

Time Out For Safety

“Ensuring all our staff go home safe at the end of the day”

TOFS provides an opportunity to discuss safety issues and concerns.

Please use TOFS to raise awareness of activities that could place your staff at risk.

Week 28

Monday 04 July 2016

Devonport Operational Safety Team

In this week's TOFS

- Human Factors - Investigating Behaviour
- June Safety Seminar Update
- Piper Alpha Disaster - Roy Thomson's Story
- The new blue book
- Stanley Knife Amnesty
- Participants Needed !!
- Women's Network Event - Feedback
- Knives and Gloves Roadshows
- Accidents
-And finally

Please don't forget to enter attendance figures and any issues raised into the TOFS database!

The 'Feedback to Team' icon on the TOFS Database Main Menu provides updates to any issues previously entered into the database.

If you have any suggestions or articles for future TOFS, please contact The Safety Culture Improvement Team.

Tel: ext. 4496

Email:

~Marine.Devonport.Safety Culture Team

Visit:

SCIT Office,

N081 (North of the Red Brick Building)

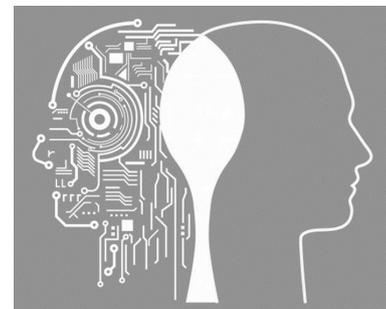


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**HOME SAFE
EVERYDAY**





Human Factors - Investigating Behaviour

Sponsored by: Devonport Operational Safety Team

Human Factors?

"Human factors refer to environmental, organisational and job factors, and human and individual characteristics which influence behaviour at work in a way which can affect health and safety.

A simple way to view human factors is to think about three aspects: the job, the individual and the organization and how they impact people's health and safety-related behaviour."

(Health and Safety Executive, United Kingdom)

Investigating behaviour

Organisations should pay more attention to human factors, especially behaviour. "Over 90% of accidents may be attributed, at least in part, to the actions or errors of people."

When it comes to examples we are spoiled for choice and unfortunately many of them are quite spectacular. They include Three Mile Island (1979), The King's Cross Fire (1987), the Herald of Free Enterprise disaster, the Union Carbide disaster at Bhopal (1984), the space shuttle Challenger explosion (1986), Piper Alpha (1988) and Chernobyl (1986). More recent examples include Buncefield (2005) and the BP Deepwater Horizon Gulf Oil Disaster (2010).

But although most accidents result from human failure, accident investigations do not always probe these behavioural causes in anything like sufficient depth. This is a serious oversight. It

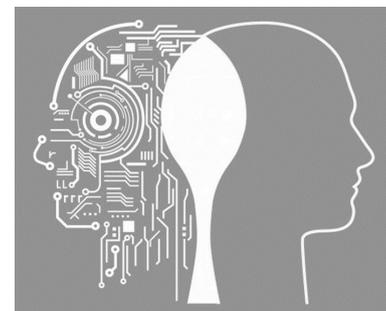


ignores vital information that could help prevent recurrence.

The HSE publication, HSG 245 (Investigating accidents and incidents) make it clear that Investigations that conclude that operator error was the sole cause are rarely acceptable. Underpinning the 'human error' there will be a number of underlying causes that created the environment in which human errors were inevitable. For example inadequate training and supervision, poor equipment design, lack of management commitment, poor attitude to health and safety."

So why are these underlying behavioural causes so often missed?

"Behavioural aspects are often difficult to



Human Factors - Investigating Behaviour

understand and investigate if the investigator simply does not have enough knowledge of human factors," says Malcolm Cope, an ergonomics and human factors senior scientist with the Health and Safety Laboratory (HSL). "They are more likely to be somebody with an appreciation of the job, eg. an engineer working on the process, or a safety adviser employed by the organisation. The temptation can be to look at the accident in black and white terms and to focus on the immediate cause."

Human failures

Human failures are grouped according to the immediacy of their consequences.

Active failures have immediate consequences and usually involve frontline workers. Examples would include an electrician getting a shock after failing to isolate high voltage equipment or an operator in a control room pressing the wrong buttons and causing a chemical escape.

Latent failures. These failures are made by those further back from the frontline. Examples include designers failing to design safe equipment or job procedures, and managers failing to provide adequate training or enforce safety standards.

Errors are unintentional. Examples of errors include misreading a display and as a result making a wrong decision which leads to an accident. Whilst errors are genuine mistakes:

Violations are deliberate and can fall into two categories:

Malicious Violations An example would be a worker deliberately operating a machine without a guard, or a worker deliberately not wearing personal protective equipment in order to save time.

