe work execution and the specialist HSE function through an integrative analysis of international OH&S frameworks, regulatory guidance, and relevant safety literature. It argues that organizational actors who **plan, resource, authorize, direct, supervise, control, and perform** work retain responsibility for executing that work safely within their respective functions, authority, and control. HSE professionals, in contrast, generally contribute through specialist functions such as advice, assistance, training, monitoring, inspection, auditing, verification, investigation, reporting, and escalation (Hale, 1995; Provan et al., 2018; Rae & Provan, 2019). Depending on organizational and legal arrangements, HSE may also possess specific approval or intervention authority.

The article proposes a **Non-Transfer Principle**: the appointment, presence, involvement, or specialist authority of HSE does not, by itself, transfer responsibility for safe operational execution from those who control and perform the work. The **Function–Authority–Control (FAC) Framework** is used as a supporting analytical approach for identifying responsibility by examining what an organizational actor is expected to do, what authority accompanies that function, and what relevant decisions or conditions the actor can control or influence.

The article concludes that organizations should distinguish clearly between **responsibility for safely executing work** and **responsibility for performing specialist HSE functions**. Recognizing this distinction can strengthen operational and line-management responsibility, reduce inappropriate dependence on HSE, clarify accountability, and improve both preventive safety management and incident investigation.

Keywords: occupational safety and health; HSE; operational responsibility; line management; safe work execution; safety responsibility; accountability; Function–Authority–Control; FAC Framework; Non-Transfer Principle

1. Introduction

Occupational safety and health (OSH) is sometimes treated within organizations as a specialist activity belonging primarily to the Health, Safety and Environment (HSE) function. When an unsafe condition, procedural deviation, or incident occurs, questions such as “**Where was HSE?**”, “**Why did HSE allow the work?**”, or “**Why did the safety officer not prevent it?**” may arise before examining who actually planned, resourced, authorized, directed, supervised, controlled, and performed the work. This perception can shift attention away from the organizational functions that possess direct authority over work execution and toward the specialist function established to advise, support, monitor, and provide assurance.

This perception is inconsistent with the way established OH&S management frameworks locate responsibility. ISO 45001 places overall accountability for the OH&S management system with top management, requires OH&S requirements to be integrated into the organization's business processes, and requires responsibilities and authorities for relevant roles to be assigned and communicated (ISO, 2018). ILO-OSH 2001 is particularly explicit, stating that OSH should be a **line-management responsibility** and should be known and accepted at all levels of the organization (ILO, 2001).

The distinction is important because HSE professionals ordinarily do not execute the organization's operational work. They do not generally control the complete range of operational resources, personnel, equipment, work methods, production priorities, or direct supervision through which work is performed. Their professional contribution more commonly includes specialist advice, support, monitoring, inspection, auditing, training, investigation, assurance, and improvement activities. Research on the role and professional identity of safety practitioners similarly demonstrates the complexity of the safety professional's position and the distinction between specialist safety work and the operational work through which safety is actually produced (Hale, 1995; Provan et al., 2018; Rae & Provan, 2019).

Safety, however, cannot be separated from operational execution. A job is not first planned operationally and then made safe by HSE; it must be **planned safely**. Equipment is not first operated and then made safe by a safety professional; it must be **operated safely**. A supervisor does not supervise production while HSE separately supervises its safety; safe supervision is an inherent part of supervising the work. The same reasoning applies to engineering, maintenance, construction, fabrication, lifting, transportation, drilling, and other organizational activities. Safety is therefore not an independent operational product delivered by the HSE function. It is an essential characteristic of how work itself is executed.

This leads to the central proposition of this article:

Safe execution of work is an operational responsibility because safety is an inherent requirement of executing the work, not a separate operational activity performed by the HSE function.

This proposition does not mean that HSE professionals have no responsibility. Safety professionals may carry substantial responsibilities within their assigned functions. These may include advising management and workers, facilitating risk assessment, supporting training, inspecting workplaces, monitoring compliance, auditing management systems, investigating incidents, analysing performance, reporting deficiencies, escalating concerns, and verifying specified requirements. Depending on

organizational arrangements and applicable legislation, HSE professionals may also possess defined approval or intervention authority. The precise HSE role therefore varies between organizations and jurisdictions and should not be reduced universally to an advisory role alone (Hale, 1995; Provan et al., 2018).

The central distinction is consequently not between **Operations having responsibility** and **HSE having no responsibility**. It is between **responsibility for safely executing and controlling work** and **responsibility for competently performing assigned specialist HSE functions**. These responsibilities may coexist, and failures in both domains may contribute to the same event.

This distinction becomes particularly important when HSE participates directly in operational processes. An HSE professional may attend a worksite, participate in a risk assessment, review a permit, conduct an inspection, verify a control, sign a document, provide specialist advice, or exercise assigned stop-work authority. Such involvement can create genuine HSE responsibility within the scope of the function being performed. It does not, however, establish by itself that responsibility for safely executing the underlying work has transferred from the managers, supervisors, workers, and operational or technical functions that continue to control and perform it.

Responsibility should therefore be examined in relation to the organizational function performed, the authority accompanying that function, and the relevant decisions, resources, conditions, or actions the actor can control or influence. This is consistent with ISO 45001's emphasis on defined responsibilities and authorities and with the broader line-management approach reflected in ILO-OSH 2001 (ISO, 2018; ILO, 2001).

Against this background, this article has three objectives. First, it establishes the conceptual and organizational basis for treating safe execution of work as an operational and line-management responsibility. Second, it examines the proper role and responsibility boundaries of the HSE function without denying the substantive responsibilities that HSE professionals themselves may hold. Third, it develops the **Non-Transfer Principle** and uses the **Function–Authority–Control (FAC) Framework** as supporting concepts for analysing responsibility where operational and HSE functions interact.

The purpose is not to reduce HSE responsibility but to locate responsibility for safe execution where the work and the authority to control it actually reside. Clearer distinction between operational execution and specialist HSE responsibility can strengthen accountability at the point where work is planned and performed, reduce inappropriate organizational dependence on HSE, and improve both preventive safety management and incident investigation.

2. Safety as an Integral Part of Work Execution

2.1 Safety Is Not a Separate Operational Activity

The central argument of this article begins with a fundamental distinction: **safety is not a separate activity performed alongside operational work; it is an inherent requirement of how the work is performed**. This position is consistent with ISO 45001, which requires organizations to integrate OH&S management-system requirements into their business processes and to establish, implement, control, and maintain the processes needed to meet OH&S requirements (ISO, 2018).

Every operational activity involves decisions concerning how work will be executed. These may include the work method, equipment, personnel, competence, sequence, timing, resources, workplace conditions, supervision, and operational controls. Such decisions simultaneously influence operational performance

and safety. They cannot meaningfully be classified as operational decisions whose safety consequences belong exclusively to another department.

A lifting operation, for example, cannot realistically be divided into an operational component performed by Operations and a separate safety component performed by HSE. Selection of suitable lifting equipment, competent personnel, an appropriate lifting method, adequate supervision, and compliance with operating limitations are simultaneously requirements for executing the lifting operation and for executing it safely.

The same principle applies to construction, fabrication, maintenance, transportation, drilling, manufacturing, electrical work, confined-space entry, excavation, and other activities. The function responsible for executing and controlling the work must incorporate the requirements necessary for executing that work safely.

2.2 Planning Work Means Planning It Safely

Responsibility for safe execution begins before physical work starts.

Managers and other responsible functions make decisions concerning work methods, equipment, materials, staffing, competence, scheduling, resources, sequencing, coordination, and operational controls. These decisions establish the conditions within which supervisors and workers subsequently perform the activity.

ISO 45001 requires organizations to establish criteria for processes and implement control of those processes in accordance with the criteria. It also addresses hazard identification in relation to how work is organized, routine and non-routine activities, infrastructure, equipment, materials, workplace conditions, human factors, and changes affecting the OH&S management system (ISO, 2018).

Consequently, safe execution cannot depend solely on actions taken at the point where the worker physically performs the task. If an unsuitable work method is selected, inadequate resources are provided, incompetent personnel are assigned, unsuitable equipment is accepted, or unrealistic operational conditions are established, significant safety determinants have already been created before execution begins.

Planning responsibility therefore includes responsibility for planning the work so that it can be executed safely.

2.3 Resourcing Work Is Part of Safety Responsibility

Resources are another direct connection between operational authority and safe execution.

Top management is required under ISO 45001 to ensure that resources needed for the OH&S management system are available (ISO, 2018). At operational levels, management decisions determine how many workers are assigned, what equipment is available, what competence is required, how much time is provided, and what supporting resources are available for the activity.

These decisions can materially affect whether established safety requirements can be implemented in practice.

An HSE professional may identify inadequate resources, advise management about the associated risk, recommend corrective action, or escalate a significant deficiency. However, where the authority to provide personnel, equipment, time, or other operational resources remains with management, HSE cannot independently substitute for that authority.

Responsibility for the safety implications of resource decisions should therefore remain connected to the organizational function that possesses authority over those resources.

2.4 Authorizing Work Includes Responsibility for Safe Execution

Authorization is also part of operational control.

An organizational actor who possesses authority to permit an activity to commence or continue exercises control over a decision that can directly affect safety. That authorization should therefore consider whether the necessary conditions for safe execution have been established.

The existence of an HSE review, recommendation, inspection, risk-assessment contribution, or other specialist involvement does not automatically remove the responsibility associated with the operational authorization decision.

Where an operational manager retains authority to decide whether, when, and under what conditions the work will proceed, the safety implications of exercising that authority remain part of the manager's responsibility.

2.5 Supervising Work Means Supervising It Safely

Supervision provides one of the clearest examples of why safety cannot be separated from execution.

A supervisor normally directs work, communicates instructions, coordinates personnel, observes task performance, responds to changing conditions, and corrects deviations within the supervisor's authority. Safety leadership research has also demonstrated the relationship between supervisory leadership practices, safety climate, and employee safety performance (Kapp, 2012; Wu et al., 2008).

These supervisory functions cannot reasonably be divided into **operational supervision** performed by the supervisor and **safety supervision** performed separately by HSE.

If a supervisor observes that a task is being performed incorrectly, that a required control is absent, or that workplace conditions have changed significantly, responding appropriately is part of supervising the work itself.

Safe supervision is therefore not an additional HSE activity attached to operational supervision. It is an inherent requirement of competent supervision.

2.6 Performing Work Means Performing It Safely

Workers also carry responsibility within the scope of their assigned functions and control.

ILO Convention No. 155 recognizes worker responsibilities in relation to occupational safety and health, including cooperation with the employer and reporting situations that workers reasonably believe present an imminent and serious danger to life or health (ILO, 1981). ISO 45001 similarly incorporates worker participation into the OH&S management system (ISO, 2018).

A competent worker who operates equipment, uses tools, follows procedures, uses required protective measures, observes operating limits, and responds to changing conditions exercises direct control over important aspects of task execution. The worker therefore carries responsibility for performing those controllable aspects of the work safely.

This does not mean that workers should be held responsible for organizational conditions beyond their authority or control. Equipment selection, staffing, engineering design, production priorities, resource allocation, or higher-level management decisions may lie elsewhere.

Responsibility for safe execution must therefore be distributed according to the actual functions and authority involved in performing and controlling the work.

2.7 Line Management and Operational Control

ILO-OSH 2001 states that OSH should be a **line-management responsibility**, known and accepted at all levels of the organization (ILO, 2001). This principle provides a particularly important foundation for understanding responsibility for safe execution.

Line-management and operational functions generally control or substantially influence the mechanisms through which work is performed, including personnel deployment, work methods, equipment, production schedules, operational priorities, task allocation, coordination, and immediate supervision. These are not peripheral safety matters. They are the mechanisms through which both operational performance and safety performance are produced.

Accordingly:

The organizational function that controls the execution of work cannot separate responsibility for the safety of that execution from responsibility for the work itself.

2.8 The HSE Function Supports Safe Execution

Recognizing safe execution as an operational responsibility does not diminish the importance of HSE professionals.

Research examining safety professionals has shown that their roles can include advising, supporting, monitoring, interpreting requirements, developing systems, facilitating safety activities, and providing organizational assurance and expertise (Hale, 1995; Provan et al., 2018). Rae and Provan (2019) further distinguish between professional “safety work” and the “safety of work,” highlighting the importance of understanding how specialist safety activities relate to the actual operational processes through which work is performed safely.

Depending on organizational arrangements, HSE may therefore:

- provide specialist advice;
- facilitate hazard identification and risk assessment;
- support development of procedures and controls;
- provide or coordinate safety training;
- inspect workplaces;
- monitor compliance;
- conduct audits;
- verify specified requirements;
- investigate incidents;
- analyse safety performance;
- report deficiencies;
- recommend improvements; and
- escalate significant concerns.

HSE is responsible for performing these assigned functions competently.

However, **supporting safe execution is not the same as assuming responsibility for executing the work safely.**

The presence of specialist HSE support does not remove the responsibilities of those who continue to plan, resource, authorize, direct, supervise, control, and perform the operational activity.

2.9 The Fundamental Responsibility Distinction

The distinction developed in this article can therefore be stated simply:

Operational and line functions are responsible for executing the work safely within the functions, authority, and control assigned to them.

The HSE function is responsible for competently performing the specialist HSE functions and authorities assigned to it.

These responsibilities may interact and, in some circumstances, overlap.

When HSE provides advice, the person possessing operational decision-making authority remains responsible for the decision made within that authority.

When HSE conducts an inspection, the function controlling the workplace remains responsible for controlling and correcting conditions within its authority.

When HSE provides training, management and supervision remain responsible for appropriately assigning and directing competent personnel.

When HSE monitors an activity, line supervision remains responsible for supervising the execution of the work.

Where HSE itself possesses a defined verification, approval, escalation, or intervention function, HSE carries responsibility for properly performing that function.

The existence of HSE responsibility therefore adds a specialist responsibility; **it does not automatically replace the responsibility inherent in operational execution.**

2.10 Section Conclusion

Safety is not an operational activity that can be separated from the work and assigned independently to the HSE function.

Planning must incorporate safe planning. Resources must support safe execution. Authorization must consider whether work can proceed safely. Supervision must include safe supervision. Workers must perform the aspects of work within their control safely.

This understanding is consistent with the integration principles of ISO 45001 and the explicit line-management responsibility established in ILO-OSH 2001 (ISO, 2018; ILO, 2001).

Accordingly, the organizational functions that plan, resource, authorize, direct, supervise, control, and perform work carry responsibility for its safe execution within their respective functions and authority. HSE supports this process through specialist functions for which it carries its own responsibility, but HSE involvement does not ordinarily substitute for the responsibility of those who control and execute the work.

3. Why the HSE Function Should Not Be Treated as the Executor of Safety

3.1 The Organizational Misconception

The existence of an HSE department can create an unintended organizational perception that safety belongs primarily to HSE. Because HSE professionals carry safety-related titles, conduct inspections, participate in risk assessments, deliver training, investigate incidents, and raise safety concerns, they may become the most visible representatives of safety within the organization.

Visibility, however, should not be confused with operational responsibility.

Research on safety professionals has long identified ambiguity surrounding their organizational position and relationship with management. Hale (1995) described the safety professional's role in terms of potentially different relationships with management, including advisory and supervisory dimensions. More recent research has similarly demonstrated the complexity of safety-professional identity and the tension between specialist safety activities and operational work (Provan et al., 2018; Rae & Provan, 2019).

The fundamental question is therefore not which department has the word “**safety**” in its title. The relevant question is:

Who possesses the authority, resources, and operational control necessary to execute the work safely?

3.2 HSE Does Not Ordinarily Execute Operational Work

In most organizational structures, HSE personnel do not perform the organization's primary operational activities.

An HSE professional does not ordinarily:

- operate production equipment;
- perform maintenance activities;
- execute lifting operations;
- fabricate or construct equipment and facilities;
- operate vehicles or mobile equipment;
- perform drilling or production activities;
- carry out technical engineering work;
- allocate the operational workforce;
- determine production schedules;
- control operational budgets and resources; or
- directly supervise the entire operational workforce.

These functions normally belong to Operations, Engineering, Maintenance, Construction, Logistics, Production, Projects, line management, supervisors, workers, or other executing functions.

If HSE does not execute these activities, it cannot reasonably substitute for the responsibility of those who do.

3.3 HSE Does Not Ordinarily Control Operational Resources

Safe execution depends heavily on resources.

