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# DROPS Forum Perth
# 3rd November 2011
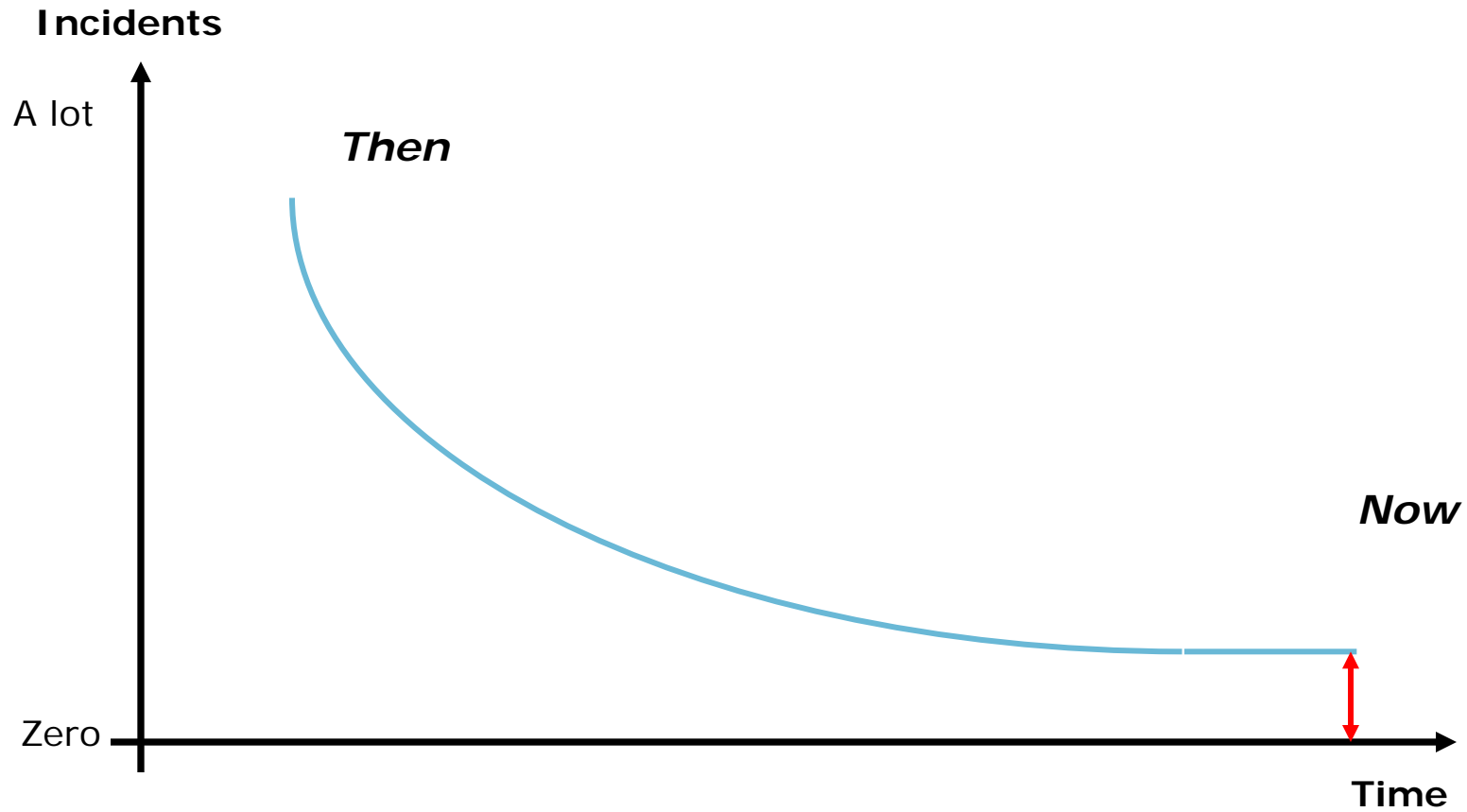
