

**safety science**

**some past and recent research areas**

**including construction**

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# content

1. introduction

2. asbestos

3. steel

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5. management

6. construction

7. predictability of accidents

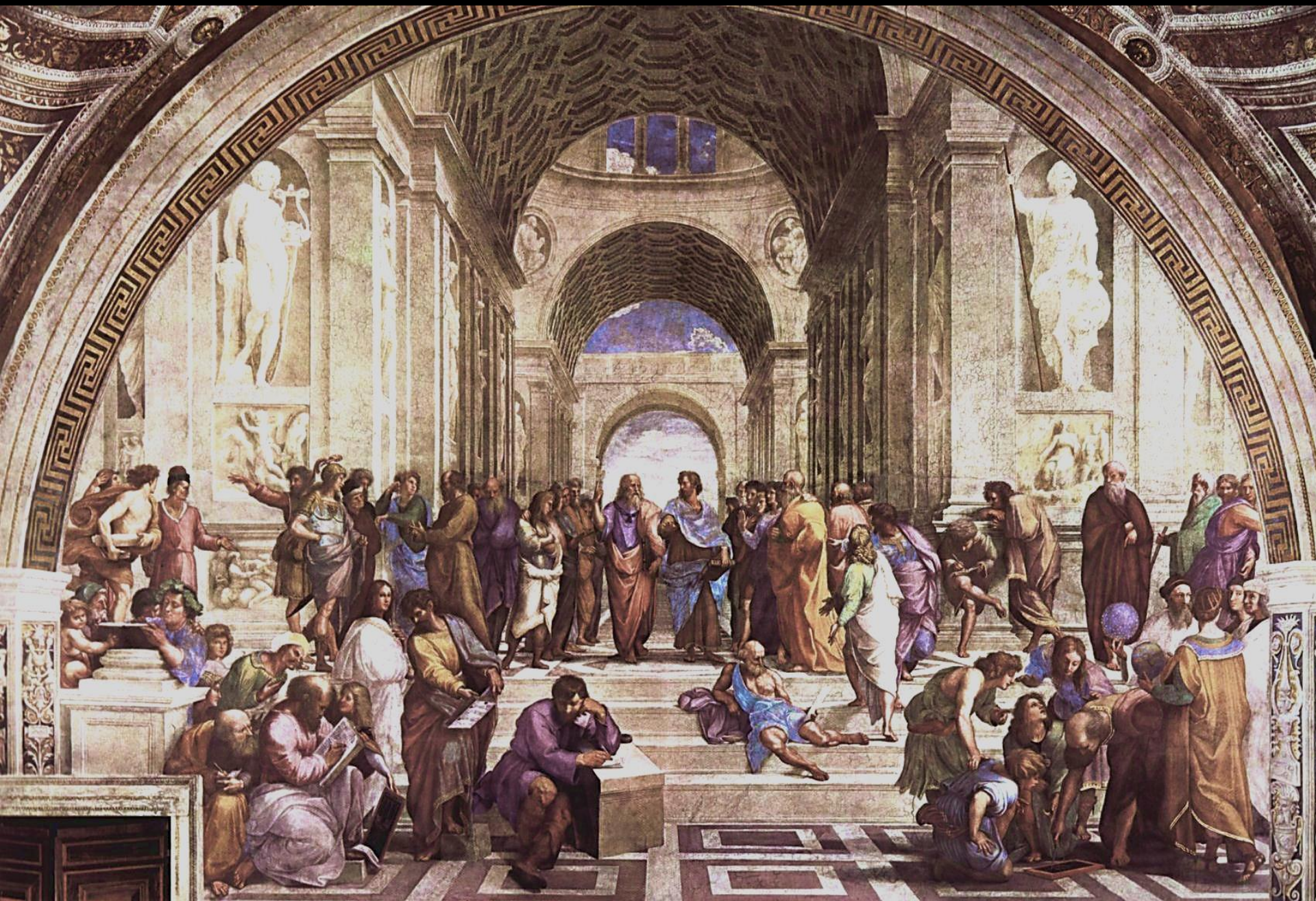
8. education

# red thread of presentation

- from mechanism to risk assessment
- from hazard to culture
- from human factor to socio-technique
- from technology push, cost reduction to disasters
- from risk assessment to design
- from management to accidents
- from rule following to critical reflection