Work may require sufficient competent personnel, suitable equipment, adequate maintenance, appropriate materials, realistic schedules, technical support, supervision, and financial resources. ISO 45001 places responsibility on top management to ensure that resources needed for the OH&S management system are available and requires OH&S requirements to be integrated into organizational business processes (ISO, 2018).

HSE may identify a resource deficiency and advise management that additional resources are necessary. It may document the concern, recommend corrective action, or escalate the issue.

However, if HSE does not possess authority to recruit personnel, purchase equipment, change production schedules, allocate budgets, or assign operational resources, it cannot independently correct those deficiencies.

This creates an important organizational principle:

Responsibility for an operational outcome should not be detached from the authority and resources necessary to influence that outcome.

3.4 HSE Does Not Ordinarily Direct the Operational Workforce

Direct supervision is one of the principal mechanisms through which work is controlled.

Supervisors and line managers normally assign tasks, communicate instructions, coordinate personnel, observe work, correct deviations, and determine whether work should continue within their authority. Supervisory leadership has been associated with safety climate and safety performance, demonstrating the importance of line supervision in shaping how work is actually performed (Kapp, 2012; Wu et al., 2008).

An HSE professional may observe unsafe behaviour and intervene, advise the supervisor, communicate a concern, or exercise specific stop-work authority where such authority exists. This does not ordinarily make the HSE professional the operational supervisor.

If line supervision retains authority to direct the workforce, responsibility for safe supervision remains with the supervisory structure.

3.5 HSE Advice Does Not Replace Operational Decision-Making

Providing specialist advice is an important HSE function.

An HSE professional may identify hazards, interpret requirements, recommend controls, advise on risk assessments, or suggest safer alternatives. Hale (1995) identified advisory expertise as an important dimension of the occupational safety professional's relationship with management.

Advice, however, is different from the authority to make and implement the operational decision.

Where an operational manager receives competent HSE advice but retains authority to select the work method, allocate resources, authorize the activity, or determine how the work will proceed, the existence of HSE advice does not transfer responsibility for that operational decision to the adviser.

Similarly, HSE remains responsible for the professional quality of the advice provided.

The two responsibilities coexist:

HSE is responsible for competent advice; the authorized operational actor is responsible for the operational decision within that actor's authority and control.

3.6 Monitoring Is Not the Same as Supervision

Monitoring is another area in which organizational roles can become confused.

HSE personnel frequently conduct workplace visits, inspections, observations, compliance monitoring, and audits. These activities may identify unsafe conditions or deviations and can provide an important independent challenge to operational arrangements.

However, periodic HSE monitoring is not equivalent to continuous operational supervision.

The supervisor responsible for the work remains responsible for directing and supervising the activity.

The presence of an HSE officer at a workplace should not create an expectation that operational supervisors can relinquish their responsibility because someone from HSE is present.

HSE is responsible for performing its assigned monitoring function competently and for taking appropriate reporting, escalation, or intervention action where required. Operational supervision remains responsible for supervising the work.

3.7 Training Does Not Transfer Responsibility for Competence Deployment

HSE departments frequently provide or coordinate safety training. This can create another mistaken inference: because HSE provides training, HSE is responsible whenever a worker subsequently performs a task unsafely.

Training provision and workforce deployment are different functions.

HSE may be responsible for developing appropriate training content, delivering training competently, maintaining relevant records, or advising management regarding competence requirements. Management and supervision, however, normally decide which workers are assigned to particular activities and whether those workers are appropriately competent and authorized for the work.

ISO 45001 requires the organization to determine necessary competence and ensure that workers are competent on the basis of appropriate education, training, or experience (ISO, 2018). Competence management is therefore an organizational requirement, not merely an HSE training activity.

3.8 Inspection and Auditing Do Not Transfer Execution Responsibility

Inspection and auditing are assurance activities.

Their purpose is generally to determine whether conditions, processes, or management arrangements conform to established requirements and whether deficiencies require attention.

If HSE identifies a deficiency during an inspection, HSE is responsible for handling that finding according to its assigned function—for example, recording, communicating, escalating, or following up the issue.

Responsibility for correcting the underlying operational deficiency normally remains with the function possessing authority and control over that condition.

Likewise, an audit does not make the auditor responsible for operating the system being audited. The auditor assesses the system; management and operational functions remain responsible for implementing and maintaining the processes under their control.

3.9 HSE Presence Does Not Mean HSE Control

The physical presence of an HSE professional at a worksite is particularly vulnerable to misinterpretation after an incident.

A question such as “**HSE was there, so why did the incident happen?**” assumes that presence equals control.

That assumption should be tested rather than accepted.

The relevant questions are:

What was HSE assigned to do?

What authority did HSE possess?

What could HSE actually control or influence?

What action was reasonably available to HSE if a hazardous condition was identified?

If HSE possessed a defined intervention responsibility and failed to exercise it appropriately, HSE responsibility may arise. But this does not automatically remove responsibility from the operational actors who created, authorized, supervised, or performed the unsafe condition.

3.10 Stop-Work Authority Does Not Make HSE the Executor

Organizations sometimes grant HSE personnel authority to stop unsafe work.

This is an important intervention mechanism, but it should not be confused with responsibility for executing the work.

If Operations plans and directs an activity while HSE possesses authority to intervene when specified unsafe conditions arise, two different responsibilities exist.

Operations remains responsible for planning, directing, supervising, and executing the work safely. HSE is responsible for appropriately exercising its intervention authority when the conditions requiring intervention are met.

If both functions fail, concurrent responsibility may exist.

Stop-work authority therefore creates an HSE responsibility within the scope of that authority; it does not automatically transfer the underlying operational responsibility to HSE.

3.11 HSE Has Genuine Responsibilities

The argument that HSE should not be treated as responsible for operational execution must not be interpreted as an attempt to exempt HSE professionals from accountability.

HSE professionals should be accountable for the competent performance of the functions assigned to them. Depending on the organization and jurisdiction, these may include advice, monitoring, inspection,

auditing, training, investigation, verification, reporting, escalation, approval, or intervention.

Some jurisdictions also impose specific statutory duties on designated safety professionals. For example, Malaysia's Occupational Safety and Health (Safety and Health Officer) Regulations 1997 assign defined duties to Safety and Health Officers, including advisory, inspection, investigation, programme-related, committee-related, and reporting functions (Malaysia, 1997).

The appropriate conclusion is therefore not that **HSE has no responsibility**.

It is that:

HSE should be accountable for its HSE functions, while the functions that execute and control operational work should remain accountable for executing that work safely.

3.12 The Misconception Reframed

The misconception challenged by this article can now be stated more precisely.

The problem is not that organizations recognize HSE responsibility. HSE has genuine responsibility.

The misconception occurs when the existence of the HSE function is interpreted to mean that **responsibility for the safe execution of operational work belongs primarily to HSE**, even though the authority, resources, supervision, and operational control required to execute that work remain elsewhere.

Such an arrangement separates accountability from control.

ILO-OSH 2001's identification of OSH as a line-management responsibility provides a fundamentally different model: safety responsibility remains integrated into the management structure through which work is controlled and performed (ILO, 2001).

3.13 Section Conclusion

HSE professionals are essential contributors to organizational safety, but their specialist role should not be confused with operational execution.

HSE may advise, assist, train, inspect, monitor, audit, verify, investigate, report, escalate, and intervene according to its assigned functions and authority. HSE should be accountable for performing those functions competently.

The operational functions, however, possess the personnel, resources, work-control mechanisms, supervisory structures, and decision-making authority through which work is actually executed.

Accordingly:

The existence of an HSE function does not transfer responsibility for safe work execution away from the organizational functions that possess the authority and control to execute the work.

4. Responsibility Follows Operational Function, Authority, and Control

4.1 Responsibility Must Be Connected to the Work

If safe execution is an operational responsibility, responsibility must be traced through the functions by which work is actually organized and performed.

An incident may involve a worker performing an unsafe action, but the conditions surrounding that action may have been influenced by decisions concerning work design, equipment, staffing, competence, scheduling, supervision, maintenance, or operational priorities. Effective responsibility analysis therefore requires examination beyond the person physically closest to the event.

ISO 45001 reflects this broader organizational approach by requiring responsibilities and authorities for relevant roles to be assigned and communicated and by integrating OH&S into organizational processes

rather than locating it within a single specialist department (ISO, 2018). ILO-OSH 2001 similarly places OSH within line-management responsibility at all levels of the organization (ILO, 2001).

Three concepts are particularly important when determining responsibility for safe execution: **function, authority, and control.**

4.2 Function: What Was the Actor Expected to Do?

The first question is:

What function was the organizational actor expected to perform?

Responsibility should begin with the actual role in relation to the work.

For example, a manager may be responsible for planning and authorizing an activity. A supervisor may be responsible for directing and supervising it. A worker may be responsible for performing the assigned task. Engineering may be responsible for technical design. Maintenance may be responsible for equipment integrity. HSE may be responsible for providing specialist advice, conducting inspections, monitoring compliance, or performing another defined HSE function.

These functions are different, and their associated responsibilities should not be collapsed into a general statement that one department is “responsible for safety.”

4.3 Authority: What Was the Actor Empowered to Decide?

The second question is:

What authority accompanied the function?

Authority may include the power to:

- select or modify a work method;
- allocate personnel;
- provide resources;
- approve or reject work;
- direct workers;
- require corrective action;
- suspend an activity;
- approve restart; or
- escalate a matter to higher authority.

ISO 45001 explicitly connects organizational roles with responsibilities and authorities, reinforcing the importance of defining not merely what people are expected to achieve but also the authority associated with their roles (ISO, 2018).

This relationship is particularly relevant to the misconception that HSE is generally responsible for safe execution.

If HSE is expected to “ensure safety” but lacks authority to select the operational method, provide manpower, purchase equipment, allocate budgets, determine production schedules, direct the operational workforce, or make the final operational decision, the organization has created a mismatch between responsibility and authority.

4.4 Control: What Could the Actor Actually Influence?

Formal authority alone does not always explain how work is controlled in practice.

The third question is therefore:

What relevant decision, condition, resource, action, or behaviour could the actor actually control or materially influence?

A manager who controls staffing and scheduling influences the conditions under which work is perform-

ed. A supervisor who directs workers controls important aspects of immediate execution. A worker controls particular actions while performing the task. Engineering controls defined technical decisions. Maintenance controls specified maintenance activities.

HSE may influence these decisions through advice, challenge, monitoring, reporting, or escalation, but influence is not necessarily equivalent to operational control.

The distinction between performing specialist “safety work” and controlling the operational work through which safety is produced is also reflected in the safety-professional literature (Provan et al., 2018; Rae & Provan, 2019).

4.5 Operational Managers

Operational managers commonly exercise substantial authority over the conditions in which work is executed.

Their decisions may include:

- selecting or approving work methods;
- assigning resources;
- determining staffing;
- setting schedules;
- coordinating activities;
- authorizing work;
- establishing operational priorities; and
- directing subordinate supervision.

These decisions can have direct safety consequences.

If a manager approves an activity without sufficient resources or knowingly permits an unsuitable method to continue, the safety implications of those decisions cannot reasonably be transferred to HSE merely because an HSE professional advised, inspected, or monitored the activity.

The manager's responsibility arises from the operational function and authority exercised.

4.6 Supervisors

Supervisors occupy a particularly important position because they connect organizational planning with actual task execution.

They commonly communicate instructions, assign tasks, coordinate personnel, observe work, correct deviations, respond to changing conditions, and exercise immediate control over work within their authority.

Research has identified associations between supervisory leadership practices, safety climate, and worker safety performance (Kapp, 2012; Wu et al., 2008).

Consequently, where a supervisor possesses authority to direct work, responsibility for directing that work safely forms part of the supervisory function.

The presence of HSE at the workplace does not transform HSE into the operational supervisor unless the organization has genuinely assigned that supervisory function and corresponding authority to HSE.

4.7 Workers

Workers possess direct control over some aspects of work execution but not necessarily over the organizational conditions under which the work is performed.

Workers may be responsible for:

- following established procedures;
- correctly using equipment;

- applying required controls;
- using protective equipment;
- observing operating limits;
- reporting hazards;
- communicating changing conditions; and
- taking appropriate action within their authority when serious danger is identified.

ILO Convention No. 155 recognizes worker obligations to cooperate with the employer and to report situations that workers reasonably believe present imminent and serious danger (ILO, 1981).

Worker responsibility, however, should not be used to shift responsibility for defective equipment, inadequate staffing, poor work design, unrealistic schedules, insufficient competence arrangements, or management decisions that workers do not control.

4.8 Engineering, Maintenance, and Other Functions

The principle of safe execution extends beyond departments formally described as “Operations.”

Engineering decisions can determine whether equipment and processes are inherently safe to operate. Maintenance decisions affect equipment integrity. Procurement decisions may affect the suitability of purchased equipment and materials. Logistics decisions may affect transportation risks. Project and construction functions may determine how work is designed, sequenced, and executed.

ISO 45001 requires organizations to address OH&S risks through operational processes and includes requirements concerning procurement, contractors, and outsourced processes (ISO, 2018).

Therefore, the term **operational responsibility** in this article should be understood functionally rather than merely departmentally.

It refers to responsibility residing with the organizational functions that **execute or control the relevant part of the work**, regardless of the department name attached to them.

4.9 HSE Responsibility Within Function, Authority, and Control

The same analysis must be applied fairly to HSE.

If HSE is assigned responsibility for providing advice, HSE should be accountable for the competence of that advice.

If HSE is assigned an inspection, HSE should be accountable for performing the inspection appropriately.

If HSE is required to report or escalate a serious deficiency, HSE should be accountable for doing so.

If HSE possesses defined verification, approval, or intervention authority, HSE should be accountable for exercising that authority appropriately.

This prevents the argument of this article from becoming an attempt to exempt HSE from responsibility. The distinction is instead that HSE responsibility should be linked to **HSE's actual function, authority, and control**, just as operational responsibility should be linked to the functions, authority, and control of operational actors.

4.10 Where Direct Control Is Absent

An actor does not necessarily become responsibility-free merely because direct corrective control is absent.

A supervisor may be unable to purchase replacement equipment but may have authority to suspend work and escalate the deficiency. A worker may be unable to redesign a process but may be required to report a serious hazard. An HSE professional may lack authority to allocate resources but may have a duty to advise management, document the concern, escalate it, or exercise defined intervention authority.

The relevant question therefore becomes:

If the actor could not directly correct the condition, what reasonable action remained available within the actor's function and authority?

This qualification is essential because responsibility cannot be reduced simply to direct physical control.

4.11 Responsibility May Be Concurrent

Responsibility for an incident or unsafe condition does not necessarily belong exclusively to one person or function.

Consider a situation in which an operational manager approves an unsuitable work method, a supervisor fails to correct an observable deviation, a worker knowingly disregards an established requirement, and an HSE professional fails to exercise a clearly assigned intervention function.

Several responsibility failures may coexist.

The operational manager's failure does not remove the supervisor's responsibility. The supervisor's failure does not eliminate the worker's responsibility. The worker's action does not remove management responsibility for the surrounding conditions. HSE's failure to intervene does not transfer the original operational responsibility to HSE.

Responsibility may therefore be **concurrent but different in nature and scope**.

4.12 Responsibility Should Not Follow Departmental Labels

The practical consequence is that responsibility should not be inferred primarily from organizational titles.

The statement:

“It was a safety issue, therefore HSE was responsible.”

does not establish responsibility.

Neither does:

“Operations owns safety, therefore HSE had no responsibility.”

Both statements are too broad.

Responsibility analysis requires examination of what each actor was expected to do, what authority was available, what relevant matters could be controlled or influenced, and what reasonable action remained available.

4.13 Section Conclusion

Safe execution of work is produced through organizational functions that make decisions, provide resources, direct personnel, control conditions, and perform tasks.

Responsibility for safe execution should therefore remain connected to those functions and to the authority and control through which the work is executed.

This applies equally to managers, supervisors, workers, Engineering, Maintenance, other executing functions, and HSE. Each should be responsible for the competent performance of the functions and authority assigned to it.

The critical distinction remains:

Operational responsibility concerns executing and controlling the work safely; HSE responsibility concerns the competent performance of the specialist HSE functions and authorities assigned to HSE.

This distinction provides the foundation for examining why HSE involvement should not automatically transfer responsibility for safe execution—a principle developed in the following section.

