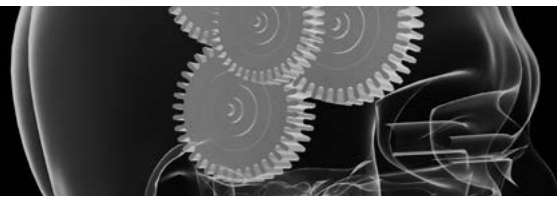


# HUMAN FACTORS

## How to take the next steps



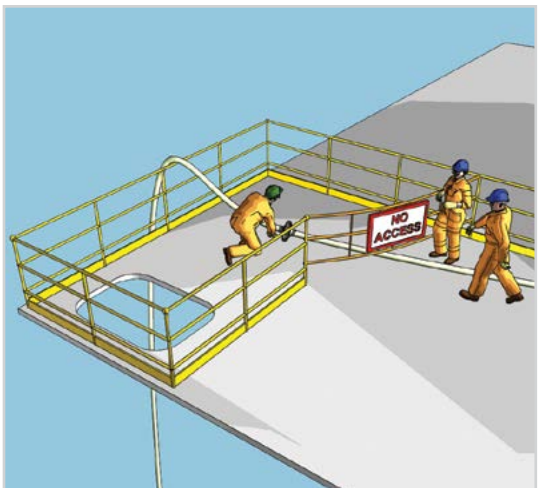
### CASE STUDY 6 - Knowing that a hazard is there DOESN'T always protect you...Fact.




#### What happened?

During installation of a temporary piping system an employee sustained serious injuries when he stepped through an opening in the deck and fell 35 feet to the deck below. The deck opening was fully enclosed by a scaffolding barrier at the time of the accident.

A new drilling service team were working on the platform. It was not clear whether operations or drilling were responsible for monitoring the work. Consequently no-one checked what was happening at the work-site. It later emerged that the team were regularly violating rules and procedures.

A supervisor was preparing light-weight plastic pipe to clean up a spill. He needed help to run the pipe across the barriered area. The employee crossed the scaffolding barrier with the supervisor's knowledge. As the work proceeded the employee gradually moved closer to the opening. Whilst the employee was moving the pipe he took a step backwards and fell through the opening.



What human factors were involved?	Barriers
<p><b>What did people do intentionally?</b></p> <p><b>The supervisor allowed him to cross the barrier</b> Within this team barriers may have been crossed routinely without any comment from supervisors.</p> <p><b>The employee crossed the barrier</b> The supervisor was involved in the job and asked the employee to help. When the boss asks you to do something people may not even think to say "no".</p>	<p> • Human Factors in Design</p>
<p><b>What did people do without meaning to?</b></p> <p><b>The employee stepped back into the opening</b> The employee knew the opening was there but believed he could avoid it. When his attention became focused on the job he stopped thinking about the hazard from the opening. The brain ignores information which is "irrelevant" to the immediate task, so it can concentrate mental resources on the job.</p>	<p> • Contractors • Risk Assessment</p>
	<p> • Leadership • Supervision • Managing Human Failure</p>

#### What can we learn from this incident?

- People falling through openings that they "know" about is a common and often fatal incident.
- Paying very close attention to one thing means we pay less attention to other things - like nearby hazards. Don't rely on people "paying attention" to prevent a serious hazard.
- We are all influenced by the behaviours of our managers, supervisors and team mates. Leaders and supervisors that allow unsafe actions or conditions send a strong message to others that this is acceptable.
- A worksite may have the best safety culture in the world, but you can't rely on that culture "rubbing off" on a new team. Keep an eye on new teams to verify that your high standards are being adopted.