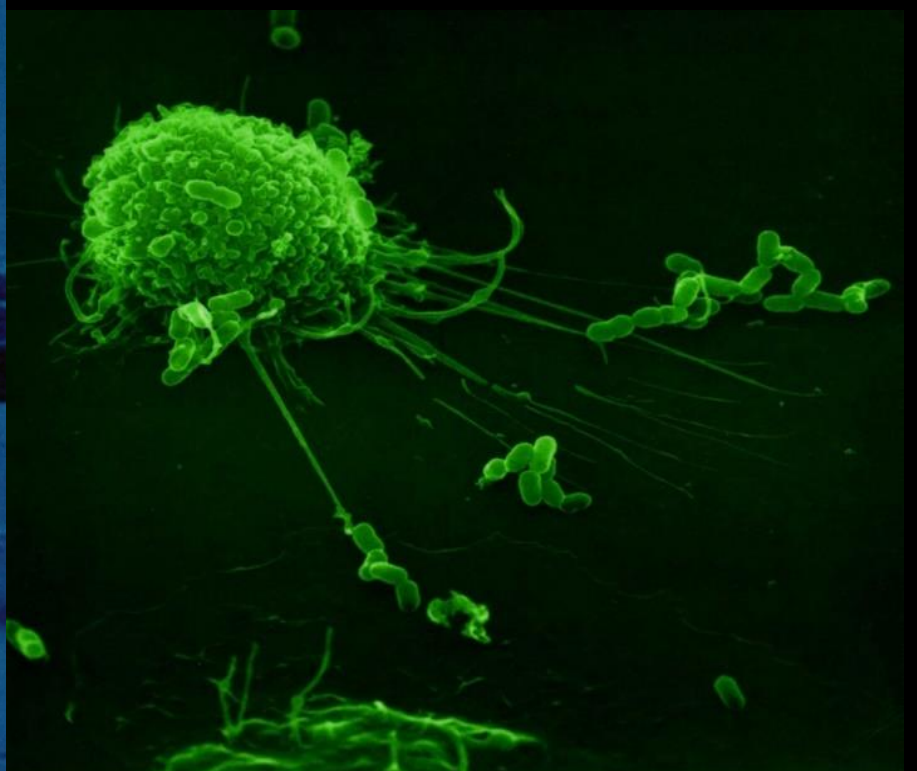
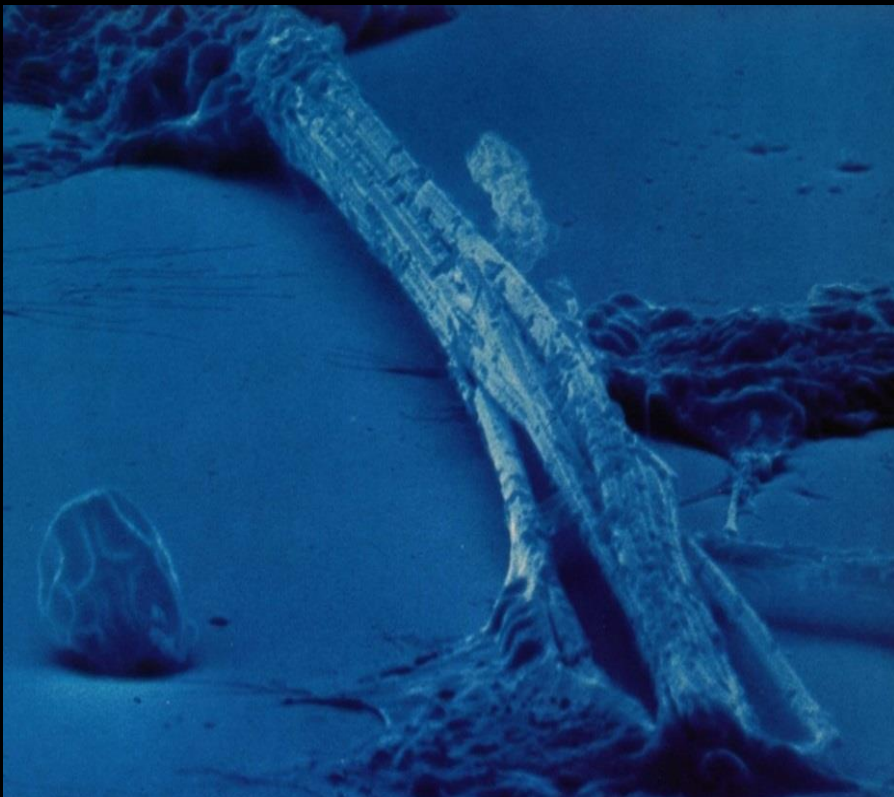