5. The Non-Transfer Principle

5.1 Why a Non-Transfer Principle Is Necessary

Once safe execution is recognized as a responsibility of the organizational functions that execute and control work, an important question follows: **what happens when HSE becomes involved in that work?**

In practice, HSE may participate in risk assessments, review procedures, inspect workplaces, attend operational activities, monitor compliance, verify specified controls, sign documents, provide advice, or exercise defined intervention authority. Such involvement can create an assumption that responsibility for safety has shifted from the operational function to HSE.

That assumption requires careful examination.

ILO-OSH 2001 identifies OSH as a line-management responsibility (ILO, 2001), while ISO 45001 requires OH&S to be integrated into organizational business processes and requires responsibilities and authorities to be assigned and communicated (ISO, 2018). These principles support an organizational structure in which specialist HSE involvement complements, rather than automatically replaces, the responsibilities embedded within operational management and execution.

This article therefore proposes the **Non-Transfer Principle**.

5.2 Statement of the Non-Transfer Principle

The appointment, presence, involvement, advice, monitoring, verification, or specialist authority of the HSE function does not, by itself, transfer responsibility for the safe execution of work from the organizational functions that plan, resource, authorize, direct, supervise, control, and perform that work. HSE remains responsible for the competent performance of the specialist functions and authorities assigned to it.

The principle distinguishes **HSE involvement in work** from **responsibility for executing the work**.

It does not suggest that HSE involvement is without responsibility. Rather, it requires the responsibilities of HSE and operational actors to be identified separately according to their respective functions and authority.

5.3 Appointment of HSE Does Not Transfer Operational Responsibility

Organizations appoint HSE professionals because specialist competence can improve the management of occupational risks. Safety professionals may provide technical knowledge, interpretation of requirements, advice, monitoring, assurance, investigation, and organizational learning (Hale, 1995; Provan et al., 2018).

The appointment of such specialists does not mean that managers cease to manage safely, supervisors cease to supervise safely, or workers cease to perform their work safely.

ILO-OSH 2001's line-management principle is particularly relevant here. The existence of specialist safety expertise does not remove OSH responsibility from the management structure through which work is controlled (ILO, 2001).

HSE appointment therefore **adds specialist capability and corresponding specialist responsibility**; it does not automatically remove responsibility from operational functions.

This distinction is also reflected in guidance from the UK Health and Safety Executive (HSE). HSE states that employers must appoint competent persons to help them meet their health and safety duties and clarifies that, even where a consultant or adviser is used, managing health and safety remains the employer's legal duty (Health and Safety Executive [HSE], n.d.).

5.4 HSE Advice Does Not Transfer Decision Responsibility

When HSE advises an operational manager, two distinct functions exist.

HSE is responsible for providing competent advice within its professional scope. The operational manager remains responsible for decisions that remain within the manager's authority.

For example, HSE may advise that additional personnel, different equipment, a revised method, or additional controls are required. If the operational manager possesses authority to allocate resources and determine how the work will proceed, responsibility for that operational decision remains associated with the manager's authority.

If the HSE advice itself is materially deficient, HSE may carry responsibility for the professional failure. One responsibility does not necessarily cancel the other.

5.5 HSE Participation in Risk Assessment Does Not Transfer Execution Responsibility

Risk assessment commonly involves participation from operational personnel, supervisors, workers, technical specialists, and HSE professionals.

HSE may facilitate the process, provide technical guidance, challenge assumptions, assist with hazard identification, or review whether the methodology has been applied appropriately.

However, the controls identified through the risk assessment must ultimately be implemented through the functions that execute and control the work.

ISO 45001 requires organizations to establish processes for hazard identification and assessment and to implement operational controls necessary to address OH&S risks (ISO, 2018). Participation by HSE in these processes does not make HSE the executor of the resulting operational controls.

5.6 HSE Inspection Does Not Transfer Responsibility for Workplace Conditions

Inspection is an important HSE activity in many organizations.

An HSE professional may inspect a workplace, identify a deficiency, communicate the finding, recommend corrective action, follow up the issue, or escalate it where necessary.

The inspection function creates responsibility for competent inspection and appropriate handling of identified deficiencies.

It does not necessarily give HSE the authority or resources to physically correct the underlying condition.

If defective equipment requires maintenance, the responsible maintenance function retains its role. If housekeeping requires operational action, the function controlling the workplace remains responsible for that action. If additional resources are required, the manager possessing resource authority remains responsible for the relevant decision.

Inspection therefore identifies and challenges conditions; it does not automatically transfer control of those conditions to the inspector.

5.7 HSE Monitoring Does Not Replace Line Supervision

HSE monitoring is similarly distinct from operational supervision.

HSE personnel may observe work to determine whether requirements are being followed, identify trends, detect deficiencies, or provide assurance to management.

The operational supervisor, however, normally retains responsibility for directing personnel and controlling immediate execution.

Research linking supervisory leadership with safety performance reinforces the importance of line supervision in shaping workplace safety behaviour and conditions (Kapp, 2012; Wu et al., 2008).

HSE monitoring therefore supplements operational supervision; it does not ordinarily replace it.

5.8 HSE Training Does Not Transfer Responsibility for Work Execution

Training provides another example of the Non-Transfer Principle.

HSE may develop training material, deliver training, coordinate programmes, or advise management regarding safety competence requirements. HSE should be responsible for the quality of those assigned training functions.

Management and supervision, however, remain responsible for decisions concerning worker assignment, competence deployment, authorization, and supervision within their respective authority.

ISO 45001 places competence requirements on the organization and requires necessary competence to be determined and appropriate actions taken to acquire and maintain it (ISO, 2018).

Providing safety training therefore does not make HSE responsible for how every trained worker subsequently executes operational work.

5.9 HSE Signatures Do Not Automatically Transfer Responsibility

Signatures are particularly vulnerable to organizational misinterpretation.

An HSE signature may represent:

- participation;
- acknowledgement;
- review;
- verification;
- recommendation;
- approval; or
- authorization.

These meanings are not equivalent.

Responsibility arising from a signature should therefore depend on **what the signature was formally intended to represent**.

If HSE signs only to confirm participation in a risk assessment, the signature should not later be interpreted automatically as HSE authorization of every operational decision associated with the work.

If, however, the organization's procedure explicitly gives HSE approval authority over a defined matter, HSE carries responsibility for properly exercising that approval authority.

5.10 Stop-Work Authority Does Not Transfer the Underlying Responsibility

Stop-work authority is one of the strongest forms of HSE intervention and therefore requires particular clarity.

Suppose Operations plans an activity, provides the personnel and equipment, selects the method, and directs execution, while HSE possesses authority to stop the activity if specified unsafe conditions are observed.

Operations remains responsible for executing the work safely.

HSE carries a separate responsibility to exercise its intervention authority appropriately.

If Operations creates or permits an unsafe condition and HSE observes that condition but fails to exercise a clearly required intervention function, responsibility may exist in both domains.

The existence of HSE stop-work authority therefore creates **additional or concurrent responsibility**, not automatic transfer of the underlying operational responsibility.

5.11 Physical Presence Does Not Equal Operational Control

The presence of HSE at a workplace should be analysed in the same way.

An HSE professional may be present to inspect, monitor, advise, observe, verify, or provide specialist assistance.

Presence alone does not establish that the person controls:

- the work method;
- the workforce;
- the equipment;
- the operational schedule;
- the resources;
- the supervisory chain; or
- the operational decision to proceed.

Consequently, after an incident, the question “**Where was HSE?**” is analytically incomplete.

The more appropriate questions are:

Who planned the work?

Who provided the resources?

Who authorized it?

Who directed and supervised it?

Who controlled the relevant aspects of the work?

Who performed it?

What was HSE specifically assigned to do?

Did each actor properly perform the function and authority assigned to that actor?

5.12 Genuine Reassignment Is Different From Assumed Transfer

The Non-Transfer Principle does not mean that an operationally relevant function can never be assigned to HSE.

Organizations may formally give HSE specific approval, verification, authorization, or intervention functions. In some circumstances, legislation may also impose specific duties on designated safety professionals. Malaysia's Occupational Safety and Health (Safety and Health Officer) Regulations 1997 provide an example of defined statutory duties assigned directly to Safety and Health Officers (Malaysia, 1997).

Where a function is genuinely assigned to HSE together with the authority necessary to perform it, HSE carries responsibility for that function.

The principle therefore prevents **assumed transfer**, not genuine assignment or reassignment.

5.13 Concurrent Responsibility

The Non-Transfer Principle also recognizes that responsibility may be concurrent.

Consider an activity in which:

- management provides inadequate resources;
- a supervisor permits an unsafe deviation;
- a worker knowingly disregards an established requirement; and
- HSE fails to escalate or intervene despite a clearly assigned duty to do so.

Each failure arises from a different function.

Assigning responsibility to HSE for the failed intervention does not eliminate management, supervisory, or worker responsibility. Likewise, identifying an operational failure does not excuse HSE from a specialist responsibility it failed to perform.

This avoids the false assumption that responsibility must always be transferred from one actor to another.

5.14 The Organizational Significance of the Principle

The Non-Transfer Principle addresses a practical organizational risk: the creation of **dependency on HSE**.

If managers believe that HSE is responsible for making their operations safe, operational ownership may weaken. Supervisors may begin to rely on HSE personnel to identify and correct conditions that should form part of normal supervision. Workers may perceive safety instructions as belonging to HSE rather than to the work itself. HSE professionals may then be expected to compensate for deficiencies in operational planning and control despite lacking the resources and authority required to do so.

This arrangement is inconsistent with the line-management responsibility emphasized in ILO-OSH 2001 and with the integration of OH&S into organizational business processes required by ISO 45001 (ILO, 2001; ISO, 2018).

5.15 Section Conclusion

HSE involvement can create genuine and sometimes substantial HSE responsibility. Advice must be competent. Inspections must be properly performed. Monitoring must be effective within its defined scope. Findings must be communicated or escalated appropriately. Verification and approval authority must be exercised competently. Intervention authority must be used when required.

None of these propositions, however, establishes that HSE thereby becomes responsible for executing the underlying operational work.

The Non-Transfer Principle therefore preserves the central distinction of this article:

Those who plan, resource, authorize, direct, supervise, control, and perform work remain responsible for its safe execution within their respective functions and authority. HSE remains responsible for the specialist HSE functions and authorities assigned to it.

6. The Role and Responsibilities of the HSE Function

6.1 HSE as a Specialist Organizational Function

Establishing that safe execution of work is an operational responsibility does not reduce the importance of the HSE function. Rather, it allows the HSE role to be defined more accurately.

Organizations employ HSE professionals because occupational safety and health requires specialist knowledge, systematic monitoring, interpretation of requirements, assurance activities, and professional support. Research examining safety practitioners demonstrates that their roles can include advising management, supporting safety systems, monitoring organizational performance, facilitating safety activities, and providing specialist expertise (Hale, 1995; Provan et al., 2018).

The HSE function therefore contributes to the organization's ability to execute work safely without ordinarily becoming the function that executes the operational work itself.

6.2 Advisory Responsibility

Providing competent advice is one of the principal functions commonly associated with HSE professionals.

HSE advice may concern:

- hazard identification;
- risk assessment;
- selection of controls;

- interpretation of legal and organizational requirements;
- safe systems of work;
- emergency arrangements;
- occupational health considerations;
- incident prevention;
- management-system requirements; and
- improvement opportunities.

Hale (1995) identifies specialist expertise and advice as important dimensions of the safety professional's organizational role.

Advisory status does not mean absence of responsibility. If an HSE professional is expected to provide specialist advice, that professional is responsible for exercising reasonable competence within the assigned scope.

The distinction concerns what happens after the advice is provided. Where another organizational actor retains authority to make the operational decision, responsibility for that decision remains with the actor possessing that authority.

6.3 Assistance and Facilitation

HSE frequently assists operational functions in performing safety-related processes.

For example, HSE may facilitate a risk assessment, assist in developing a procedure, support a toolbox discussion, help investigate a hazard, or guide a supervisor in interpreting a requirement.

Facilitation is valuable because specialist knowledge can improve the quality of operational decision-making. It should not, however, transform the facilitator into the owner of the operational activity.

If HSE facilitates a risk assessment for a lifting operation, the personnel responsible for planning, supervising, and performing the lift remain responsible for implementing the operational controls within their authority.

HSE is responsible for the quality of the facilitation or specialist assistance it provides.

6.4 Training and Competence Support

HSE departments often develop, coordinate, or deliver safety training.

Their responsibilities may include identifying training requirements within their specialist scope, developing suitable material, delivering training competently, maintaining records, evaluating training effectiveness, or advising management regarding competence requirements.

ISO 45001 requires organizations to determine the necessary competence of workers whose activities affect OH&S performance and to ensure competence on the basis of appropriate education, training, or experience (ISO, 2018).

The organizational requirement for competence extends beyond the HSE department. Management and supervisory functions retain responsibility for ensuring that appropriately competent and authorized personnel are assigned to work within their control.

HSE training therefore **supports competence; it does not replace management responsibility for competent deployment and supervision of personnel.**

6.5 Monitoring and Workplace Inspection

Monitoring and inspection allow HSE to provide an additional level of observation and assurance.

HSE personnel may inspect workplaces, observe work practices, assess compliance with requirements, identify unsafe conditions, record findings, recommend corrective action, and follow up unresolved issues.

These activities create genuine HSE responsibility. An assigned inspection should be performed competently, significant findings should be communicated appropriately, and required escalation should occur.

However, an inspection does not transfer ownership of the inspected workplace to HSE.

The operational function controlling the workplace remains responsible for maintaining conditions and correcting deficiencies within its authority. HSE remains responsible for the inspection and for the actions required of HSE when deficiencies are identified.

6.6 Auditing and Assurance

Auditing provides a more systematic examination of whether organizational arrangements conform to established requirements and are effectively implemented.

ISO 45001 requires organizations to conduct internal audits of the OH&S management system at planned intervals (ISO, 2018). HSE personnel may coordinate or participate in these audits, although the precise arrangement varies between organizations.

An auditor's responsibility concerns the competent and objective performance of the audit. The auditor does not become responsible for operating every process examined during the audit.

This distinction illustrates the broader relationship between HSE and Operations:

HSE may provide assurance regarding how work is controlled without becoming the organizational function responsible for executing that work.

6.7 Incident Investigation

HSE commonly facilitates, coordinates, or participates in incident investigations.

Depending on organizational arrangements, its responsibilities may include collecting evidence, supporting causal analysis, identifying management-system weaknesses, documenting findings, tracking recommendations, analysing trends, and communicating lessons learned.

ISO 45001 requires organizations to establish processes for reporting, investigating, and taking action to determine and manage incidents and nonconformities (ISO, 2018).

Where HSE is assigned an investigation function, HSE should be responsible for performing that function competently.

Conducting an investigation, however, does not make HSE responsible for the operational failures discovered by the investigation. Responsibility for those failures must be analysed according to the functions, authority, and control of the actors involved.

6.8 Reporting and Escalation

HSE professionals may identify conditions that they cannot directly correct because the necessary operational or resource authority lies elsewhere.

In such cases, reporting and escalation become important HSE responsibilities.

An HSE professional who identifies a significant hazard may be expected to:

- communicate the concern;
- explain its significance;
- recommend appropriate action;
- document the finding;
- escalate unresolved matters; and
- follow established intervention procedures.

Lack of direct operational control therefore does not mean that HSE has no responsibility.

It means that HSE responsibility may consist of **identifying, advising, reporting, escalating, or intervening**, rather than physically executing the corrective action.

6.9 Verification and Approval

Some organizations assign HSE formal verification or approval functions.

Where HSE is required to verify that a specified condition has been satisfied, HSE carries responsibility for competent performance of that verification.

Where HSE possesses genuine authority to approve or reject a defined matter, HSE similarly carries responsibility for exercising that authority appropriately.

The scope of such authority should be clearly defined.

An HSE approval relating to a particular safety requirement should not automatically be interpreted as HSE acceptance of every operational, engineering, supervisory, or technical aspect of the activity unless the organizational arrangement explicitly assigns such authority.

Responsibility should follow the actual scope of the approval.

6.10 Intervention and Stop-Work Authority

HSE may also possess authority to intervene or stop work when specified unsafe conditions arise.

Such authority creates a direct HSE responsibility.

If an HSE professional observes a condition that clearly meets established intervention criteria and fails to act despite possessing the required authority and opportunity, responsibility may arise for failure to exercise that function.

However, the intervention responsibility remains distinct from responsibility for creating or controlling the underlying operational condition.

Operations may be responsible for an unsafe work arrangement while HSE is simultaneously responsible for failing to exercise required intervention authority.