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# Dropped Objects – as seen from an HSE Managers desk
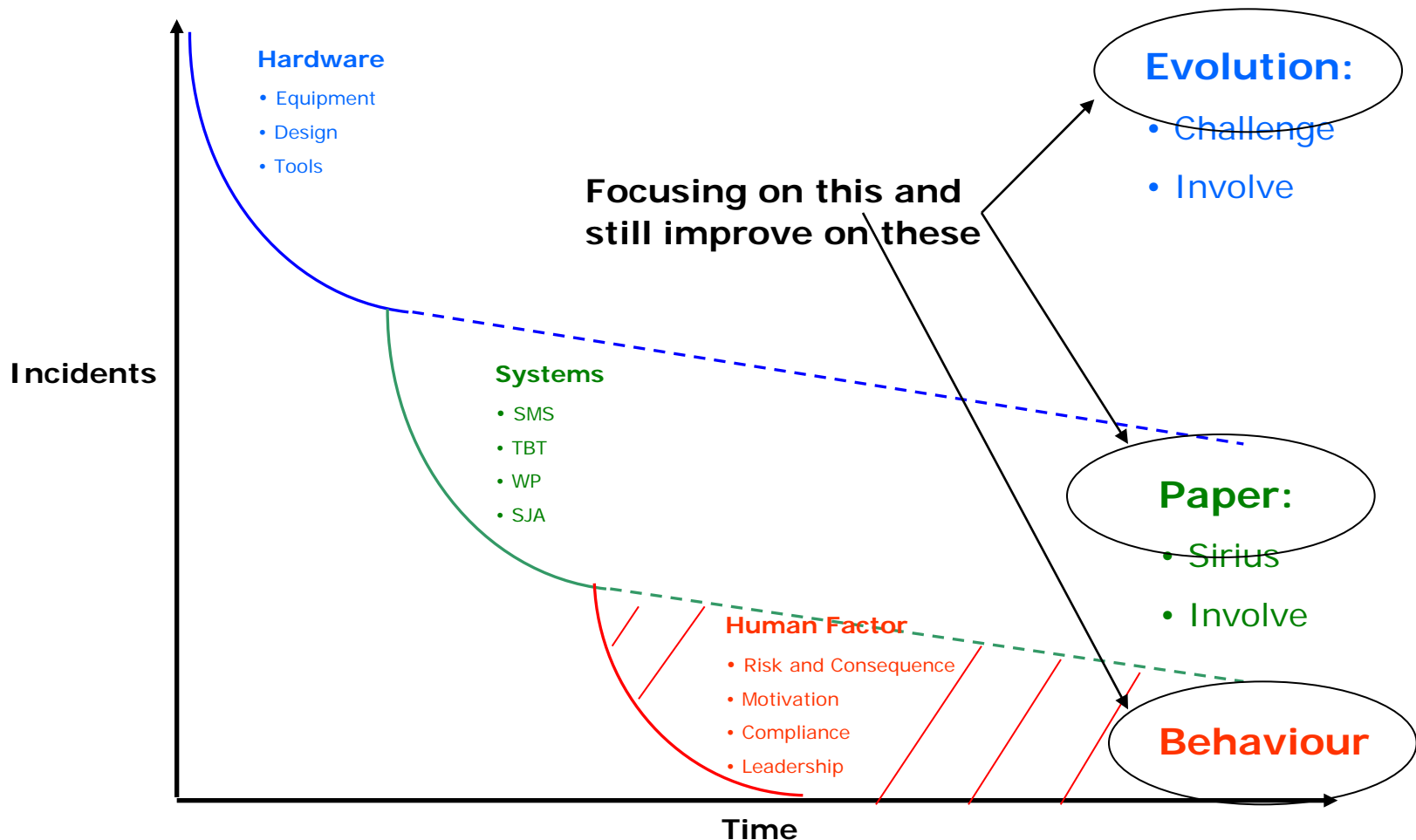
# Spot the challenge!