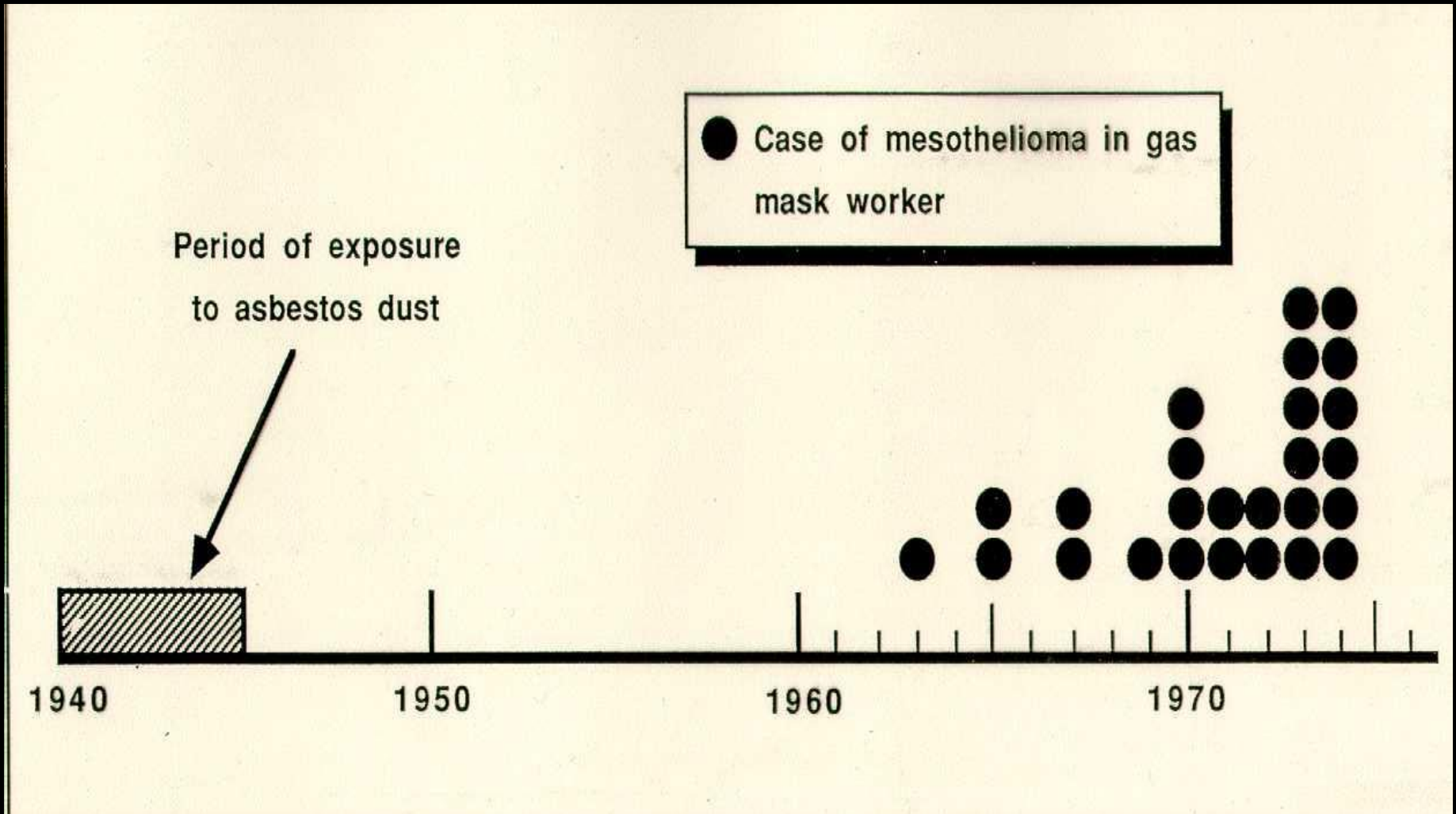
# 1 introduction