This is an example of **concurrent but different responsibility**.

6.11 Statutory Responsibilities of Safety Professionals

The responsibilities of HSE professionals cannot be defined universally because applicable legislation varies between jurisdictions.

Some legal systems impose specific duties on designated safety professionals. Malaysia's Occupational Safety and Health (Safety and Health Officer) Regulations 1997, for example, assign Safety and Health Officers duties that include advising the employer, inspecting workplaces, investigating certain incidents, assisting safety and health programmes and committees, collecting and analysing statistics, and performing other prescribed functions (Malaysia, 1997).

This demonstrates why it would be inaccurate to state categorically that HSE is **only advisory**.

The more defensible position is that HSE carries responsibility for whatever specialist, organizational, or statutory functions are genuinely assigned to it, while responsibility for operational execution remains with the functions that control and perform that work unless an operational function has genuinely been reassigned.

6.12 HSE Responsibility and Operational Responsibility Can Coexist

The relationship between HSE and operational responsibility should therefore not be treated as an either/or question.

Consider several examples.

If HSE provides technically deficient advice and an operational manager makes a poor decision based on that advice, responsibility may need to be examined in both functions.

If HSE fails to report a serious hazard while Operations fails to maintain equipment adequately, separate failures may coexist.

If HSE fails to exercise mandatory stop-work authority while a supervisor continues an unsafe activity, both responsibility domains may be relevant.

Recognizing operational responsibility does not protect HSE from accountability. Recognizing HSE responsibility does not transfer operational execution responsibility to HSE.

6.13 The Appropriate Organizational Position of HSE

The HSE function can therefore be understood as a **specialist enabling, advisory, assurance, monitoring, and intervention function**, with the exact combination depending on organizational and legal arrangements.

Its purpose is to strengthen the organization's capacity to manage occupational risks and execute work safely.

Research distinguishing professional safety activities from the safety of operational work is relevant to this distinction. Rae and Provan (2019) describe the difference between “safety work”—activities performed in the name of safety—and the actual “safety of work.” This distinction helps explain why a large amount of HSE activity does not itself substitute for safe operational execution.

The effectiveness of HSE should therefore not be judged by whether it has assumed operational responsibility, but by how effectively its specialist functions help the organization identify risks, improve controls, monitor performance, challenge deficiencies, learn from events, and support those who manage and execute the work.

6.14 Section Conclusion

HSE has genuine and important responsibilities.

It may advise, assist, facilitate, train, inspect, monitor, audit, investigate, verify, report, escalate, approve, or intervene according to the functions and authority assigned to it. HSE should be accountable for performing those functions competently.

These responsibilities, however, should not be confused with responsibility for executing operational work.

The distinction remains:

Operational functions are responsible for executing and controlling their work safely. HSE is responsible for competently performing the specialist HSE functions and authorities assigned to it.

Recognizing this distinction strengthens rather than weakens accountability because responsibility is placed with the organizational actors who possess the corresponding function, authority, and ability to act.

7. Why the Misconception Persists in Organizations

7.1 Visibility of HSE Creates Perceived Ownership

One reason safety responsibility becomes associated primarily with HSE is the visibility of the HSE function.

HSE professionals conduct inspections, attend meetings, participate in risk assessments, deliver training, investigate incidents, review documents, issue reports, monitor compliance, and communicate safety requirements. Because many activities carrying an explicit “**safety**” label are performed by HSE, employees and managers may gradually associate safety itself with the HSE department.

This creates a distinction between **visible safety activities** and the less visibly labelled decisions that actually determine how work is executed.

A manager allocating sufficient competent personnel may not describe that decision as a “safety activity,” yet it can directly affect safe execution. A supervisor correcting an improper work method may regard the action simply as supervision, although it simultaneously controls safety. A maintenance technician restoring equipment integrity is performing maintenance, but the quality of that work directly influences whether the equipment can subsequently be operated safely.

The most visible safety activities are therefore not necessarily the activities with the greatest control over safe work execution.

7.2 The Word “Safety” in the HSE Title

Departmental terminology can reinforce the misconception.

Because the HSE function explicitly contains the word **Safety**, an intuitive but misleading inference may arise:

Safety issue → Safety department → HSE responsibility.

This reasoning assigns responsibility according to the name of the department rather than according to the function, authority, and control associated with the work.

Organizational responsibility does not operate effectively in this manner. A department name identifies an area of professional specialization; it does not automatically transfer operational responsibility for every organizational outcome associated with that specialization.

Hale (1995) identified the complex relationship between safety professionals and management, while later research has shown that safety practitioners can occupy multiple roles involving expertise, advice, coordination, monitoring, and organizational influence (Provan et al., 2018). These roles should not be confused with ownership of every operational activity having safety consequences.

7.3 Safety Activities Can Become Separated From Operational Work

Another source of the misconception is the organizational separation between activities explicitly labelled as **safety work** and ordinary operational activities.

Risk assessments, safety meetings, audits, inspections, safety reports, training programmes, statistics, and investigations may become identified as the organization's principal safety activities because they are visible, documented, and frequently coordinated by HSE.

Rae and Provan (2019) distinguish between “**safety work**” and the “**safety of work.**” This distinction is highly relevant to the present argument. Activities undertaken in the name of safety may support safe operations, but they are not identical to the actual conditions and behaviours through which operational work is performed safely.

An organization may therefore perform substantial amounts of safety work while still failing to execute operational work safely.

7.4 Dependence on HSE Can Weaken Operational Ownership

Where HSE becomes perceived as the primary owner of safety, operational personnel may begin to depend excessively on the HSE function.

A manager may expect HSE to identify whether a planned activity is safe rather than ensuring that safety is incorporated into operational planning.

A supervisor may wait for an HSE officer to correct an unsafe condition rather than treating correction as part of normal supervision.

Workers may perceive safety instructions as requirements imposed by HSE rather than requirements inherent in performing their work correctly.

Such dependency conflicts with the line-management responsibility described in ILO-OSH 2001 (ILO, 2001) and with ISO 45001's requirement to integrate OH&S into organizational business processes (ISO, 2018).

The organizational objective should therefore be **HSE support without operational dependency on HSE.**

7.5 “HSE Will Check It” Is Not a Control Strategy

The expectation that HSE will subsequently inspect or monitor an activity can also weaken responsibility at the point of execution.

An inspection is inherently secondary to the execution process. It may identify a deficiency, but the deficiency has already been created or permitted by the process being inspected.

For example, if a supervisor permits an incorrect lifting arrangement, the existence of a later HSE inspection does not make the arrangement acceptable until HSE identifies it. The responsibility to establish and maintain the correct arrangement exists before HSE arrives.

Similarly, an operational control should not depend primarily on the expectation that an HSE professional will detect every deviation.

HSE monitoring can provide an additional layer of assurance, but it should not become a substitute for competent planning, supervision, and execution.

7.6 The “Where Was HSE?” Reaction After Incidents

The misconception becomes particularly visible after incidents.

When an event occurs, organizations may quickly ask:

“Where was the safety officer?”

This question may be relevant if an HSE professional had a defined monitoring or intervention responsibility. However, asking it first can unintentionally narrow the investigation.

A complete analysis should also ask:

Who planned the work?

Who selected the method?

Who provided the resources and equipment?

Who authorized the activity?

Who supervised it?

Who controlled the relevant aspects of the work?

Who performed it?

What controls were required?

Who possessed authority to implement those controls?

What was HSE specifically assigned to do?

The HSE question should therefore be one part of the responsibility analysis, not a substitute for analysing how the work itself was managed.

7.7 HSE Presence Can Create a False Sense of Transfer

Operational personnel may sometimes behave differently when an HSE professional is present.

The presence of HSE can create an implicit expectation that the HSE professional is now watching the safety of the activity and will intervene if something becomes unsafe.

This expectation can create a dangerous psychological and organizational transfer of responsibility even when no formal transfer has occurred.

The operational supervisor may still possess the authority to direct the work. The workers still control their actions. Management still controls resources and operational arrangements. HSE may simply be monitoring or advising.

The presence of HSE therefore should strengthen operational control, not replace it.

7.8 HSE Signatures Can Reinforce the Misconception

Documents can create similar problems.

Risk assessments, permits, lifting plans, inspection forms, method statements, and other documents may contain an HSE signature. If the meaning of the signature is not clearly defined, operational personnel may interpret it as:

“HSE has approved the job, so safety is now HSE's responsibility.”

This interpretation may be incorrect.

The signature may represent review, participation, verification of a specified element, acknowledgement, or formal approval. Each carries a different responsibility.

Organizations should therefore define the meaning and scope of HSE signatures rather than allowing responsibility to be inferred retrospectively from the existence of a signature.

7.9 Broad HSE Job Descriptions Can Create Unrealistic Accountability

Job descriptions sometimes use broad language such as:

“The HSE Officer is responsible for ensuring workplace safety.”

Such wording may appear reasonable but can create an unrealistic responsibility assignment if the HSE officer lacks corresponding operational authority.

An HSE professional cannot independently “ensure” safe execution where decisions concerning manpower, equipment, work methods, maintenance, scheduling, technical design, and supervision are controlled by other functions.

ISO 45001 requires organizational responsibilities and authorities to be assigned and communicated (ISO, 2018). Responsibility statements should therefore correspond to what the role is actually empowered to perform.

More precise wording would define the specific HSE functions—such as advising, monitoring, inspecting, auditing, reporting, facilitating, verifying, or escalating—rather than assigning an undefined responsibility for all workplace safety.

7.10 Management Systems Can Become HSE Systems

Another organizational risk occurs when the OH&S management system itself becomes treated as an HSE departmental system.

HSE may coordinate procedures, records, audits, statistics, training programmes, investigations, and management-system documentation. Because HSE administers many of these processes, other departments may perceive the OH&S management system as something maintained by HSE for the organization.

This perception conflicts with ISO 45001's integration approach. The standard places leadership obligations on top management and requires OH&S management-system requirements to be integrated into the organization's business processes (ISO, 2018).

An OH&S management system should therefore govern **how the organization manages and performs work**, rather than operate as a parallel HSE administrative system.

7.11 Misplaced Accountability Can Affect HSE Effectiveness

Treating HSE as responsible for operational execution can also weaken the HSE function itself.

If HSE professionals are expected to compensate continuously for deficiencies in planning, supervision, maintenance, competence management, and operational discipline, their specialist role can become reactive.

Instead of analysing trends, improving systems, advising management, auditing controls, developing competence, investigating underlying causes, and providing independent challenge, HSE personnel may spend excessive time policing routine operational behaviour.

Research on safety professionals has highlighted tensions between administrative, compliance, advisory, and operational expectations placed on the profession (Hale, 1995; Provan et al., 2018).

Clearer responsibility boundaries can therefore strengthen both operational ownership and the effectiveness of HSE.

7.12 Shared Commitment Is Not the Same as Undifferentiated Responsibility

Organizations frequently state that:

“Safety is everyone's responsibility.”

The statement can be useful in expressing shared commitment, but it is insufficient as a responsibility model.

Everyone may contribute to safety, but everyone does not possess the same function, authority, resources, or control.

A worker cannot allocate a departmental budget. An HSE officer may not control production staffing. A supervisor may not redesign equipment. A maintenance technician may not authorize a production schedule. A senior manager may not directly control every individual task action.

Effective responsibility therefore requires both **shared commitment** and **defined responsibility**.

The general commitment may belong to everyone, while specific responsibility must correspond to organizational function, authority, and control.

7.13 Correcting the Misconception

Correcting the misconception does not require reducing HSE involvement.

It requires changing how that involvement is understood.

The organizational message should not be:

“Safety belongs to HSE.”

Nor should it be:

“HSE has no responsibility because Operations owns safety.”

A more accurate organizational message is:

“Every function must execute the work under its control safely. HSE provides specialist support, advice, assurance, monitoring, challenge, and intervention according to its assigned responsibilities and authority.”

This formulation preserves operational responsibility while recognizing genuine HSE accountability.

7.14 Section Conclusion

The misconception that safety is primarily an HSE responsibility can arise from HSE visibility, departmental terminology, specialist safety activities, HSE presence, signatures, broad job descriptions, and organizational dependence on safety professionals.

These factors can make HSE appear to own safety even when the resources, authority, supervision, and operational control necessary to execute work remain with other organizational functions.

Correcting the misconception requires reconnecting safety with work execution.

The function that executes or controls a part of the work must execute or control that part safely. HSE supports, monitors, challenges, and provides specialist expertise to that process but does not ordinarily replace the responsibility of the executing function.

This distinction provides the basis for translating the article's argument into a practical responsibility-analysis framework.

8. The Function–Authority–Control (FAC) Framework

8.1 Purpose of the Framework

The preceding sections establish that safe execution of work should remain connected to the organizational functions that plan, resource, authorize, direct, supervise, control, and perform the work. They also establish that HSE carries genuine responsibility for its assigned specialist functions without automatically assuming responsibility for operational execution.

A practical method is therefore required to determine responsibility when several organizational actors participate in the same activity.

This article uses the **Function–Authority–Control (FAC) Framework** for that purpose.

FAC asks three fundamental questions:

Function — What was the actor expected to do?

Authority — What was the actor empowered to decide, require, approve, reject, direct, stop, or escalate?

Control — What relevant decision, resource, condition, action, behaviour, or process could the actor actually control or materially influence?

Together, these questions help identify the actor's **domain of responsibility**.

8.2 Conceptual Representation

The framework can be expressed conceptually as:

Assigned Function + Corresponding Authority + Relevant Control → Domain of Responsibility

This expression is not intended as a mathematical formula. Responsibility cannot be calculated simply by assigning numerical values to these elements.

Rather, FAC provides a structured way to determine whether responsibility attributed to an organizational actor corresponds with what that actor was expected, empowered, and practically able to do.

The framework is particularly useful in challenging generalized statements such as:

“HSE was responsible because it was a safety issue.”

FAC replaces that assumption with an examination of the actual organizational arrangement.

8.3 Function

The first FAC dimension is **Function**.

Responsibility analysis should begin by identifying what the actor was expected to do in relation to the work or condition under examination.

Relevant evidence may include:

- job descriptions;
- organizational procedures;
- permits;
- risk assessments;

- delegation arrangements;
- contractual requirements;
- management instructions;
- professional responsibilities;
- training and competence requirements; and
- applicable legal requirements.

The question should be specific.

For an operational manager, the function may involve planning, resourcing, authorizing, or coordinating work.

For a supervisor, it may involve directing and supervising execution.

For a worker, it may involve performing the assigned task in accordance with established requirements.

For HSE, it may involve advising, facilitating, training, inspecting, monitoring, auditing, verifying, investigating, reporting, escalating, or intervening.

This approach avoids treating the general term “**safety responsibility**” as if it were a single organizational function.

8.4 Authority

The second FAC dimension is **Authority**.

Once the function has been identified, the analysis should determine what authority accompanied it.

Authority may include the power to:

- select a work method;
- allocate resources;
- assign personnel;
- authorize or reject work;
- direct workers;
- require corrective action;
- approve or reject a defined matter;
- suspend an activity;
- escalate a concern; or
- authorize restart.

ISO 45001 requires responsibilities and authorities for relevant roles to be assigned and communicated, demonstrating the organizational importance of linking expected responsibilities with corresponding authority (ISO, 2018).

This dimension is particularly important when examining HSE accountability.

If HSE is described broadly as responsible for workplace safety but lacks authority over operational manpower, equipment, work methods, schedules, budgets, maintenance, and direct supervision, responsibility for operational execution has been separated from the authority required to control that execution.

8.5 Control

The third dimension is **Control**.

Formal authority does not always reveal who actually influences how work is performed. FAC therefore examines practical control as well.

The question is:

What relevant decision, resource, condition, action, behaviour, or process could the actor actually control or materially influence?

For example, an operational manager may control resources and scheduling. A supervisor may control immediate work direction. A worker may control particular task actions. Engineering may control technical design decisions. Maintenance may control specified equipment-maintenance activities.

HSE may influence operational decisions through specialist advice, monitoring, challenge, reporting, escalation, verification, or intervention. However, the distinction between specialist safety activity and control of operational work remains important (Provan et al., 2018; Rae & Provan, 2019).

8.6 FAC and Safe Work Execution

FAC directly supports the central proposition of this article.

Consider a maintenance activity.

If Maintenance selects the method, assigns the personnel, controls the equipment, and performs the task, Maintenance carries responsibility for executing those aspects of the work safely.

