From Compliance to Proactive Safety and What Canadian Senior Leaders Must Understand

Compliance is only the starting point

Many Canadian organizations say safety is a priority, but their leadership practices tell a more complicated story. Safety receives attention after an injury, after a regulator appears, after a serious near miss, or when the dashboard turns red. The system may be legally compliant on paper, but the culture remains reactive. The organization waits for evidence of harm before it changes how work is planned, supervised, resourced, and measured.

That approach is no longer strong enough. Compliance matters, but compliance alone does not prove that an employer is managing risk well. A workplace can have policies, training records, inspections, a JHSC, and a low injury rate while still carrying serious uncontrolled hazards. The real test is whether the organization can identify where risk is building, act before workers are harmed, and show that controls are working in the field.

This is where senior leadership matters. The safety department can design programs, supervisors can enforce procedures, and workers can report hazards, but senior leaders create the conditions that determine whether prevention has authority. They decide whether production pressure overrides controls, whether supervisors have enough time to supervise, whether corrective actions receive resources, whether worker concerns are treated as intelligence, and whether safety performance is judged by injury counts or by the strength of the control system.

For Canadian employers, moving from compliance to proactive safety is not a branding exercise. It is a governance issue, a due diligence issue, and a culture issue. Senior leaders do not need to become technical OHS specialists, but they must understand what their decisions signal to the organization and what evidence would exist if a serious incident were investigated tomorrow.

Senior leaders have a real OHS role

Canadian OHS systems are built on shared responsibility, but shared responsibility does not mean diluted accountability. CCOHS states that directors, senior managers, senior executives, CEOs, COOs, vice presidents, and others in key leadership positions play an important role in developing and maintaining a healthy and safe work culture. These leaders have an overall responsibility to provide a healthy and safe workplace and to ensure that adequate resources are provided to meet the organization’s OHS objectives. [1]

That is a practical point, not just a legal one. Senior leaders may not decide exactly how a lockout procedure is written or how a confined space rescue plan is executed, but they decide whether the people responsible for those controls have the budget, staffing, training, authority, and time to do the work properly. They decide whether safety is considered

when acquiring equipment, setting project schedules, staffing a shift, approving overtime, entering a new market, accepting a customer requirement, or launching a new process.

CCOHS also explains that senior management must be committed to ensuring the OHS policy is carried out with no exceptions and that the policy should have the same importance as other organizational policies. The same guidance says senior management demonstrates commitment by providing resources such as time, money, and personnel, ensuring required training or certification, making health and safety information available, including health and safety performance in appraisals at all levels, and attending health and safety meetings. [2]

Those expectations expose a common weakness. Many organizations tell workers that safety comes first, but their leadership systems reward speed, output, cost control, and customer satisfaction more consistently than hazard control. Workers learn quickly from what gets resourced, what gets measured, what gets tolerated, and what gets questioned in meetings. If senior leaders only ask about injury rates, the organization will manage the scoreboard. If they ask about unresolved risk, control verification, serious near misses, and corrective action quality, the organization begins to manage prevention.

Culture is what leaders resource, measure, and tolerate

Safety culture is often described as “the way we do things around here.” That phrase is useful because it points to behaviour, not slogans. WorkSafeBC explains that workplace culture includes shared practices, attitudes, and perceptions that influence behaviour, and that it is shaped by leadership, management, supervision, mentoring, workplace conditions, and the design and logistics of production. It also connects culture, proactive management, and safety performance. [3]

This means culture is not separate from operations. It is built into the way work is planned and governed. If safety controls are delayed because capital approval is slow, workers learn that risk can wait. If a supervisor who stops unsafe work is treated as a barrier to production, workers learn that stopping work is politically expensive. If near misses disappear into a reporting system with no feedback, workers learn that reporting is symbolic. If high-risk corrective actions age for months while senior leaders receive green dashboard reports, the culture is telling a story that the safety policy does not admit.