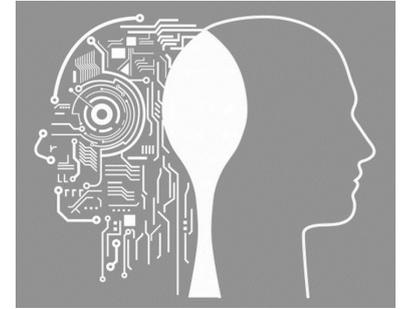
Optimising Violations— These actions are not what we should be doing but sometimes do when we perceive there is a benefit them Corner-cutting; i.e. speeding in your car—following the path of least resistance, – "I know a better way of doing this".

Mike Gray, a principal specialist inspector with the HSE lists other factors to consider when looking for the deeper causes of accidents:

"Although morale and complacency are difficult to measure they can influence behaviour to make accidents more likely. Another important factor is the culture within the organisation, particularly the degree of management involvement and leadership.

In its publication, HSG 48, HSE is in no doubt. "Organisational factors have the greatest influence on individual and group behaviour".

"Organisational factors set the context in which everything else happens," explains Mike Gray. "One of the most important organisational factors



Human Factors - Investigating Behaviour

of course, is leadership. Leadership sets the expectations. It sets the culture and it is hard for an individual to stand against a prevailing culture whether good or bad.

"In many organisations, managers at the top can be saying all the right things, but the message somehow gets lost or changed by the time it has filtered down to the bottom," says Phoebe Smith, HSL's principal human factors specialist. "For example, it can be transformed into subtle hints suggesting a production verses safety situation. This can lead to unspoken pressure to take shortcuts."

Knee-jerk blame after an accident will almost certainly be counter-productive because it will undermine workers' trust and create an atmosphere of suspicion in which they will be reluctant to be open about what happened. And once that trust has gone a vital source of knowledge will be lost to the organisation

Accident investigations should therefore involve workers. Not only will their expertise of the workplace and job help to determine the causes of the accident; they can also provide a comparison between safety culture at the top and the bottom of the organisation.

And, of course, the degree of worker involvement is yet another indicator of an organisation's safety

Discussion points



Optimising Violations are actions that are not what we should be doing but sometimes do when we perceive there is a benefit :

- If you have cut corners to get a job done have you fed back why?
- What would happen if we operated plant and equipment outside its authorised arrangements and conditions?
- What errors have you made in the past and what was the consequence?
- When we do make errors do you think it is important to report them so we can all learn from them?

June Safety Seminar Update

Sponsored by: Devonport Operational Safety Team

At the Safety Seminar held on the 1st July there was a presentation from the Health & Safety Laboratory (HSL). HSL is a division of the Health & Safety Executive and is one of the world's leading providers of health and safety solutions to industry, government and professional bodies.



HSL's extensive facilities situated in the Derbyshire Peak District.

In summary;

- HSL are the Health and Safety Executive's Laboratory.
- They have been developing health and safety solutions for over a 100 years.
- Understanding and reducing health and safety risks by analysing data and testing products/components and machines etc.
- Delivering research, consultancy & specialist training.
- HSL employs over 350 scientific, medical and technical specialists, who help make working environments and working lives safer, in the UK and around the world.
- At this site they can recreate crashes, explosions and fires etc to both resolve

investigations and understand the impact of a system failure.

HSL are a national resource that can be and is tapped into by UK industry and as such the Operational Safety Team have visited their facilities and recently HSL staff visited Devonport and toured the site. We are looking to build on this relationship as we believe their contribution will help us to keep staff safe as they have done with many other companies they have worked alongside.

- Friday's seminar delivered a detailed overview of HSL's operations as well as a talk on some of the investigations they have carried out by one of the team of engineers based in Buxton. They also brought with them some of the failed components that have led to accidents/incidents and explained how they examine these to determine the root cause.
- So whether it's Hillsborough or the more recent Didcot Power Station collapse HSL have been involved.
- If you are interested in HSL's operations then please contact either Rhys Blackaller or John Crowl from the Operational safety Team.





Piper Alpha Disaster - Roy Thomson's Story

Sponsored by: Devonport Operational Safety Team

On July 6th 1988 the Piper Alpha rig, in the North Sea, became a raging fireball after an explosion when a gas leak ignited. Of the 228 people on board, 167 died

Roy Thomson thought he had accidentally killed a fellow oil-rigger on Piper Alpha when he ran through thick black smoke and leapt from the blazing rig.