If the operational supervisor authorizes access to the equipment and coordinates the surrounding operation, the supervisor carries responsibility for those decisions within the assigned authority.

If HSE advises on the risk assessment and subsequently monitors compliance, HSE carries responsibility for competent advice and monitoring.

The fact that HSE participates in the activity does not transfer the maintenance or supervisory functions to HSE.

FAC therefore allows responsibility for safe execution to remain connected to the functions through which execution actually occurs.

8.7 Relevant Control Rather Than Total Control

An actor does not need to control the entire activity before responsibility can arise.

Complex work is normally distributed among several organizational functions.

For example:

- Engineering may control technical design;
- Operations may control production arrangements;
- Maintenance may control equipment maintenance;
- a supervisor may control immediate work direction;
- workers may control specific task actions; and
- HSE may control or influence defined verification, monitoring, escalation, or intervention functions.

Each actor may therefore possess a different responsibility domain within the same activity.

The relevant question is not:

“Who controlled the whole job?”

but:

“Who controlled or materially influenced the particular decision, condition, resource, action, or process under examination?”

8.8 Where Direct Control Is Absent

Direct control is not the only basis for responsibility.

An actor who cannot personally correct a condition may still possess responsibility to take another reasonable action.

For example, an HSE professional may lack authority to purchase replacement equipment but may be responsible for identifying the deficiency, advising the responsible manager, escalating the concern, or

exercising intervention authority where applicable.

A supervisor may lack budget authority but may possess authority to suspend the activity and request additional resources.

A worker may lack authority to redesign the work but may possess responsibility to report a hazardous condition or take other action provided by organizational or legal arrangements. ILO Convention No. 155 recognizes worker responsibilities concerning cooperation and communication of situations reasonably believed to present imminent and serious danger (ILO, 1981).

FAC therefore asks an additional question:

Where direct corrective control was absent, what reasonable reporting, escalation, challenge, refusal, or intervention action remained available?

8.9 FAC and HSE Responsibility

FAC should be applied to HSE in exactly the same manner as to operational functions.

If HSE was expected to advise:

Was competent advice provided?

If HSE was expected to inspect:

Was the inspection performed appropriately?

If HSE was required to communicate a serious deficiency:

Was it communicated?

If escalation was required:

Was the matter escalated appropriately?

If HSE possessed defined verification or approval authority:

Was that authority exercised competently?

If intervention was required:

Did HSE intervene?

This ensures that the argument that safe execution is operational responsibility does not become an excuse for HSE failure.

HSE remains accountable within its own domain of function, authority, and control.

8.10 FAC and Concurrent Responsibility

FAC also prevents responsibility analysis from becoming a search for a single responsible department.

Suppose an operational manager authorizes an unsuitable method, a supervisor permits an unsafe deviation, a worker disregards an established requirement, and HSE fails to exercise a clearly assigned intervention function.

FAC would analyse each actor separately.

The manager may carry responsibility for the authorization decision.

The supervisor may carry responsibility for deficient supervision.

The worker may carry responsibility for the controllable unsafe action.

HSE may carry responsibility for failure to perform the assigned intervention function.

These responsibilities can coexist because they arise from different functions and authority.

8.11 FAC and the HSE Misconception

The FAC framework provides a direct test of the misconception challenged by this article.

When someone states:

“HSE is responsible for safety,”

FAC asks:

What specific function is being attributed to HSE?

Does HSE possess the authority required to perform that function?

Does HSE control the resources, decisions, conditions, or actions necessary to produce the expected outcome?

If the issue concerns operational staffing, work methods, equipment, supervision, scheduling, or task execution and these remain controlled by operational functions, assigning responsibility for their safe execution to HSE would create a mismatch between accountability and control.

If the issue instead concerns deficient HSE advice, inspection, monitoring, verification, reporting, escalation, or intervention, HSE responsibility may be clearly established.

FAC therefore does not predetermine that responsibility belongs to Operations or HSE. It identifies responsibility according to the organizational mechanisms through which the relevant outcome could actually be influenced.

8.12 FAC and Existing Responsibility Matrices

Organizations commonly use responsibility-assignment tools such as RACI matrices to identify who is responsible, accountable, consulted, or informed.

FAC serves a different but complementary purpose.

A responsibility matrix may state that a particular role is responsible for an activity. FAC asks whether that responsibility is supported by:

a clearly assigned function,

corresponding authority, and

relevant practical control or an effective escalation mechanism.

FAC may therefore reveal a responsibility that appears clear on paper but cannot realistically be fulfilled because the actor lacks the necessary authority or control.

8.13 Practical FAC Analysis

For a specific work activity, decision, condition, or failure, FAC can be applied through the following sequence:

1. Identify the specific matter under examination.
2. Identify the organizational actors connected to that matter.
3. Determine what each actor was expected to do.
4. Determine what authority accompanied each function.
5. Determine what each actor could actually control or materially influence.
6. Where direct control was absent, identify available reporting, escalation, challenge, refusal, or intervention mechanisms.
7. Determine whether each actor performed the assigned function appropriately.
8. Identify separate or overlapping responsibility domains.

This sequence allows responsibility to be examined without beginning with assumptions based on departmental titles.

8.14 FAC Is an Organizational Framework, Not a Legal Test

FAC is proposed in this article as a framework for analysing **organizational responsibility**.

It does not determine legal liability.

Applicable legislation may impose duties independently of an organization's internal distribution of functions, authority, and control. Legal duties may also be non-transferable or may apply simultaneously to several duty holders.

For example, Safe Work Australia emphasizes that work health and safety duties cannot simply be transferred or contracted out (Safe Work Australia, n.d.). Jurisdiction-specific legislation must therefore be considered independently of internal organizational responsibility arrangements.

FAC should consequently be used to clarify organizational responsibility, not to override statutory duties or legal tests.

8.15 Section Conclusion

The FAC Framework provides a practical method for analysing responsibility without relying on departmental labels or generalized statements about who “owns safety.”

Its central relationship is:

Assigned Function + Corresponding Authority + Relevant Control → Domain of Responsibility

Applied to safe work execution, FAC reinforces the central argument of this article: responsibility should remain connected to the organizational functions that possess the authority and control through which work is planned, resourced, authorized, directed, supervised, controlled, and performed.

Applied to HSE, the same framework establishes genuine HSE accountability for the specialist functions and authorities assigned to HSE.

FAC therefore supports rather than replaces the central proposition:

Safe execution of work is an operational responsibility; HSE responsibility lies in the competent performance of its assigned specialist functions and the appropriate exercise of its assigned authority.

9. Applying the Principle to Common Organizational Situations

9.1 Purpose of Practical Application

The distinction between operational responsibility and HSE responsibility becomes clearest when applied to actual workplace situations. In many cases, both operational personnel and HSE professionals participate in the same activity, but their participation does not mean that they possess the same function, authority, or responsibility.

The following examples apply the central proposition of this article, the Non-Transfer Principle, and the Function–Authority–Control (FAC) Framework to common organizational situations. The purpose is not to assign legal liability, which depends on applicable legislation and specific facts, but to demonstrate how organizational responsibility can be analysed without automatically treating HSE as responsible for the safe execution of work.

9.2 Risk Assessment

Risk assessment is frequently perceived as an HSE activity because HSE professionals may provide the methodology, facilitate the assessment, participate in discussions, review documentation, or challenge the adequacy of proposed controls.

However, ISO 45001 treats hazard identification, risk assessment, and operational control as organizational processes rather than activities belonging exclusively to a safety department (ISO, 2018).

Consider an operational team preparing for a maintenance activity. The maintenance personnel understand the task, equipment, tools, sequence, and technical requirements. Operations may control the plant conditions and interfaces. The supervisor controls immediate execution. HSE may contribute specialist knowledge concerning hazard identification, risk-assessment methodology, or organizational requirements.

HSE participation does not make HSE responsible for executing the resulting controls.

If Maintenance is required to isolate equipment, Maintenance remains responsible for performing the assigned isolation-related functions safely. If Operations must establish particular plant conditions, Operations remains responsible for those conditions. If the supervisor must brief and control the workforce, that responsibility remains with supervision.

HSE remains responsible for the quality of the HSE function it performs in the assessment.

9.3 Permit-to-Work Systems

Permit-to-work systems provide another common area of confusion because HSE may participate in developing, auditing, monitoring, or sometimes verifying elements of the system.

A permit, however, does not physically execute the work. The effectiveness of the permit system depends on the organizational actors who identify the work, establish conditions, isolate hazards, authorize the activity, communicate requirements, supervise execution, and comply with the permit conditions.

If an operational authority issues a permit, the responsibility associated with that authorization remains with the designated issuing authority.

If the performing authority accepts the permit and executes the work, responsibility for execution remains with the relevant performing function.

If HSE audits the permit system, HSE is responsible for competent auditing.

Where HSE has been formally assigned a specific verification or approval function within the permit process, HSE carries responsibility for that defined function. The existence of the HSE signature or verification does not automatically transfer the responsibilities of the permit issuer, performing authority, supervisor, or workers to HSE.

9.4 Lifting Operations

A lifting operation illustrates particularly well why safety cannot be separated from execution.

Safe lifting may depend on:

- appropriate lift planning;
- suitable lifting equipment;
- equipment integrity;
- competent operators and riggers;
- correct rigging arrangements;
- assessment of load characteristics;
- appropriate ground or supporting conditions;
- effective communication;
- exclusion-zone control; and
- competent supervision.

These are elements of executing the lifting operation itself.

An HSE professional may review documentation, observe the lift, inspect conditions, provide advice, monitor compliance, or intervene where authority exists. These activities may contribute significantly to safety.

They do not ordinarily make HSE the person executing or controlling the lift.

If the lifting supervisor controls the lifting operation, the safety of that control forms part of the supervisory responsibility. If an operator controls the equipment, safe operation forms part of the operator's responsibility. If management provides unsuitable equipment or inadequate competence, responsibility may arise at that level.

HSE remains responsible for whatever specialist function it was assigned.

9.5 Maintenance Activities

Maintenance provides another useful example because equipment condition frequently has direct safety consequences.

Suppose HSE identifies a defective machine guard during an inspection.

HSE may be responsible for recording the deficiency, communicating it, recommending action, escalating the matter, or exercising intervention authority where applicable.

HSE does not ordinarily possess the technical function or resources to repair the machine.

The maintenance function responsible for restoring equipment integrity retains responsibility for performing the repair competently. The operational function controlling use of the equipment may be responsible for ensuring that unsafe equipment is not used pending correction. Management may carry responsibility for providing the necessary maintenance resources.

The existence of the HSE inspection therefore does not transfer responsibility for equipment integrity to HSE.

9.6 Work at Height

Work at height may require appropriate access equipment, fall-prevention or protection measures, competent personnel, suitable anchorage, inspection of equipment, planning, and supervision.

HSE may advise on requirements, inspect conditions, provide training support, monitor the activity, or exercise intervention authority.

The function planning the work remains responsible for establishing an executable safe method within its authority. The supervisor remains responsible for controlling execution. Workers remain responsible for using the provided systems correctly within their competence and control.

If HSE identifies a serious deficiency and fails to take an action clearly required within its assigned authority, HSE responsibility may also arise.

Again, responsibilities coexist rather than transfer automatically.

9.7 Contractor Activities

Contractor work can create particularly complex responsibility arrangements.

ISO 45001 requires organizations to coordinate relevant procurement processes with contractors to identify hazards and assess and control OH&S risks arising from contractor activities and operations (ISO, 2018).

The presence of a contractor does not eliminate the responsibilities of the host organization, nor does the presence of the host organization's HSE personnel make HSE responsible for executing the contractor's work.

Responsibility should instead be analysed according to the contractual and organizational arrangements.

The contractor may control its workforce, methods, equipment, and immediate supervision. The host operational function may control site conditions, interfaces, access, simultaneous operations, or authorization. HSE may monitor, advise, audit, verify specified requirements, or escalate concerns.

FAC analysis identifies the responsibility domain of each actor rather than assuming that all contractor safety belongs to the HSE department.

9.8 Unsafe Behaviour Observed by HSE

Consider a worker performing an activity contrary to an established requirement while an HSE professional observes the behaviour.

It would be incorrect to conclude automatically that responsibility has transferred to HSE because HSE witnessed the act.

The worker may carry responsibility for the controllable behaviour. The supervisor may carry responsibility if adequate supervision was absent or if the deviation had been permitted. Management responsibility may arise if organizational conditions encouraged or enabled the behaviour.

HSE's responsibility depends on its assigned function and authority.

If HSE was required to intervene, warn, report, escalate, or stop the activity and failed to do so, HSE may carry responsibility for that failure.

The HSE failure does not erase the responsibilities of the other actors.

9.9 Unsafe Condition Reported by HSE but Not Corrected

Consider a different situation in which HSE identifies a serious unsafe condition, reports it to the responsible manager, recommends corrective action, and follows the established escalation process, but the manager possessing the necessary resource authority does not act.

In this case, HSE may have properly performed its assigned function.

If HSE lacks the authority and resources to implement the correction independently, continued attribution of the underlying condition to HSE would disconnect responsibility from operational authority.

The manager who possesses the authority to provide the necessary resources or take the required operational decision should be examined within that responsibility domain.

This example demonstrates why responsibility cannot be determined merely by asking who first identified the safety problem.

9.10 Inadequate HSE Advice

The reverse situation must also be recognized.

Suppose an operational manager seeks specialist advice from HSE concerning a significant hazard. HSE provides advice that falls materially below the competence reasonably expected of the assigned professional function, and that deficiency contributes to an unsafe decision.

The proposition that safe execution is an operational responsibility should not be used to dismiss the HSE failure.

HSE may carry responsibility for deficient professional advice, while the operational decision-maker's responsibility must be examined according to the authority exercised, information available, and surrounding circumstances.

This demonstrates again that responsibility can be concurrent and function-specific.

9.11 Failure to Exercise Stop-Work Authority

Suppose an HSE professional has clearly defined authority to stop an activity when specified serious conditions exist. The professional observes such a condition, has a reasonable opportunity to intervene, but does not exercise the assigned authority.

HSE may carry responsibility for failure to perform that intervention function.

However, if the unsafe condition arose because Operations selected an unsuitable method, a supervisor permitted the condition, or workers departed from established requirements, those responsibility domains remain relevant.

HSE's failure to stop unsafe work does not retrospectively make HSE the function that planned, supervised, or executed the work.

9.12 Incident Investigation

Following an incident, responsibility analysis should begin with the failed work process rather than with departmental labels.

The investigation should identify:

- what happened;
- what work was being performed;
- what controls were required;
- what controls failed or were absent;
- who planned the relevant aspects of the work;
- who provided resources;
- who made relevant technical decisions;
- who authorized the activity;
- who supervised execution;
- who controlled or materially influenced the relevant aspects of the work;
- who performed the work;
- what HSE functions were assigned; and
- whether each actor appropriately exercised the function and authority available.

ISO 45001 requires incident investigation to identify causes and determine whether similar incidents or nonconformities exist or could potentially occur (ISO, 2018).

Beginning an investigation with the assumption that HSE was responsible because the event involved safety can prevent examination of the operational decisions and systemic conditions that produced the event.

9.13 Example of FAC Analysis

Consider a hypothetical lifting incident in which a load is dropped.

The investigation establishes that:

- management approved the activity despite insufficient time for preparation;
- the lifting supervisor accepted an unsuitable lifting arrangement;
- the operator proceeded despite an observable abnormal condition;
- HSE had previously advised that additional controls were required; and
- HSE was not assigned operational approval authority for the lift.

FAC analysis would examine each function separately.

Management: Did management's scheduling or resource decisions contribute to the conditions of execution, and what authority did management possess?

Lifting supervision: Was the supervisor responsible and authorized to establish and control the lifting arrangement?

Operator: What conditions could the operator observe and control, and what action was required within the operator's competence and authority?

HSE: What advice, monitoring, escalation, or intervention function was assigned, and was that function performed appropriately?

The analysis does not begin with:

“It was a safety incident, therefore HSE failed.”

It begins with the work and traces responsibility through the functions that created, controlled, supervised, performed, and monitored it.

9.14 Practical Lesson

Across these examples, the same principle remains consistent.

HSE involvement may be extensive. HSE may participate before, during, and after an activity. It may possess important professional and intervention responsibilities.

But involvement should not be confused with execution.

The function that plans a part of the work must plan it safely. The function that provides resources must provide resources adequate for safe execution. The function that authorizes work must exercise that authority with its safety implications in view. The function that directs the work must direct it safely. The function that supervises the work must supervise it safely. The function that controls a part of the work must control it safely. The function that performs the work must perform it safely. HSE must competently perform the specialist HSE functions assigned to it.