The opposite is also true. When leaders fund controls quickly, visit worksites to ask intelligent safety questions, attend JHSC discussions, remove barriers to corrective action, and expect supervisors to verify critical controls, workers see that safety has operational weight. A culture of proactive safety is built when the organization repeatedly proves that prevention can change business decisions.

This is why senior leaders need to be cautious with culture campaigns that rely too heavily on messaging. Posters, values statements, safety moments, and slogans may reinforce expectations, but they cannot substitute for resourcing, supervision, hazard correction, and accountability. Workers judge culture by what happens when safety conflicts with production. That is the moment where leadership credibility is either strengthened or lost.

The internal responsibility system needs leadership, not passivity

Canada’s internal responsibility system is often summarized as everyone being responsible for workplace health and safety. CCOHS describes the internal responsibility system as an employer-worker partnership for ensuring a safe and disease-free workplace, with each person or group sharing

responsibility and working collaboratively to solve issues and make improvements. It also notes that the system is the underlying philosophy of OHS legislation in all Canadian jurisdictions. [4]

Senior leaders sometimes misunderstand this principle. They treat shared responsibility as if safety can be delegated downward to the safety manager, JHSC, supervisors, or workers. That is not what the internal responsibility system means. Workers have the right and responsibility to report hazards, participate, follow safe work practices, and refuse unsafe work where the law allows. Supervisors have duties to inform, instruct, direct, and correct. The JHSC provides a joint forum for participation and improvement. But senior leadership must ensure the system works.

A proactive senior leader should therefore ask whether the internal responsibility system is functioning in practice. Are workers reporting hazards, or are they quiet because nothing changes? Does the JHSC see meaningful trend data, or only sanitized injury summaries? Do supervisors have authority to stop work, or are they quietly expected to keep production moving? Are corrective actions closed because controls were verified, or because someone updated a spreadsheet? Are contractors and temporary workers included in the same prevention system as employees?

The internal responsibility system is strongest when information moves in both directions. Workers and supervisors surface risk from the field. Senior leaders remove barriers, allocate resources, and make prevention part of strategic decision-making. When the system works this way, safety culture becomes more than participation. It becomes shared control over risk.

Due diligence is built before the incident

Due diligence is where leadership culture becomes evidence. CCOHS describes due diligence in OHS as the reasonable precautions taken by employers to prevent harm in the course of work. It explains that an employer must implement a plan to identify possible workplace hazards and take appropriate corrective action to prevent incidents or injuries. CCOHS also makes a critical point that leaders should not overlook: due diligence is demonstrated by actions taken before an event occurs, not after. [5]

This matters because after a serious incident, investigators rarely look only at the moment of injury. They look backward. They ask what the organization knew or should have known. Were there previous near misses? Were inspections identifying the same hazard? Were corrective actions overdue? Were supervisors undertrained or overloaded? Did workers raise concerns? Did the JHSC discuss the issue? Did management defer funding, staffing, repairs, or training?

A senior leader who sees due diligence as a legal defence misses the deeper point. Due diligence is an operating discipline. It is the habit of identifying foreseeable risk, assigning ownership, implementing controls, verifying that controls work, and documenting the response. The documentation matters, but only because it reflects the work that was actually done.

In a proactive organization, due diligence is not stored in binders and retrieved after a regulator arrives. It is visible in decision records, maintenance priorities, project approvals, hiring plans, training systems, supervisor expectations, JHSC minutes, corrective action logs, and leadership dashboards. Senior leaders should be able to answer one direct question at any time: what are our highest

unresolved risks, and what are we doing about them now?

The Criminal Code raises the stakes for people who direct work

Senior leaders also need to understand that OHS accountability in Canada is not limited to provincial or federal OHS statutes. Section 217.1 of the Criminal Code creates a legal duty for everyone who undertakes, or has the authority, to direct how another person does work or performs a task to take reasonable steps to prevent bodily harm arising from that work or task. The current Criminal Code provision remains in force, and federal justice guidance explains that the Westray Law created an OHS duty for organizations and individuals who direct work in Canada. [6] [7]

This does not mean every workplace injury becomes a criminal case. It does mean senior leaders should avoid the dangerous assumption that serious safety failures are only regulatory matters handled by the safety department. When decisions about staffing, resources, scheduling, production, supervision, or known hazards create foreseeable danger, leadership conduct can become part of the investigation.