## Raphael School of Athens 16<sup>th</sup> century



# 2 asbestos

## latency period & mechanism



## 2 asbestos

### occupation and mesothelioma

<b>Industry</b>	<b>risk/100 workers</b>	<b>risk ratio</b>	<b>n</b>
insulation industry	4.7	328	59
ship building, maintenance	1.2	83	196
refinery	0.3	24	12
train/tram building	0.2	15	10
stone, glass, cement	0.1	9	23
construction	0.07	5	102
chemical industry	0.06	4	13
all other industries	0.01	1	254

# 3 steel works



we are here to produce

this is a very dangerous plant

we work like this for years  
without too much trouble

we do not need procedures,  
because we are experienced

everybody is responsible for  
his own safety

**victims are always to blame**

**accidents will always happen**

# 4 theories - models - metaphors

## Heinrichs' metaphors statistical correlations

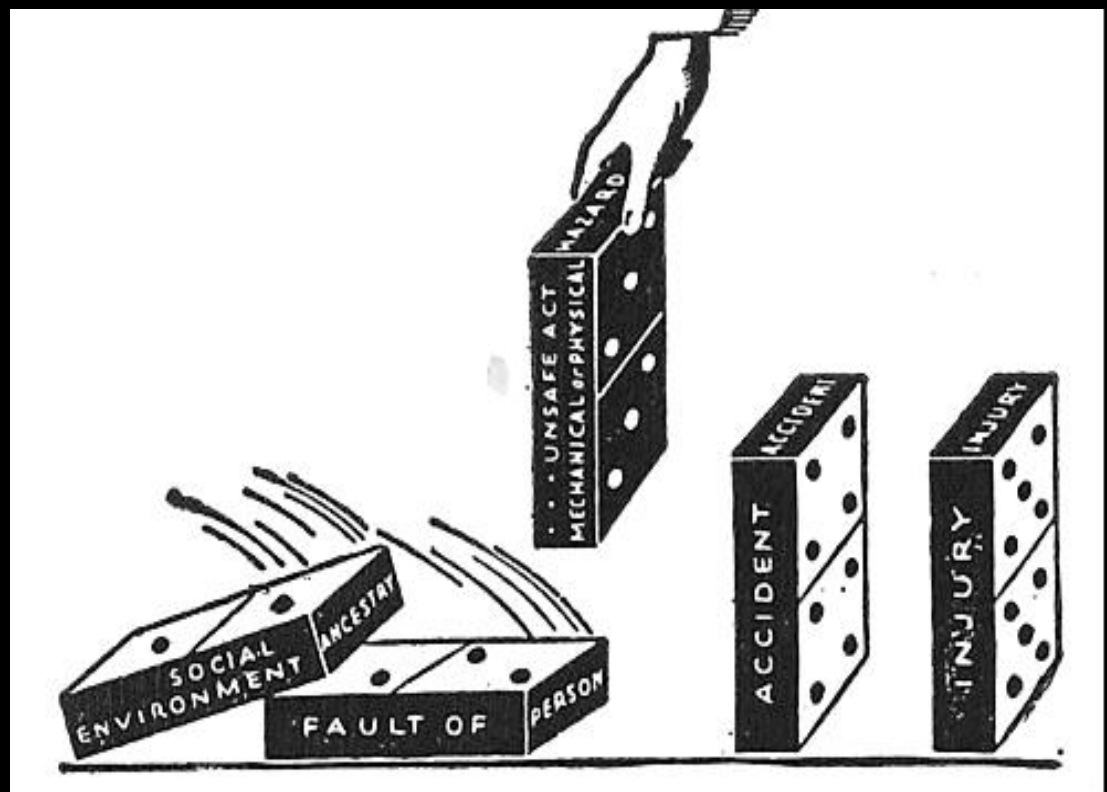
1927 costs: 1 : 4 (direct : indirect)