9.15 Section Conclusion

Practical workplace situations demonstrate why responsibility for safety cannot be allocated simply according to the presence of HSE or the safety-related nature of an event.

Risk assessment, permit systems, lifting operations, maintenance, work at height, contractor management, workplace monitoring, and incident investigation all involve multiple organizational functions.

The appropriate responsibility question is therefore not:

“Who was responsible for safety?”

It is:

“Who was responsible for the function, decision, resource, condition, supervision, action, or control through which the work was to be executed safely?”

This approach keeps safe execution connected to operational responsibility while preserving clear accountability for the specialist functions performed by HSE.

10. Organizational Consequences of Misplacing Responsibility

10.1 Why Responsibility Allocation Matters

The distinction between operational responsibility and HSE responsibility is not merely theoretical. How an organization understands responsibility influences planning, supervision, decision-making, resource allocation, incident investigation, and everyday behaviour.

If responsibility for safe execution is perceived to belong primarily to HSE, while the authority and resources required to execute the work remain with operational functions, the organization creates a structural mismatch between **responsibility and control**.

This is inconsistent with the line-management responsibility emphasized by ILO-OSH 2001 and with ISO 45001's requirement to integrate OH&S into organizational business processes and assign appropriate responsibilities and authorities (ILO, 2001; ISO, 2018).

10.2 Weakening of Line-Management Ownership

One significant consequence of treating safety as an HSE responsibility is the potential weakening of line-management ownership.

Managers make decisions concerning work methods, personnel, equipment, schedules, priorities, resources, and operational authorization. These decisions can directly shape the conditions under which work is performed.

If managers perceive safety as something that HSE will subsequently check, approve, or control, safety considerations may become separated from normal operational decision-making.

This position is also supported by OSHA's Recommended Practices for Safety and Health Programs. OSHA places management leadership with business owners, managers, and supervisors and identifies management responsibilities that include providing sufficient resources, integrating safety and health into business decisions, planning and budgeting, assigning responsibilities and authorities, and holding people accountable for performance (Occupational Safety and Health Administration [OSHA], n.d.).

The result can be a two-stage mentality:

Operations decides how the work will be done; HSE determines whether it is safe.

This separation contradicts the central principle developed in this article. The work method and the safe work method should not be treated as two different decisions.

10.3 Weakening of Supervisory Responsibility

A similar problem can arise at supervisory level.

Supervisors normally control immediate work execution. They assign tasks, communicate instructions, coordinate workers, observe performance, respond to changing conditions, and correct deviations.

Research has demonstrated relationships between supervisory leadership practices, safety climate, and safety performance (Kapp, 2012; Wu et al., 2008).

If supervisors begin to depend on HSE personnel to identify unsafe acts, correct unsafe conditions, or enforce routine operational requirements, normal supervisory responsibility can weaken.

The HSE officer may then become an informal substitute supervisor for safety matters despite lacking the broader operational authority of the actual supervisor.

10.4 Creation of a Safety-Policing Culture

Misplaced responsibility can transform HSE into a policing function.

Instead of concentrating on specialist advice, risk analysis, assurance, system improvement, auditing, investigation, trend analysis, competence support, and organizational learning, HSE personnel may spend substantial time continuously observing workers and correcting routine operational deviations.

This can create the perception that workers behave safely **for HSE** rather than because safe behaviour is part of correctly performing the job.

Research concerning safety professionals has identified tensions between advisory, administrative, compliance, and operational expectations placed on the role (Hale, 1995; Provan et al., 2018).

An excessive policing model may therefore weaken both operational responsibility and the strategic effectiveness of the HSE function.

10.5 Reactive Rather Than Preventive Safety Management

When HSE is expected to detect unsafe conditions during execution, organizational attention can shift from prevention to detection.

A stronger system seeks to prevent unsafe conditions through:

- competent planning;
- suitable engineering;
- appropriate equipment;
- adequate resources;
- competent personnel;
- effective maintenance;
- realistic scheduling;

- clear operational controls; and
- competent supervision.

HSE monitoring can provide an additional layer of assurance, but it should not become the primary mechanism by which unsafe execution is prevented.

ISO 45001 emphasizes proactive hazard identification, assessment of risks, operational planning and control, competence, and continual improvement (ISO, 2018). These requirements reinforce prevention through organizational processes rather than dependence on safety personnel detecting every deficiency during work.

10.6 Responsibility Without Authority

A particularly serious organizational problem occurs when HSE is described as responsible for safety but lacks authority over the factors that determine operational execution.

For example, HSE may not control:

- operational budgets;
- workforce numbers;
- equipment procurement;
- maintenance priorities;
- production schedules;
- technical design;
- operational methods;
- task assignment; or
- direct line supervision.

If HSE is nevertheless expected to “ensure” that all operational work is safe, responsibility has been assigned without corresponding authority.

Such arrangements can produce accountability in name without the practical ability to deliver the expected outcome.

This does not mean that HSE is powerless. HSE may possess significant influence through advice, monitoring, reporting, escalation, verification, or intervention. The issue is that these forms of influence should not be confused with control of the operational resources and decisions themselves.

10.7 Operational Authority Without Recognized Safety Responsibility

The reverse mismatch can also occur.

An operational manager may possess substantial authority over personnel, equipment, schedules, methods, and production decisions while believing that the safety consequences of those decisions belong to HSE.

This creates **authority without corresponding recognition of safety responsibility**.

The organization then separates the power to create or control operational conditions from perceived accountability for their safety consequences.

The line-management approach in ILO-OSH 2001 helps prevent this separation by locating OSH responsibility within the management structure itself (ILO, 2001).

10.8 Distortion of Incident Investigation

Misplaced responsibility can significantly affect incident investigation.

If an investigation begins with the assumption that an incident represents an HSE failure, attention may focus immediately on questions such as:

- Was HSE present?

- Did HSE inspect the area?
- Did HSE conduct training?
- Did HSE sign the document?
- Why did HSE not stop the activity?

These questions may be legitimate, but they are incomplete if asked without examining the operational system.

A more comprehensive investigation must also examine who:

- designed the work;
- selected the method;
- provided the equipment;
- allocated personnel;
- established the schedule;
- authorized the activity;
- directed the workforce;
- supervised execution;
- maintained the equipment; and
- performed the task.

ISO 45001 requires organizations to investigate incidents and determine causes so that appropriate corrective action can be taken (ISO, 2018). A responsibility model focused primarily on HSE may obscure operational and systemic causes and therefore weaken organizational learning.

10.9 The Risk of Correcting the Wrong Function

When responsibility is misplaced, corrective actions may also be directed toward the wrong organizational function.

For example, after an operational incident, an organization might respond by:

- increasing the number of HSE inspections;
- requiring additional HSE signatures;
- increasing HSE presence;
- adding more safety forms;
- providing additional general safety training; or
- increasing HSE reporting requirements.

These measures may sometimes be appropriate, but they will not necessarily correct failures in engineering, maintenance, operational planning, staffing, supervision, equipment selection, or resource allocation.

Rae and Provan's (2019) distinction between “safety work” and the “safety of work” is relevant here. Increasing activities performed in the name of safety does not necessarily correct the operational conditions through which work becomes safe or unsafe.

10.10 Growth of Bureaucratic Safety Controls

Misplaced responsibility may also encourage organizations to create additional administrative controls around HSE.

If management believes HSE must ensure safety without giving HSE control over operational execution, the organization may attempt to compensate through additional forms, signatures, approvals, checklists, and reporting requirements.

These mechanisms can have legitimate purposes, but excessive reliance on them may create the appearance of stronger safety management without addressing the underlying operational control.

An HSE signature on a document cannot substitute for competent supervision.

An additional checklist cannot substitute for suitable equipment.

More inspections cannot substitute for adequate maintenance.

Additional training cannot substitute for competent operational planning and appropriate resource allocation.

Administrative safety activities should support operational control, not conceal its absence.

10.11 Potential Conflict Between HSE and Operations

Unclear responsibility boundaries can also create conflict between HSE and operational functions.

Operations may perceive HSE as interfering with work, while HSE may perceive Operations as ignoring safety requirements. Each function may then attempt to protect itself by documenting the failures of the other.

This adversarial relationship is counterproductive.

A clearer model recognizes that the functions have different but complementary responsibilities.

Operations must execute work safely.

HSE must competently perform its specialist advisory, assurance, monitoring, and intervention functions.

Both contribute to the same organizational objective without requiring one function to assume the other's role.

10.12 Impact on Safety Culture

Responsibility allocation also influences safety culture.

If workers repeatedly hear that safety belongs to the HSE department, they may come to regard safety requirements as external restrictions imposed by safety personnel.

If instead safety is consistently incorporated into how work is planned, supervised, and performed, it becomes part of normal operational competence.

ISO 45001 places emphasis on leadership, worker consultation and participation, organizational roles, and integration of OH&S into business processes (ISO, 2018). These elements support an organizational culture in which safety is embedded in work rather than delegated to a specialist department.

10.13 Impact on the HSE Profession

Correct responsibility allocation also benefits HSE professionals.

When HSE is not expected to act as the substitute operational owner of safety, specialists can devote greater attention to functions for which their expertise provides distinctive value.

These may include:

- analysing risk;
- interpreting requirements;
- identifying systemic weaknesses;
- auditing controls;
- examining trends;
- supporting competence;
- investigating incidents;
- advising leadership;
- evaluating management-system effectiveness; and

- challenging organizational assumptions.

Provan et al. (2018) highlight the complexity of safety-professional identity, while Rae and Provan (2019) draw attention to the relationship between professional safety activities and actual operational safety.

Clear responsibility boundaries can help ensure that HSE expertise strengthens operational safety rather than compensating continuously for routine failures of operational control.

10.14 From HSE Ownership to Operational Integration

The organizational objective should therefore not be to reduce HSE involvement but to change the relationship between HSE and operational execution.

The shift can be expressed as:

From: “HSE is responsible for making the work safe.”

To: “The responsible operational function must execute the work safely, supported and challenged by HSE within HSE's assigned specialist role.”

This shift is consistent with the integration of OH&S into organizational processes required by ISO 45001 and with the line-management responsibility described in ILO-OSH 2001 (ISO, 2018; ILO, 2001).

10.15 Section Conclusion

Misplacing responsibility for safe execution can weaken line-management ownership, undermine supervision, create excessive dependence on HSE, encourage reactive policing, distort incident investigation, generate unnecessary bureaucracy, and separate accountability from operational authority. The solution is not to remove HSE responsibility.

It is to locate each responsibility where the corresponding function and authority exist.

Operations and other executing functions should be accountable for executing and controlling their work safely. HSE should be accountable for competently performing its assigned specialist functions and exercising its assigned authority.

This allocation strengthens both operational ownership and HSE effectiveness while maintaining the central principle that safe execution of work is inseparable from the execution of work itself.

11. Practical Implications for Organizational Responsibility

11.1 Translating the Principle Into Organizational Practice

If safe execution of work is an operational responsibility, organizations should reflect this principle in their structures, procedures, job descriptions, work-control systems, performance expectations, and incident investigations.

It is insufficient to state generally that “**safety is everyone's responsibility.**” Although such a statement may encourage shared commitment, it does not identify who is responsible for specific decisions, resources, controls, and actions.

ILO-OSH 2001 states that OSH should be a line-management responsibility and that responsibility, accountability, and authority for the development, implementation, and performance of the OSH management system should be allocated within the organization (ILO, 2001). ISO 45001 similarly requires responsibilities and authorities for relevant roles to be assigned and communicated and requires OH&S requirements to be integrated into organizational business processes (ISO, 2018).

Organizations should therefore translate general safety commitment into clearly defined responsibility at each level of work execution.

11.2 Define Operational Responsibilities Explicitly

Operational job descriptions and procedures should explicitly recognize that responsibility for performing a function includes responsibility for performing it safely.

A manager responsible for planning work should therefore be responsible for incorporating applicable safety requirements into that planning.

A manager responsible for allocating resources should consider whether those resources are adequate for safe execution.

A supervisor responsible for directing work should be responsible for directing and supervising it safely.

A worker responsible for performing a task should be responsible for performing the controllable aspects of that task in accordance with applicable requirements.

Engineering, Maintenance, Procurement, Logistics, Projects, and other functions should similarly recognize the safety implications of the decisions and activities within their authority.

This approach embeds safety into the function rather than creating a separate parallel responsibility assigned to HSE.

11.3 Define HSE Responsibilities Precisely

HSE responsibilities should also be clearly defined.

Broad statements such as:

“HSE is responsible for ensuring safety at the workplace.”

should be avoided where they imply an outcome that HSE lacks the operational authority and resources to control.

Instead, HSE responsibilities should identify the actual functions assigned to the role, such as:

- providing specialist advice;
- facilitating risk assessment;
- supporting development of controls;
- providing or coordinating training;
- conducting inspections;
- monitoring compliance;
- auditing management systems;
- investigating incidents;
- analysing performance;
- reporting deficiencies;
- escalating unresolved concerns;
- verifying specified requirements; and
- exercising defined intervention authority.

Such clarity makes HSE accountable without incorrectly converting HSE into the executor of operational work.

11.4 Align Responsibility With Authority

Responsibility assignments should be tested against corresponding authority.

For every significant responsibility, organizations should ask:

Does this role possess sufficient authority to fulfil the responsibility being assigned?

If a supervisor is responsible for stopping unsafe work, the supervisor must have authority to stop it.

If a manager is responsible for providing suitable resources, the manager must possess or have access to the necessary resource authority.

If HSE is responsible for escalating unresolved significant risks, clear escalation channels must exist. If HSE is given formal approval or intervention responsibility, the scope and authority associated with that function should be explicit.

Responsibility without corresponding authority creates ambiguity and can produce accountability for outcomes that the role cannot reasonably control.

11.5 Clarify the Meaning of HSE Approval and Signatures

Organizations should define what HSE signatures on operational documents actually mean.

For each signature, the procedure should clarify whether HSE is:

- acknowledging participation;
- confirming that a review occurred;
- providing advice;
- verifying a specified requirement;
- recommending acceptance;
- approving a defined safety element; or
- exercising formal authorization.

The scope of responsibility should correspond to the meaning of the signature.

This prevents an HSE signature from later being interpreted as blanket acceptance of the entire operational activity.

11.6 Keep Risk Assessment With the Work

Risk assessment should not be treated as a document produced by HSE for Operations.

The people who understand, plan, supervise, and perform the work should participate meaningfully because they possess knowledge and control relevant to execution. HSE can provide methodology, facilitation, specialist knowledge, challenge, and assurance.

ISO 45001 requires processes for hazard identification and assessment of OH&S risks and requires operational controls to address those risks (ISO, 2018).

The practical objective should therefore be:

Operational personnel assess and control the risks of their work with appropriate HSE specialist support—not HSE assessing the work on behalf of those who execute it.

11.7 Keep Supervision With Line Management

Routine safety observation and correction should form part of normal operational supervision.

Supervisors should not depend on HSE officers to identify obvious deviations, enforce basic work requirements, or continuously direct workers regarding routine safe execution.

Research linking supervisory leadership and safety performance supports the importance of supervision in workplace safety (Kapp, 2012; Wu et al., 2008).

HSE workplace monitoring should provide additional assurance and independent challenge, not substitute for the supervisory chain.

This operational emphasis is also reflected in guidance from the International Association of Oil & Gas Producers (IOGP). Its Process Safety Fundamentals are specifically directed toward front-line personnel, supervisors, and managers, including those working in operations, maintenance, and wells, emphasizing the role of these operational functions in preventing process safety events and maintaining effective controls (International Association of Oil & Gas Producers [IOGP], 2020).

11.8 Use HSE Monitoring as Assurance

HSE monitoring is most valuable when it tests whether operational controls are functioning rather than

becoming the primary control itself.

For example, instead of merely counting unsafe acts corrected by HSE, organizations can examine:

- whether supervisors identify and correct deviations themselves;
- whether operational inspections are effective;
- whether risk controls are implemented before work begins;
- whether maintenance deficiencies are corrected by responsible functions;
- whether operational managers close safety actions within their authority; and
- whether repeated HSE findings indicate a weakness in line-management control.

This shifts HSE from being the routine executor of safety controls toward providing assurance about whether the operational system is controlling its own work effectively.