The practical takeaway is not fear. It is discipline. Leaders should make sure that the organization has clear lines of authority, competent supervisors, effective hazard reporting, meaningful investigations, timely corrective action, worker participation, contractor control, and documentation showing that reasonable steps were taken. The more serious the hazard, the more important it is that leadership can show active oversight and timely response.

A proactive safety culture therefore protects workers first, but it also protects the organization and its leaders. It reduces reliance on after-the-fact explanation by creating real-time evidence that risk was known, discussed, controlled,

and verified.

Proactive safety starts with better leadership questions

Senior leaders do not need to receive every incident detail, but they do need to ask questions that reveal whether the safety system is working. Too many executive safety reviews still begin and end with lagging indicators: how many injuries occurred, how many days were lost, how many claims were filed, and whether the dashboard is green. Those numbers have value, but they are not enough.

A proactive leadership review should focus on the signals that show risk before harm occurs. What serious near misses happened this month? Which hazards are recurring? Which high-risk corrective actions are overdue? What critical controls were verified and where did verification fail? What are workers reporting that we have not resolved? Where are supervisors asking for help? What work changes, staffing pressures, contractor issues, fatigue concerns, or schedule demands are increasing exposure?

These questions change the behaviour of the organization because they change what leaders make visible. If executives ask only about injury counts, managers will try to protect the count. If executives ask about control integrity, managers will have to understand whether the work is actually safe. That is the shift from compliance reporting to proactive governance.

WorkSafeBC’s leadership guidance emphasizes embedding health and safety in every aspect of the workplace, setting clear expectations, encouraging accountability, measuring outcomes of health and safety activities, promoting near-miss investigation, and being transparent about safety issues. [8] Those are leadership behaviours, not safety department tasks.

They require senior leaders to participate in the safety system, challenge comfortable answers, and resource the fixes that field-level data makes visible.

Supervisors turn leadership intent into workplace reality

No senior leader can create proactive safety without capable supervisors. Supervisors are where policies meet actual work. They decide whether procedures are followed, whether workers are coached, whether new hazards are escalated, whether near misses become learning moments, and whether production pressure is allowed to compromise controls.

This is why leadership culture and supervisor accountability must be connected. A company can have excellent values, but if supervisors are overloaded, undertrained, under-resourced, or punished for stopping unsafe work, the culture will drift. Workers experience the organization through the supervisor in front of them. If that supervisor dismisses hazards, rushes pre-job planning, ignores weak controls, or treats reports as complaints, the leadership message collapses at the point of exposure.

Senior leaders should therefore monitor supervisor capacity as a safety control. How many workers, contractors, sites, or shifts can one supervisor realistically oversee? Are supervisors trained in their OHS duties? Do they understand psychological health and safety, violence prevention, fatigue, working alone, harassment, high-risk work, and contractor coordination? Do they have authority to stop work and access resources? Are they measured on control verification and corrective action, not only output?

A proactive safety culture does not leave supervisors to interpret safety priorities on their own. It gives them clear expectations, practical tools, time to observe work,

escalation pathways, and leadership support when safety decisions affect productivity.

Worker voice is a leading indicator

Senior leaders often underestimate the value of worker voice. Workers see weak signals before executives do. They know which procedures don’t fit the work, which tools fail, which shortcuts are becoming normal, which customers create violence risk, which shifts are fatigued, and which supervisors are quietly tolerating unsafe conditions.

A proactive culture turns that knowledge into structured intelligence. Hazard reports, near misses, JHSC themes, inspection comments, refusal trends where applicable, safety observations, maintenance requests, and worker feedback should all help leadership understand where risk is building. The goal is not to flood the boardroom with raw reports. The goal is to ensure that worker concerns reach decision-makers in a form that triggers action.