**Incidents**

A lot

*Then*

*Now*

Zero

**Time**

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# DO Statistic

- 2 out of 10

    Fixed

- 8 out of 10

    Man handled



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# Our approach.
## Can the tools of today solve the challenges of tomorrow?



**Hardware**
- Equipment
- Design
- Tools

**Systems**
- SMS
- TBT
- WP
- SJA

**Human Factor**
- Risk and Consequence
- Motivation
- Compliance
- Leadership

**Focusing on this and still improve on these**

**Evolution:**
- Challenge
- Involve

**Paper:**
- Sirius
- Involve

**Behaviour**

Incidents

Time

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# An example….

Deck crew were preparing stores to backload to a supply vessel. Two subs (weighing ~100 kg each) were placed on a pallet (made of pine wood).

The pallet was rigged using 2 x 3 tonne slings, single wrapped and choked at opposite ends (refer photo). Weight was "taken up" and the Roustabout checked to ensure it would hold.

All clear was given and load lifted at a height of approximately 1.5m for an approximate distance of 10m to the open top container.

As the load was being lowered into the container, the pallet began to fail and gave way approximately 1ft from the bottom of the container, breaking into pieces. As the subs were strapped together they remained joined during the drop. Estimated energy ~ 588J.

All persons involved in the lift were formally qualified in rigging and slinging, as required for conducting lifts onboard.

No adequate explanation could be found as to why a pallet lifting appliance was not used.

# Humans makes mistakes, but we need to be able to understand why, to be able to (re)establish the appropiate barriers.

# Unfortunately we can not suspend the laws of gravity.

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# Behaviour:
# What have we done so far?

- KPI for rig management

- Award system including DO's and 3rd party personnel

- Leadership training at higher level

- Safety Leadership training with a behaviour approach

- Compliance training and verifying what has been done to comply with existing requirements

- Introducing just culture in parts of our organization and making the individual take responsibility

- Process based SMS

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# Behaviour:
# What we would like to do!

- Be able to understand why persons take the wrong decisions, despite training and experience

- Improve the individuals risk and consequence understanding

- Develop a training concept that supports the learning environment

- Develop and understand leading indicators and be able to spot individuals with a potential erratic safety behaviour

- Implement just culture throughout the organization, and have the individual take responsibility for own safety

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# The (DROPS) Challenge?

- Develop and supply Human Factor understanding in how we deal with DO's

- Evaluate usefulness of current "tools" and methods with a view towards the future, such as:

  - Design

  - Learning environment

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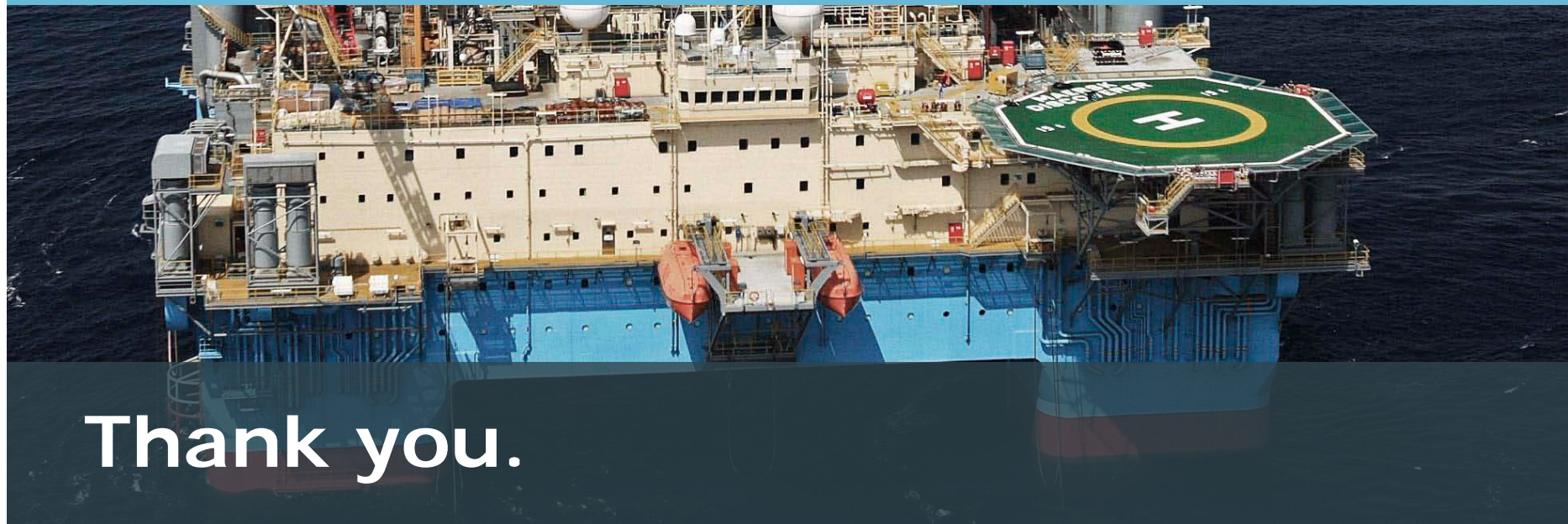
# Thank you.

Safety is a state of mind –
Accidents are an abscence of mind

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