11.9 Establish Effective Escalation Mechanisms

Because HSE may identify significant deficiencies without possessing direct authority to correct them, organizations need clear escalation arrangements.

These should define:

- who receives significant HSE concerns;
- what level of management possesses corrective authority;
- when escalation is mandatory;
- how unresolved matters are elevated;
- when work should be suspended;
- who can authorize restart; and
- how decisions are documented.

An HSE professional should not be held responsible for independently correcting a condition outside HSE authority when the organizational mechanism requires another function to act. HSE should, however, remain accountable for using the available reporting, escalation, or intervention mechanism appropriately.

11.10 Management Should Own Safety-Related Operational Decisions

Where management possesses authority over operational decisions, the associated safety considerations should form part of management accountability.

This includes decisions concerning:

- staffing;
- equipment;
- competence;
- maintenance;
- schedules;
- production priorities;
- work methods;
- contractor arrangements;
- procurement;
- operational changes; and
- resource allocation.

ISO 45001 places leadership and accountability requirements on top management and requires integration of OH&S into business processes (ISO, 2018). ILO-OSH 2001 similarly emphasizes line-management responsibility (ILO, 2001).

Management should therefore not be able to make an operational decision while treating the safety consequences of that same decision as belonging separately to HSE.

11.11 Performance Measurement Should Reinforce Operational Ownership

Organizational performance systems can unintentionally reinforce the misconception if safety indicators are treated only as HSE performance measures.

Operational managers and supervisors should be evaluated on relevant safety aspects of the work they control.

These may include:

- effectiveness of operational risk controls;
- quality of supervision;
- timely correction of deficiencies;
- maintenance of safe conditions;
- competence management;
- implementation of corrective actions;
- management of change;
- contractor control; and
- response to identified risks.

HSE performance measures should focus on the quality and effectiveness of HSE's own specialist functions rather than making HSE solely accountable for organization-wide safety outcomes over which it lacks complete control.

11.12 Incident Investigations Should Follow the Work

Incident investigations should begin with the work process and failed controls rather than with the assumption that a safety event represents an HSE failure.

Investigators should identify:

1. what work was being performed;
2. what should have happened;
3. what actually happened;
4. what controls were required;
5. which controls failed or were absent;
6. which functions controlled those matters;
7. what authority each actor possessed;
8. what HSE functions were assigned; and
9. whether each actor performed the assigned function appropriately.

ISO 45001 requires organizations to investigate incidents, determine causes, and take corrective action (ISO, 2018).

Applying FAC during investigation can help prevent responsibility from being assigned according to organizational title rather than the actual mechanisms that produced the event.

11.13 Corrective Actions Should Target the Responsible Function

Corrective actions should address the function in which the weakness actually occurred.

If the failure concerns equipment integrity, corrective action may primarily involve Maintenance or Engineering.

If the failure concerns inadequate staffing, resource allocation, or scheduling, management action may be required.

If the failure concerns supervision, the supervisory system should be addressed.

If the failure concerns deficient HSE advice, monitoring, escalation, verification, or intervention, corrective action should address the HSE function.

This prevents organizations from responding to operational failures merely by increasing HSE inspections, HSE staffing, HSE signatures, or safety documentation.

11.14 Leadership Communication Should Reinforce the Correct Message

Leadership language strongly influences organizational perceptions of responsibility.

Statements such as:

“HSE is responsible for safety.”

should be replaced with more accurate messages such as:

“Every function is responsible for executing the work under its control safely, and HSE provides specialist support, assurance, challenge, and intervention according to its assigned role.”

Similarly, when a safety problem occurs, leadership should avoid immediately directing the issue to HSE without first identifying the function that controls the underlying work.

This reinforces the principle that safety is embedded in operational execution.

11.15 A Practical Responsibility Test

Before assigning responsibility for a safety-related issue, organizations can apply a simple sequence:

Who was responsible for the work or decision?

Who possessed the authority to control it?

Who controlled or materially influenced the relevant condition?

What was HSE specifically assigned to do?

Did each actor properly perform the function within that actor's authority and control?

This test translates the FAC framework into routine organizational decision-making.

11.16 The Desired Organizational Model

The desired organizational arrangement is neither **HSE ownership of safety** nor **absence of HSE accountability**.

It is an integrated model in which:

Operations and other executing functions own the safe execution of the work they control.

HSE owns the competent performance of its assigned specialist HSE functions.

Management provides the authority, resources, and organizational arrangements necessary for both.

This model is consistent with the integration approach of ISO 45001 and the line-management responsibility emphasized in ILO-OSH 2001 (ISO, 2018; ILO, 2001).

11.17 Section Conclusion

The practical application of the article's central proposition requires organizations to embed safety responsibility directly into the functions through which work is planned, resourced, authorized, directed, supervised, controlled, and performed.

HSE responsibilities should be clearly defined and supported by appropriate authority, but HSE should not be assigned generalized accountability for operational outcomes it does not control.

The organizational objective can therefore be summarized as:

Do not transfer safety away from the work. Make safe execution part of the responsibility for executing the work, and use HSE expertise to support, monitor, challenge, and strengthen that execution.

12. Discussion

12.1 Reconnecting Safety With the Execution of Work

The central argument of this article is that **safe execution of work is an operational responsibility because safety is inseparable from the execution of the work itself**. This position challenges the organizational misconception that the presence of an HSE function makes HSE primarily responsible for whether operational work is performed safely.

The distinction is important because organizations do not normally assign HSE the full range of authority and resources through which operational work is executed. Decisions concerning work methods, personnel, equipment, maintenance, scheduling, technical arrangements, production priorities, supervision, and operational authorization generally remain within management, operational, technical, and supervisory structures.

ILO-OSH 2001 provides particularly important support for this position by identifying OSH as a **line-management responsibility** (ILO, 2001). ISO 45001 similarly requires OH&S requirements to be integrated into organizational business processes and places leadership and accountability obligations on top management rather than constructing OH&S as an independent responsibility of a safety department (ISO, 2018).

The implication is fundamental: **an organization cannot separate responsibility for performing work from responsibility for performing that work safely**.

12.2 Safety Is a Characteristic of Work, Not a Separate Product of HSE

A major source of confusion is the tendency to conceptualize safety as something produced separately from operational work.

In practice, safe work is produced through the quality of operational decisions and actions.

A safe lifting operation results from appropriate planning, suitable equipment, competent personnel, correct rigging, effective communication, appropriate supervision, and correct execution. A safe maintenance activity results from appropriate isolation, suitable tools, competent personnel, correct procedures, equipment integrity, coordination, and supervision.

HSE may contribute specialist knowledge, challenge, monitoring, assurance, or intervention to these activities. However, HSE does not ordinarily perform the operational actions through which the work itself is executed.

This distinction is consistent with Rae and Provan's (2019) differentiation between “**safety work**” and the “**safety of work**.” Activities explicitly performed in the name of safety can support safe work, but they should not be confused with the operational processes through which safety is actually achieved.

12.3 Why “Safety Is Everyone's Responsibility” Is Not Enough

Organizations commonly use the statement:

“Safety is everyone's responsibility.”

At the level of shared commitment, the statement has value. Managers, supervisors, workers, technical personnel, HSE professionals, and others can all contribute to organizational safety.

As an accountability model, however, the statement is incomplete.

Different actors possess different functions, authority, resources, competence, and control. A worker cannot normally allocate organizational resources. An HSE officer may not control production staffing. A supervisor may not control engineering design. An engineer may not directly supervise operational workers.

Responsibility must therefore be more precisely defined.

A stronger formulation is:

Everyone is responsible for the safety implications of the functions, decisions, actions, and conditions within their assigned authority and control.

This allows shared responsibility without making responsibility indistinguishable.

12.4 Operational Responsibility Is Broader Than the Operations Department

An important clarification is that **operational responsibility**, as used in this article, should not be interpreted as referring only to a department formally named “Operations.”

Safe execution may depend on several executing or controlling functions.

Engineering may control design.

Maintenance may control equipment integrity.

Procurement may influence equipment and material suitability.

Projects may control construction arrangements.

Logistics may control transportation activities.

Line managers may control resources and authorization.

Supervisors may control immediate work direction.

Workers may control specific task actions.

The relevant principle is therefore functional:

The organizational function that executes or controls a part of the work carries responsibility for executing or controlling that part safely.

This interpretation prevents the misconception about HSE from merely being replaced by an equally simplistic claim that every safety responsibility belongs to an Operations department.

12.5 HSE Responsibility Remains Substantive

The argument advanced in this article should not be interpreted as minimizing HSE responsibility.

HSE professionals can influence organizational safety substantially. Their specialist competence may affect hazard recognition, risk assessment, regulatory interpretation, training, monitoring, auditing, incident investigation, assurance, and organizational learning. Research has demonstrated the complexity and importance of safety-professional roles within organizations (Hale, 1995; Provan et al., 2018).

HSE should therefore be held accountable for competent performance of its assigned functions.

If HSE provides materially deficient specialist advice, responsibility may arise.

If an assigned inspection is negligently performed, responsibility may arise.

If a serious deficiency should be escalated but is not, responsibility may arise.

If HSE possesses defined intervention authority and fails to exercise it appropriately, responsibility may arise.

Recognizing these responsibilities strengthens the article's argument because it demonstrates that the distinction being proposed is not designed to protect HSE from accountability. It is designed to locate **each responsibility with the function capable and expected to perform it.**

12.6 Advice and Decision-Making Must Be Distinguished

The relationship between HSE advice and operational decision-making deserves particular attention.

Specialist advice can materially influence a decision. Therefore, an HSE professional should be accountable for exercising appropriate professional competence when providing that advice.

However, advice does not automatically constitute decision-making authority.

Where an operational manager possesses authority to accept, reject, modify, or implement a recommendation, the operational decision remains within that manager's responsibility domain.

The distinction can be summarized as:

The adviser is responsible for competent advice; the authorized decision-maker is responsible for the decision within the decision-maker's authority.

Depending on the circumstances, failures in both domains may coexist.

12.7 Monitoring and Supervision Must Be Distinguished

A similar distinction applies between HSE monitoring and operational supervision.

Monitoring provides observation, challenge, and assurance. Supervision directs and controls the work.

Where HSE observes an activity, HSE may carry responsibility for taking whatever monitoring, reporting, escalation, or intervention action is assigned. The supervisor nevertheless remains responsible for directing and supervising the work within the supervisor's authority.

This distinction is particularly important because supervisory leadership has been associated with safety climate and worker safety performance (Kapp, 2012; Wu et al., 2008).

Increasing HSE presence should therefore not become a substitute for competent line supervision.

12.8 Authority Is Central to Meaningful Accountability

The article's argument also highlights a fundamental organizational problem: **accountability without corresponding authority**.

An organization may state that HSE is responsible for ensuring safety while giving HSE little or no authority over staffing, equipment, maintenance, budgets, production schedules, work methods, technical decisions, or direct supervision.

Such an arrangement creates an expectation of an outcome without providing control over many of the mechanisms required to produce it.

Conversely, operational managers may possess extensive authority over these factors while perceiving their safety consequences as belonging to HSE.

Both arrangements are problematic.

ISO 45001's requirement to assign and communicate responsibilities and authorities supports the need for organizational alignment between what a role is expected to achieve and the authority available to perform that role (ISO, 2018).

12.9 The Non-Transfer Principle

The Non-Transfer Principle proposed in this article addresses the point at which the misconception most commonly arises:

The appointment, presence, involvement, advice, monitoring, verification, or specialist authority of the HSE function does not, by itself, transfer responsibility for the safe execution of work from the organizational functions that plan, resource, authorize, direct, supervise, control, and perform that work. HSE remains responsible for the competent performance of the specialist functions and authorities assigned to it.

The principle is deliberately qualified by the phrase “**does not, by itself, transfer.**”

Organizations may genuinely assign HSE specific verification, approval, authorization, or intervention functions. Legislation may also impose particular duties on safety professionals, as illustrated by Malaysia's Occupational Safety and Health (Safety and Health Officer) Regulations 1997 (Malaysia, 1997).

The principle therefore does not prevent genuine assignment of responsibility. It prevents responsibility from being **assumed to have transferred merely because HSE became involved**.

12.10 The FAC Framework

The Function–Authority–Control (FAC) Framework developed in Section 8 provides a supporting method for applying the responsibility distinction advanced in this article. By examining assigned function, corresponding authority, and relevant control, FAC helps analyse responsibility without presuming that it belongs to a particular department. Its value in the present argument is therefore analytical: it supports identification of the organizational mechanisms through which responsibility for safe execution and specialist HSE functions should be examined.

12.11 Concurrent Responsibility Is Not Transfer of Responsibility

A significant implication of the responsibility analysis developed in this article is that responsibility need not be exclusive.

An operational manager may make a deficient resource decision. A supervisor may permit an unsafe deviation. A worker may knowingly disregard a requirement. HSE may fail to exercise an assigned intervention function.

All of these failures may contribute to the same event.

Recognizing HSE responsibility in such circumstances does not mean operational responsibility has transferred to HSE. Likewise, recognizing operational responsibility does not eliminate HSE responsibility.

The responsibilities are **concurrent because different actors failed within different responsibility domains**.

This distinction is important for both organizational learning and fair accountability.

12.12 Implications for Incident Investigation

The argument has direct implications for incident investigation.

Investigations should not begin by asking which department “owned safety.” They should begin by reconstructing the work.

The investigation should determine how the activity was planned, resourced, authorized, directed, supervised, controlled, and performed. It should then identify what specialist HSE functions applied and whether those functions were performed competently.

This approach is consistent with ISO 45001's emphasis on determining causes and taking appropriate corrective action following incidents and nonconformities (ISO, 2018).

It also reduces the risk that organizations respond to operational failures primarily by increasing HSE inspections, HSE staffing, HSE signatures, or safety documentation while leaving the underlying operational weakness unchanged.

12.13 Implications for Organizational Safety Culture

The way responsibility is described influences how safety is perceived throughout the organization.

Where safety is repeatedly associated with HSE, workers and managers may perceive safety requirements as external requirements imposed on operational work.

Where safety is embedded within operational responsibility, safe execution becomes part of professional and operational competence.

The question changes from:

“What does HSE require us to do?”

to:

“What is required to execute this work correctly and safely?”

HSE then contributes specialist expertise to answering and assuring that question rather than becoming the organizational owner of the work's safety.

12.14 Implications for HSE Effectiveness

Clearer responsibility boundaries can also improve the effectiveness of HSE.

When HSE is not expected to compensate continuously for routine failures of operational supervision and control, HSE professionals can devote greater attention to specialist activities that add distinctive organizational value.

These include risk analysis, management-system assurance, regulatory interpretation, trend analysis, incident learning, competence support, auditing, strategic advice, and independent challenge.

This is consistent with research emphasizing the varied and complex professional identity of safety practitioners (Hale, 1995; Provan et al., 2018).

The objective is therefore not **less HSE**, but **better use of HSE expertise alongside stronger operational ownership**.

12.15 Limitations of the Argument

Several limitations should be recognized.

First, organizational structures differ substantially. Some HSE professionals possess extensive operational or approval authority, while others operate primarily in advisory and assurance roles. Responsibility must therefore be determined from the actual organizational arrangement rather than from the HSE title alone.

Second, legal duties vary between jurisdictions. Statutory obligations may apply independently of internal organizational arrangements, and the Non-Transfer Principle and FAC Framework should not be interpreted as legal tests. Safe Work Australia, for example, emphasizes that work health and safety duties cannot simply be transferred or contracted out (Safe Work Australia, n.d.).

Third, the FAC Framework and Non-Transfer Principle are conceptual contributions developed in this article. They have not yet been empirically validated across industries or jurisdictions.

Fourth, actual incidents are often influenced by complex interactions among organizational systems, human factors, technical conditions, and external pressures. FAC should therefore support rather than replace comprehensive causal investigation.

12.16 Future Research

Future research could examine how organizations actually allocate perceived responsibility between operational functions and HSE.

Potential areas include:

- whether managers and supervisors perceive HSE as responsible for operational safety;
- whether HSE job descriptions assign responsibility without corresponding authority;
- how HSE signatures are interpreted after incidents;
- whether stronger line-management ownership reduces dependence on HSE;
- how different industries distribute HSE approval and intervention authority;
- whether FAC improves consistency in organizational responsibility analysis; and
- how the Non-Transfer Principle operates across different regulatory environments.

Empirical testing would help determine whether clearer distinction between operational execution and specialist HSE responsibility improves accountability, safety culture, and incident learning.

12.17 Discussion Summary

The analysis supports a clear organizational distinction.