Senior leaders should be especially careful when reporting volume drops. Fewer reports may look like improvement, but in a high-risk operation it may indicate distrust, fatigue, fear, or lack of feedback. Workers stop reporting when reporting produces blame, delay, or silence. They report more consistently when they see corrective action, receive feedback, and believe leadership is prepared to fix the conditions they identify.

Worker voice is not a cultural nice-to-have. In a prevention system, it is one of the earliest forms of risk detection. Ignoring it leaves the organization dependent on injuries to tell it what workers may have been trying to say for months.

Proactive safety requires control verification

One of the biggest differences between compliance and proactive safety is verification. Compliance often asks whether a program exists, whether training was completed, whether an inspection was performed, or whether a corrective action was closed. Proactive safety asks whether the control is working where the risk exists.

This distinction matters because many serious incidents occur in organizations that had policies and procedures. The failure is often not the absence of a document. It is the gap between the document and the work. A lockout procedure exists, but workers bypass it during jams. A fall protection policy exists, but anchors are unsuitable. A harassment policy exists, but supervisors ignore early complaints. A contractor management program exists, but site coordination breaks down. A training module exists, but no one verifies competence in the field.

Senior leaders should expect evidence of control verification for critical risks. That may include field observations, supervisor checks, JHSC inspections, audits, permit reviews, maintenance records, competency verification, emergency drills, and trend analysis. The most important controls should be tested more deliberately because failure could produce the most serious harm.

This is where safety culture becomes measurable. A proactive organization does not assume that controls work because they were designed. It checks. It corrects. It learns. It closes the loop.

What senior leaders should do differently

Canadian senior leaders can move their organizations toward proactive safety by changing the way safety is governed. The first shift is to make safety part of operational strategy, not a separate compliance report. Capital projects, staffing decisions, procurement, production targets, customer commitments, technology changes, and restructuring should all include OHS risk review where they affect how work is performed.

The second shift is to strengthen the executive dashboard. Senior leaders should still review lagging indicators, but they should also see serious near misses, high-potential hazards, recurring inspection findings, critical control verification, worker reporting trends, supervisor capacity, contractor performance, and overdue high-risk corrective actions. The dashboard should explain what decision is required, not merely display what happened.

The third shift is to resource correction. Nothing damages safety culture faster than repeatedly identifying hazards and failing to fix them. If high-risk corrective actions remain open because of budget, staffing, maintenance, or competing priorities, senior leaders need to know and decide. Silence at that level is not neutrality. It is acceptance of unresolved risk.

The fourth shift is to make accountability specific. Safety accountability should not be limited to general statements about caring for people. Executives, managers, supervisors, and workers need defined responsibilities that can be observed and reviewed. Leaders should know who owns each critical risk, who verifies the controls, who resolves barriers, and who escalates when the system is not working.

The better standard for Canadian senior leaders

The future of OHS leadership in Canada is not compliance versus culture. It is compliance strengthened by culture, governance, and prevention. Compliance gives the floor. Culture determines whether people act before the law forces them to. Governance determines whether safety information reaches the right level. Proactive safety determines whether leaders use that information before harm occurs.

Senior leaders must understand that safety culture is not created by declaring priorities. It is created by the decisions workers see every day. Do leaders fund controls? Do they listen to hazard reports? Do they support supervisors who stop work? Do they investigate near misses? Do they ask what controls failed? Do they review overdue actions? Do they include safety in business decisions? Do they verify that the work matches the procedure?

If the answer is yes, the organization begins to move from compliance to proactive safety. If the answer is no, the organization may still have a safety program, but it does not yet have a leadership system that can reliably prevent harm.

For Canadian senior leaders, that is the message. Safety is not just a policy to approve, a report to review, or a department to fund. It is a leadership responsibility that must be visible in how the organization plans work, manages pressure, listens to workers, supports supervisors, and responds to risk before someone gets hurt.