Unable to see, and his boots melting, Mr Thomson charged into another man at the edge of the rig's platform, shoving him over the side. Together they tumbled and plummeted 120ft into the North Sea.

While he doesn't remember hitting the water, he recalls the fall felt like a long time; he then remembers the struggle and 'panic' to get back to the surface.

Mr Thomson, who was 23 at the time, clung onto the man he thought he'd accidentally pushed off the Piper Alpha oil rig, 120 miles off Aberdeen.

But he was filled with horror when he realised the man he was clinging to was dead.

'I held on to a guy in the water for a while, thinking it was the man I'd pushed off. He was the only person close to me when I came back to the surface. But it turned out I was clutching a dead body,' he said.

On that tragic day, 167 of the 228 people aboard the oil rig perished, either from the inferno that engulfed the entire rig, or from drowning in the perilous North Sea.



Survivors: Roy Thomson, 48, left, and Mike Jennings's right

Survivors' guilt took over Mr Thomson but also the terror that he had killed someone he believed he was responsible for another man's death.

In 2013 he read the book *Fire in the Night*, that Roy finally got a clue about the identity of the stranger he pushed off the edge.

Mr Thomson, said a passage in the book says a man came out of the smoke screaming that he was on fire and pushed off Mike Jennings from the edge.

In 2013 Mr Thomson and Mr Jennings were reunited for the first time since the fateful and tragic night - and found they have lived just 25 miles from each other.

Mr Jennings, told Mr Thomson he had been deliberating jumping when someone shoved him over the edge, taking the decision of his hands.

They now think the shove may have saved his life, since moments later the entire rig was engulfed in flames.

New Version of the Blue Book

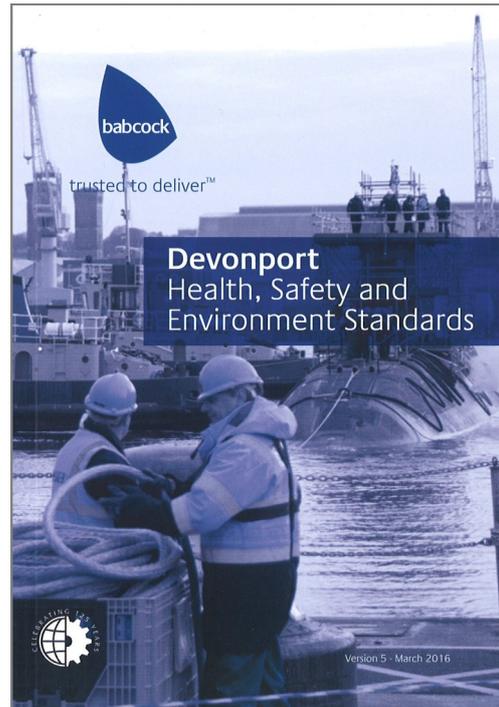
Sponsored by: Michael Lagomarsino - Safety Support Manager

NEW! 2016 Devonport Health, Safety and Environment Standards (Blue Book)

The long and anticipated new version of the Devonport Health, Safety and Environment Standards (Blue Book) 2016 has now been printed and is available to be distributed amongst the workforce.

If you require 30 or less these can be sent by internal post (Please provide Post Code). If you require more than this you can collect them from N152.

Any questions please ask Mike Lagomarsino (Safety Support Manager) x4310 or Charlie Ede (Senior Safety Support Manager) x3722



Stanley Knife Amnesty

Have you Exchanged?

The Martor Secupro 625.



The amnesty will be held between:

- 27/06/16—29/07/16
- You will be able to exchange your Stanley Knife for a Martor Secupro 625 at your local retail store.
- 1 Martor knife per exchange/per person.
- You will not require a chit during the amnesty period.

Anyone seen to be using or have in their possession a retractable bladed Stanley knife that is not a Martor 625 will be asked to stop work and return the knife to the nearest Retail Store.



**HOME SAFE
EVERYDAY**

Participants Needed !!

Hello everyone,
I am David Cross a Human Factors Specialist in Engineering Services located in COB 2. I'm currently studying a Master's degree in Applied Ergonomics. To complete my degree I am seeking volunteers to take part in my experiment for my final year project.

The experiment will run until 31st August. For the experiment you will be asked to assemble something together. The experiment should not last more than 1 hour. Anyone can take part. You do not need to be experienced in assembling things together.

The company directors below have allowed you to take part in company time.
Mike Homer (Director Engineering Services) - Chris Tomkins (Director Devonport Operations)
Mike Whalley (Director Warships) - Gavin Leckie (Director Submarine Support)

You could win 1 of 2 £60 prizes in a prize draw competition after the project has finished.