Safety should not be conceptualized as a separate product delivered by the HSE function. It is a characteristic of how work is planned and executed.

HSE has important and substantive responsibilities, but those responsibilities ordinarily concern specialist safety functions rather than control of the complete operational process.

The central relationship can therefore be stated as:

Those who execute and control work are responsible for executing and controlling it safely. HSE is responsible for competently performing the specialist HSE functions and authorities assigned to it.

This distinction preserves HSE accountability while directly challenging the misconception that the existence of an HSE function transfers responsibility for safe operational execution away from the functions that actually control and perform the work.

13. Recommendations for Organizations

13.1 Establish Safe Execution as an Operational Responsibility

Organizations should formally establish that responsibility for an operational function includes responsibility for executing that function safely.

This principle should be reflected in policies, procedures, job descriptions, responsibility matrices, training, leadership communication, performance management, and incident-investigation processes.

The organizational message should be clear:

Safety is not a separate operational activity delegated to HSE. Safe execution is part of executing the work correctly.

This approach is consistent with ILO-OSH 2001, which identifies OSH as a line-management responsibility, and with ISO 45001, which requires OH&S requirements to be integrated into organizational business processes (ILO, 2001; ISO, 2018).

13.2 Make Safety Explicit in Line-Management Responsibilities

Organizations should avoid assuming that managers and supervisors understand automatically that operational responsibility includes safety responsibility.

Management responsibilities should explicitly include the safety implications of:

- work planning;
- resource allocation;
- staffing;
- competence;
- equipment selection;
- maintenance;
- scheduling;
- operational priorities;
- work authorization;
- contractor management;
- management of change; and
- supervision.

This does not create a separate safety role for line management. It clarifies that these existing operational functions must be performed safely.

13.3 Define HSE Responsibilities by Specific Functions

HSE job descriptions should avoid broad and potentially misleading statements such as:

“Responsible for ensuring workplace safety.”

unless the organization has genuinely provided the role with authority and control corresponding to such a broad responsibility.

HSE responsibilities should instead describe the specific functions assigned, which may include:

- advising;
- assisting;
- facilitating;
- training;
- inspecting;
- monitoring;
- auditing;
- investigating;
- analysing;
- verifying;
- reporting;
- escalating; and
- intervening.

Where HSE possesses approval or stop-work authority, the scope of that authority should also be clearly defined.

This makes HSE accountability specific and meaningful rather than broad but practically unenforceable.

13.4 Align Responsibility, Authority, and Resources

Organizations should review whether responsibility assignments are supported by corresponding authority and resources.

A role should not be expected to produce an outcome while another function retains exclusive control over the decisions and resources necessary to produce it.

For operational functions, this means ensuring that managers and supervisors possess sufficient authority to control the work for which they are responsible.

For HSE, it means ensuring that specialist responsibilities—such as monitoring, escalation, verification, or intervention—are supported by clearly defined authority and organizational access.

ISO 45001's requirement to assign and communicate responsibilities and authorities supports this alignment (ISO, 2018).

13.5 Keep Risk Ownership With Those Who Control the Work

Risk assessment should involve the people who understand and control the activity.

HSE may provide specialist knowledge, methodology, facilitation, and challenge, but operational personnel should remain actively involved in identifying hazards, selecting controls, and implementing those controls.

Risk assessment should therefore not become:

“HSE assessing the risk of someone else's work.”

It should become:

“Those responsible for the work assessing and controlling its risks with appropriate HSE specialist support.”

This helps integrate risk management into operational decision-making rather than separating it into an HSE process.

13.6 Strengthen Supervisory Ownership

Organizations should reinforce that routine control of work belongs to the supervisory structure.

Supervisors should be expected to:

- understand the applicable controls;
- communicate requirements;
- verify readiness for work;
- observe execution;
- correct deviations;
- respond to changing conditions; and
- suspend work when necessary within their authority.

HSE monitoring should test and strengthen this supervisory system rather than replace it.

Research linking supervisory leadership with safety climate and safety performance supports the importance of this responsibility (Kapp, 2012; Wu et al., 2008).

13.7 Use HSE as a Specialist and Assurance Function

Organizations should make deliberate use of HSE expertise where it provides distinctive value.

HSE should have sufficient organizational position and access to:

- provide independent professional advice;
- challenge inadequate risk controls;
- identify systemic weaknesses;
- monitor implementation;
- conduct or support audits;
- analyse trends;
- investigate incidents;
- interpret applicable requirements;
- support competence development;
- report significant deficiencies; and
- escalate unresolved risks.

This allows HSE to strengthen operational control without becoming a substitute for it.

The distinction between professional safety activities and the actual safety of operational work identified by Rae and Provan (2019) is particularly relevant to this organizational arrangement.

13.8 Define HSE Intervention Authority

Where HSE has authority to stop work, reject a condition, withhold a defined approval, or require escalation, organizations should document:

- the circumstances in which the authority applies;
- the limits of the authority;
- the action expected from HSE;
- the escalation pathway;
- who is responsible for correcting the underlying condition; and
- who possesses authority to authorize restart.

This protects against two opposite problems: HSE being held accountable for authority it does not possess, and HSE avoiding accountability for authority it has genuinely been assigned.

13.9 Clarify HSE Signatures

Every HSE signature required on an operational document should have a defined meaning.

Organizations should specify whether the signature represents:

- participation;
- acknowledgement;
- review;
- verification;
- recommendation;
- approval; or
- authorization.

Responsibility should correspond to that defined meaning.

An HSE signature should not become a retrospective mechanism for transferring responsibility for the entire activity to HSE.

13.10 Build Effective Escalation Systems

HSE professionals frequently identify conditions that require action by managers possessing greater operational or resource authority.

Organizations should therefore establish escalation systems that allow unresolved concerns to move to the appropriate decision-making level.

The system should answer:

Who must act?

Within what authority?

What happens if action is not taken?

When must the matter be escalated?

When should work be suspended?

Who can authorize restart?

Where HSE lacks direct corrective authority, effective escalation becomes an important component of HSE responsibility.

13.11 Measure Operational Safety Performance at the Operational Level

Safety performance should not be treated primarily as an HSE departmental performance indicator.

Managers and supervisors should be evaluated on safety-related outcomes and processes within their control.

Relevant measures may include:

- implementation of operational controls;
- quality of supervision;
- closure of deficiencies;
- maintenance of equipment integrity;
- competence management;
- contractor control;
- effectiveness of management of change;
- timely implementation of corrective actions; and
- response to identified risks.

HSE should similarly be evaluated on the quality and effectiveness of its own specialist functions.

This aligns accountability with organizational control.

13.12 Reframe Incident-Investigation Questions

Incident investigations should avoid beginning with:

“Why did HSE fail to prevent this?”

unless the evidence establishes that prevention of the specific condition fell within an assigned HSE function and authority.

The investigation should instead reconstruct how the work was managed:

Who planned it?

Who provided the resources?

Who made the relevant technical decisions?

Who authorized it?

Who supervised it?

Who performed it?

Who controlled the failed barrier or condition?

What was HSE specifically required to do?

Did each function perform its responsibility appropriately?

This approach is consistent with ISO 45001's requirement to investigate incidents, determine causes, and identify appropriate corrective actions (ISO, 2018).

13.13 Direct Corrective Actions to the Function That Controls the Cause

Organizations should resist responding automatically to incidents by adding more HSE inspections, signatures, personnel, training, or documentation.

Corrective action should target the function associated with the identified cause.

An engineering deficiency requires engineering correction.

A maintenance deficiency requires maintenance correction.

A supervision deficiency requires supervisory improvement.

A resource deficiency requires management action.

A competence-deployment problem requires action from the functions controlling competence and assignment.

A deficient HSE audit, inspection, advice, escalation, verification, or intervention requires correction within HSE.

This approach addresses the actual source of failure rather than merely increasing visible “safety work” (Rae & Provan, 2019).

13.14 Apply the Non-Transfer Principle

Organizations should formally recognize and apply the Non-Transfer Principle developed in Section 5. Incorporating the principle into responsibility policies can help clarify responsibility during planning, execution, assurance, and incident investigation.

13.15 Use FAC to Test Responsibility Assignments

Organizations can use the Function–Authority–Control (FAC) Framework when designing roles or investigating failures.

For each significant responsibility, ask:

Function: What is this person or department expected to do?

Authority: What is the person or department empowered to decide or require?

Control: What relevant resources, decisions, conditions, actions, or processes can the person or department actually control or materially influence?

Where direct control is absent:

What reporting, escalation, challenge, refusal, or intervention mechanism is available?

If responsibility is assigned without corresponding authority, control, or an effective escalation mechanism, the organizational arrangement should be reconsidered.

13.16 Reinforce the Principle Through Leadership

Senior leadership has a critical role in preventing responsibility from migrating toward HSE.

When an operational safety problem is raised, leaders should direct accountability first toward the function that controls the relevant work while also examining whether HSE properly performed its specialist role.

Leadership should consistently reinforce the message:

“You are responsible for executing the work under your control safely. HSE will support, advise, monitor, challenge, and intervene according to its assigned role, but HSE does not execute your work for you.”

This message aligns responsibility with the organizational authority through which work is performed.

13.17 Preserve HSE Independence and Professional Challenge

Operational ownership should not be used to silence HSE challenge.

HSE professionals require sufficient organizational access, professional independence, and escalation authority to raise concerns even when those concerns conflict with production or operational priorities.

An effective model therefore requires both:

strong operational responsibility for safe execution, and

a competent HSE function capable of independent professional advice, assurance, challenge, and intervention.

Weakening either side would undermine the intended model.

13.18 Recommended Organizational Principle

Organizations can summarize the recommended responsibility model in the following statement:

Every organizational function is responsible for safely executing and controlling the work within its assigned function and authority. The HSE function supports this responsibility through competent specialist advice, assistance, training, monitoring, assurance, auditing, investigation, reporting, escalation, verification, and intervention as assigned. HSE involvement does not, by itself, transfer responsibility for safe execution from the functions that control and perform the work.

13.19 Section Conclusion

The practical objective is not to move responsibility away from HSE and place it indiscriminately on Operations. It is to place each responsibility with the organizational actor that possesses the corresponding function, authority, and control.

For the execution of work, this means embedding safety directly into operational, technical, supervisory, and worker responsibilities.

For HSE, it means clearly defining and enforcing accountability for specialist HSE functions.

The resulting organizational model is straightforward:

Those who execute the work must execute it safely. Those who control the work must control it safely. HSE must competently perform the specialist functions assigned to HSE.

14. Conclusion

The central purpose of this article has been to challenge the misconception that responsibility for safety rests primarily with the HSE function simply because HSE is the organization's specialist safety function.

The analysis supports a different conclusion:

Safe execution of work is an operational responsibility because safety is an inherent requirement of executing the work itself.

Work is made safe or unsafe through the decisions and actions by which it is planned, resourced, authorized, directed, supervised, controlled, and performed. The organizational functions exercising these responsibilities therefore cannot separate the safety consequences of their decisions from responsibility for the work itself.

This conclusion is consistent with ILO-OSH 2001, which explicitly identifies OSH as a **line-management responsibility**, and with ISO 45001, which requires OH&S requirements to be integrated into organizational business processes and places leadership, accountability, responsibilities, and authorities throughout the organizational structure (ILO, 2001; ISO, 2018).

14.1 Safe Execution Cannot Be Delegated as a Separate Activity

Safety should not be conceptualized as an additional operational activity that can be separated from the work and delegated to HSE.

Planning work includes planning it safely.

Providing resources includes providing resources adequate for safe execution.

Authorizing work includes considering whether the conditions necessary for safe execution exist.

Directing work includes directing it safely.

Supervising work includes supervising it safely.

Controlling work includes controlling the aspects of the work within the function's authority safely.

Performing work includes performing the aspects within the worker's competence and control safely.

Engineering, maintenance, procurement, projects, logistics, and other functions similarly carry responsibility for the safety implications of the work and decisions within their respective functions and authority.

Accordingly, responsibility for safe execution remains embedded within the organizational processes through which work is executed.

14.2 HSE Has Genuine but Different Responsibilities

This article has not argued that HSE has no responsibility.

HSE professionals perform important specialist functions and should be accountable for performing those functions competently. Depending on organizational and legal arrangements, these may include advice, assistance, facilitation, training, monitoring, inspection, auditing, investigation, analysis, reporting, escalation, verification, approval, and intervention.

Research on safety professionals demonstrates the complexity and significance of these specialist roles (Hale, 1995; Provan et al., 2018). The distinction between professional “safety work” and the actual “safety of work” further illustrates why specialist safety activities should not automatically be equated with operational control of work (Rae & Provan, 2019).

Where HSE provides advice, HSE is responsible for competent advice.

Where HSE conducts an inspection, HSE is responsible for competent inspection and appropriate handling of findings.

Where HSE is required to escalate a significant concern, HSE is responsible for escalation.

Where HSE possesses defined verification, approval, or stop-work authority, HSE is responsible for exercising that authority appropriately.

These are substantive responsibilities. They do not, however, automatically make HSE responsible for executing the underlying operational work.

14.3 The Non-Transfer Principle

The Non-Transfer Principle developed in Section 5 reinforces this distinction by rejecting assumed transfer of responsibility merely because HSE is appointed, present, involved, or exercises a specialist function. It does not prevent genuine assignment of defined responsibilities to HSE, including verification, approval, authorization, or intervention functions, nor does it displace duties imposed by applicable legislation. Its purpose is to preserve the distinction between HSE responsibility for its assigned functions and responsibility for the safe execution of work controlled and performed by other organizational actors.

14.4 Function, Authority, and Control

The article has also proposed the Function–Authority–Control (FAC) Framework as a supporting method for examining organizational responsibility according to assigned function, corresponding authority, and relevant control. FAC does not predetermine responsibility according to departmental labels; rather, it supports analysis of the responsibility domains of the organizational actors involved. As emphasized throughout this article, the framework supports rather than replaces the central proposition concerning responsibility for safe work execution.

14.5 Responsibility Can Be Concurrent

Responsibility does not always need to be transferred from one actor to another.

An operational manager may make a deficient resource decision. A supervisor may fail to control an unsafe deviation. A worker may fail to follow an established requirement. HSE may fail to provide competent advice or exercise assigned intervention authority.

These failures may coexist.

HSE responsibility for a specialist failure does not eliminate operational responsibility for the work. Operational responsibility similarly does not excuse HSE from performing its assigned functions.

This concept of **concurrent but function-specific responsibility** provides a more realistic basis for organizational accountability than attempting to identify a single department responsible for “safety.”

14.6 Implications for Organizations

Organizations should clearly distinguish responsibility for safe work execution from responsibility for specialist HSE functions and ensure that both are supported by appropriate authority and organizational arrangements. This requires responsibility to remain connected to the functions through which work is planned, resourced, authorized, directed, supervised, controlled, and performed, while HSE responsibilities are defined according to the specialist functions and authority actually assigned to HSE. Such clarity can strengthen operational ownership while preserving genuine HSE accountability.

14.7 Implications for Incident Investigation

The responsibility distinction developed in this article also has implications for incident investigation. Investigations should reconstruct the functions, decisions, controls, and failures through which the work was executed and separately examine whether HSE competently performed any specialist functions assigned to it. This helps direct accountability and corrective action toward the organizational functions associated with the actual causes rather than assuming that a safety event is necessarily an HSE failure.

14.8 Final Proposition

The misconception challenged in this article ultimately arises from confusing **specialist responsibility for HSE functions** with **responsibility for safely executing operational work**.

The distinction can be summarized as follows:

Safety is not something that HSE adds to operational work after the work has been planned. Safety is a requirement of how the work itself must be planned and executed.

Therefore:

Those who plan the work must plan it safely.

Those who resource the work must provide resources adequate for safe execution.

Those who authorize the work must exercise that authority safely.

Those who direct, supervise, and control the work must direct, supervise, and control it safely.

Those who perform the work must perform the aspects within their control safely.

Those who provide specialist HSE support must perform their assigned HSE functions competently.

The existence of the HSE function strengthens the organization's capacity to manage occupational risks. It does not ordinarily replace the responsibility of the organizational functions through which work is executed.

The final organizational principle is therefore:

Safe execution of work is an operational responsibility. HSE is a specialist function that advises, supports, monitors, assures, challenges, verifies, investigates, escalates, and intervenes according to its assigned role and authority. HSE involvement does not, by itself, transfer responsibility for safe execution from those who control and perform the work.

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