1928 causes: 88 : 10 : 2 (human : technical : God)

1929 mechanism: 1 : 29 : 300 (serious : minor : no harm)

1931 management: training, selection, safety technique

1941 sequence, dominos:



Heinrich W (1927). The "incidental" cost of accidents. National safety News 17(2):18-20

Heinrich W (1928). The origin of accidents. National safety News 18(1):9-13

Heinrich W (1929). The foundation of major injury. National Safety News 19(1):9-11, 59

Heinrich W (1931). Industrial accident prevention, a scientific approach

Heinrich W (1941). Industrial accident prevention, a scientific approach 2<sup>nd</sup> edition



## 4 modern times 1933



Heijermans (NI) 1905. Job, working hours, crowded workplaces  
Eastman (US) 1910. Dangerous machines, repeated accidents  
Home Office (UK) 1911. High workload, industrial fatigue  
DeBlois (US) 1926. One learns from risks, hazard  $\equiv$  energy  
Vernon (UK) 1936. External causes of accidents

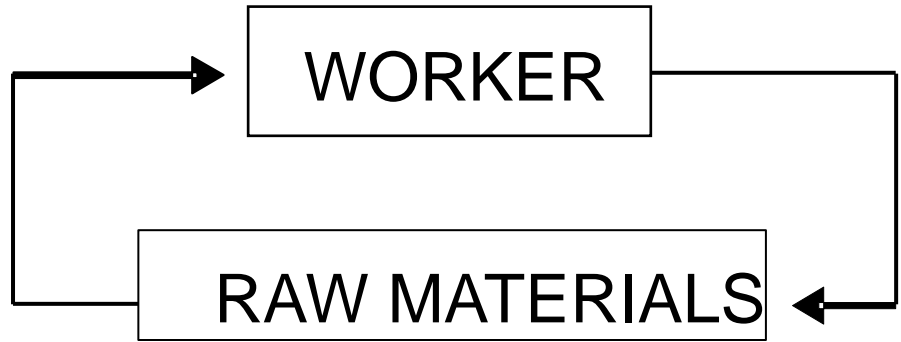
# 4 theories - models - metaphors

## complexity of men-machine systems

direct feedback

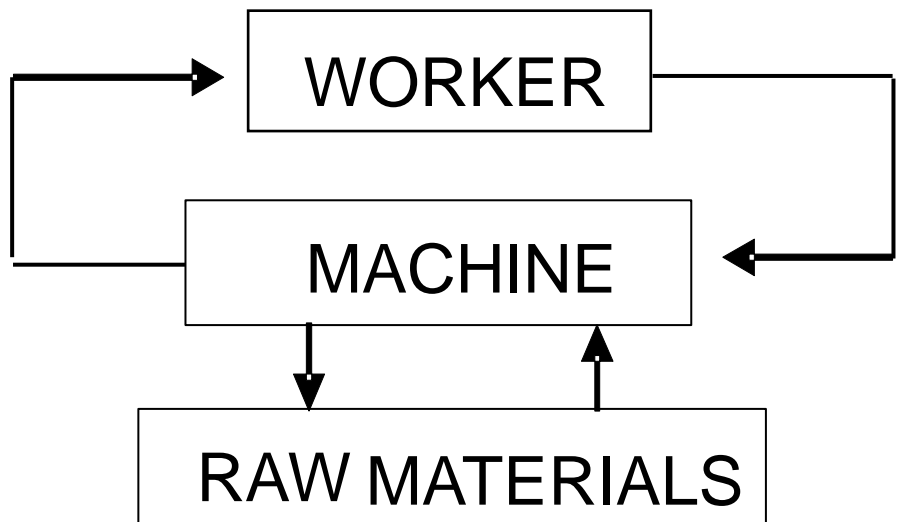
PRODUCTION

1800



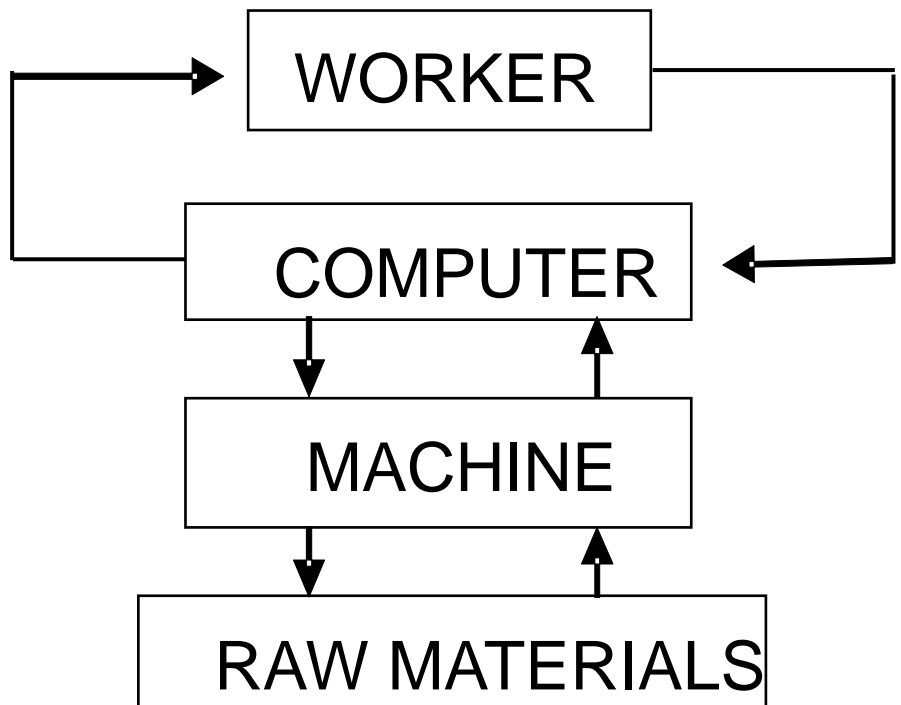
energy source

1900

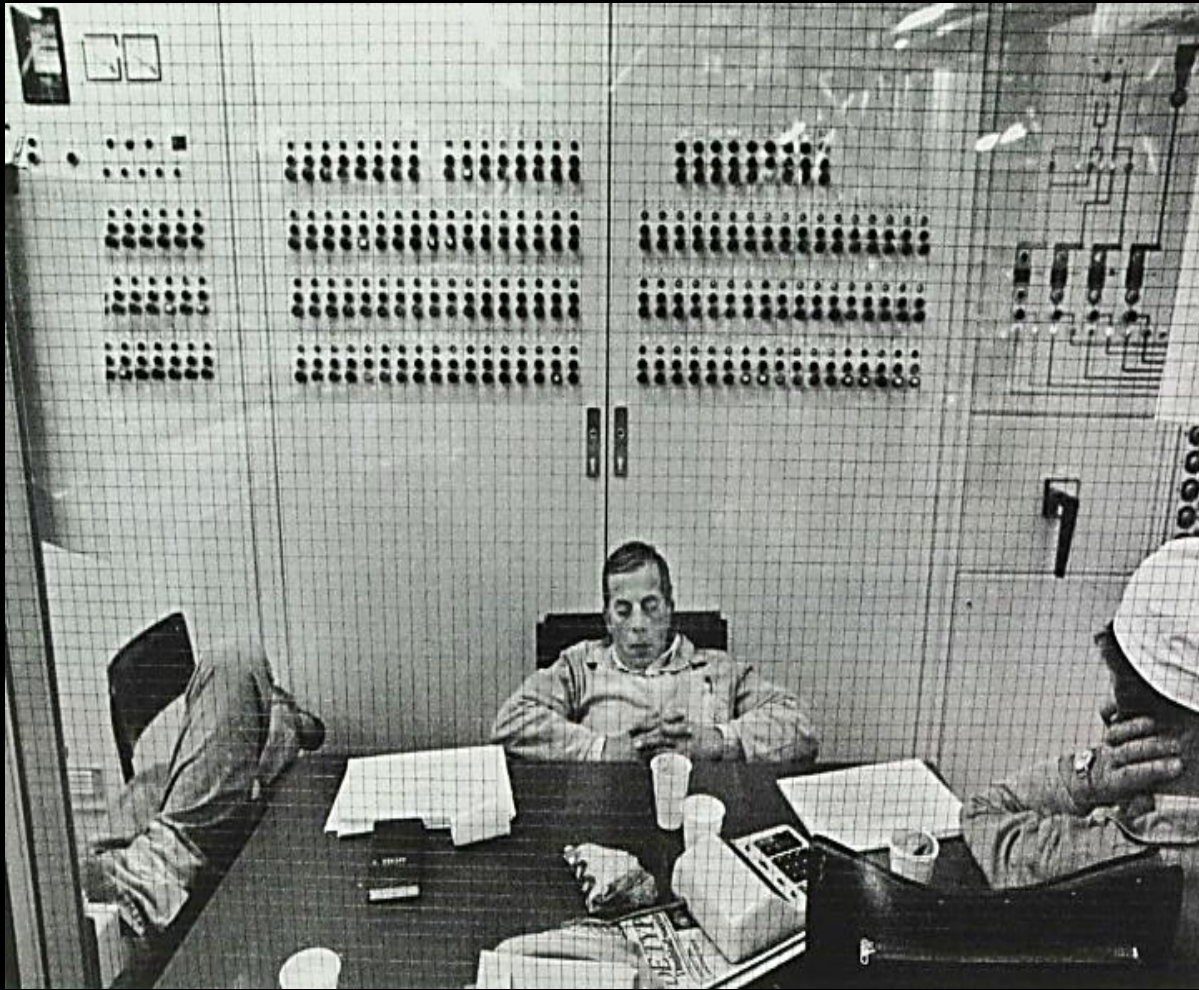


logic aid

1980



# 4 theories - models - metaphors automation



# 4 theories - models - metaphors

## Aberfan Barry Turner 1978



- rigid risk perception and a strong believe in the organisation;