If you would like to take part you **must be aged 18 or over and be able to read and follow written instructions.** - If you have boots **and** overalls please bring them.

If you would like to take part in the experiment you can either:

Contact me at David.Cross1@babcockinternational.com or ring ext 3626 to arrange a time & date.

or

Sign-up to a recruitment poster which will be located across different areas of the site (see dates on the chart).

| NEMSFAC | SUBSFAC | FRC | COB 2 |
|--|------------------|--|------------------|
| 4 th – 8 th July | 11th – 15th July | 18 th – 22 nd July | 25th – 29th July |

Look for the yellow posters

Women's Network Event - Feedback



The first women's network event took place last week on Friday 24th June in Sails.

The event was well attended with 74 attendees. The event included a skills workshop by Skills4, a presentation from Rachael Sumner from Barclays Bank, a short presentation from the M&T head of Diversity and Inclusion and a networking session.

Thank you to all of those who supported the event. The committee has received lots of great feedback which they are currently working though to organise the next event. Watch this space for the next event.....

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"Ensuring all our staff go home safe at the end of the day"



Knives and Gloves Roadshows

Sponsored by: Devonport Operational Safety Team

During June and July, the Safety Culture Improvement Team are holding six Knives and Gloves Roadshows. The first four have now taken place.

Two more roadshows are planned this week. On Tuesday 5th July in the DDF and on Thursday 7th July outside CWEW south yard.

Please come along to see the new 'Traffi' Gloves which are currently being trialled on site and the latest 'Martor' safety knives. Representatives from both Martor and Traffi Gloves will be present at each roadshow. Also in attendance will be the company's Occupational Hygienists and members of the SCIT.

You will also be able to view the results of the recent knife survey .

Discussion points

- Take a look at the Traffi gloves and give some feedback to the SCIT.
- Take a look at the New Safety Knife and talk to the supplier Martor.

Knives and Gloves Road Show - venues



| | |
|-------------------|-----------------------|
| DDF (WO24) | South Yard |
| Main Lobby | (SO57) |
| | (Outside CWEW) |

| | |
|-----------------------|-----------------------|
| 11:00 to 13:00 | 11:00 to 13:00 |
|-----------------------|-----------------------|





This week's accidents

Total Accidents

65 to date

8 in week

LAST YEAR

63 to date

4 in week

Lost time Accidents

10 to date

1 in week

LAST YEAR

8 to date

1 in week

| Lost Time Accidents | | | | | |
|---------------------|------------------------|---------------------|------------------------|------------------------|--|
| Location | Part of Body | Nature of Injury | Direct Cause of Injury | Type of Person | Brief Description of Accident |
| N102 | Multiple Injuries | Cuts & Bruises | Fall on the Level | Babcock Industrial | When exiting a Radiological area within the PCD Facility the IP tripped over a C3 Boot barrier falling heavily causing bruising to his arms and legs. |
| Other Accidents | | | | | |
| Location | Part of Body | Nature of Injury | Direct Cause of Injury | Type of Person | Brief Description of Accident |
| HMS Argyll | Eyes | Eyes - Foreign Body | Blown / Falling Dust | Babcock Industrial | IP was pulling overhead cable when dust got into his eye. IP was wearing safety glasses. |
| HMS Northumberland | Leg / Ankle | Cuts & Bruises | Fall on the Level | Contractor | IP was climbing out of bilge when he slipped on a girder and caught his thigh on a pipe bracket which ripped through his overalls and scratched his leg. |
| 2 Basin NW | Head / Neck | Other | Misc | Babcock Industrial | P was in Diving Caravan when contents gauge whip burst behind his head causing jerking movement to neck and ringing in both ears. |
| 2 Basin NW | Head / Neck | Other | Misc | Babcock Industrial | IP was supervising a dive when colleagues contents gauge hose burst causing a very loud bang and IP sustaining ringing and discomfort to ear. |
| 2 Basin NW | Head / Neck | Other | Misc | Babcock Industrial | IP was sat by another diver whose HP air hose burst causing pain to both ears. |
| HMS Trenchant | Arm / Wrist / Shoulder | Strain / Sprain | Power Driven Machinery | Babcock Industrial | IP was using a pneumatic gun which "bit in" causing handle to twist and twisting his hand. Initial injury on 15th June with only minor discomfort, but aggravated on 22nd June when flogging up flanges. |
| Subsac Store | Trunk / Back | Strain / Sprain | Lifting Strain | Babcock Non Industrial | IP was removing items from storage and twinged lower back - items inappropriately stored and not easily accessible. |

And finally ...

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Cooking on ~~Gas~~... *No Electric!*