- focus on underground hazards;
- minimalizing unexpected dangers;
- organisational exclusivity; signals not coming from members, are not taken seriously;
- information, communication problems between departments.

# 4 theories - models - metaphors

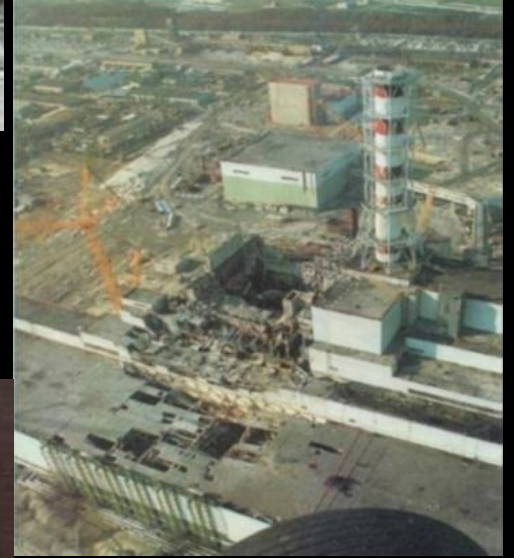
## accident definition

An accident is the result of a complex series of events, related to energy transfer, failing barriers, and control systems, causing faults, errors, unsafe acts, and unsafe conditions and changes in process and organisational conditions.

**Bhopal 1984**



**Tjernobyli 1986**



**Challenger 1986**



**Zeebrugge 1987**



**Piper Alpha 1988**

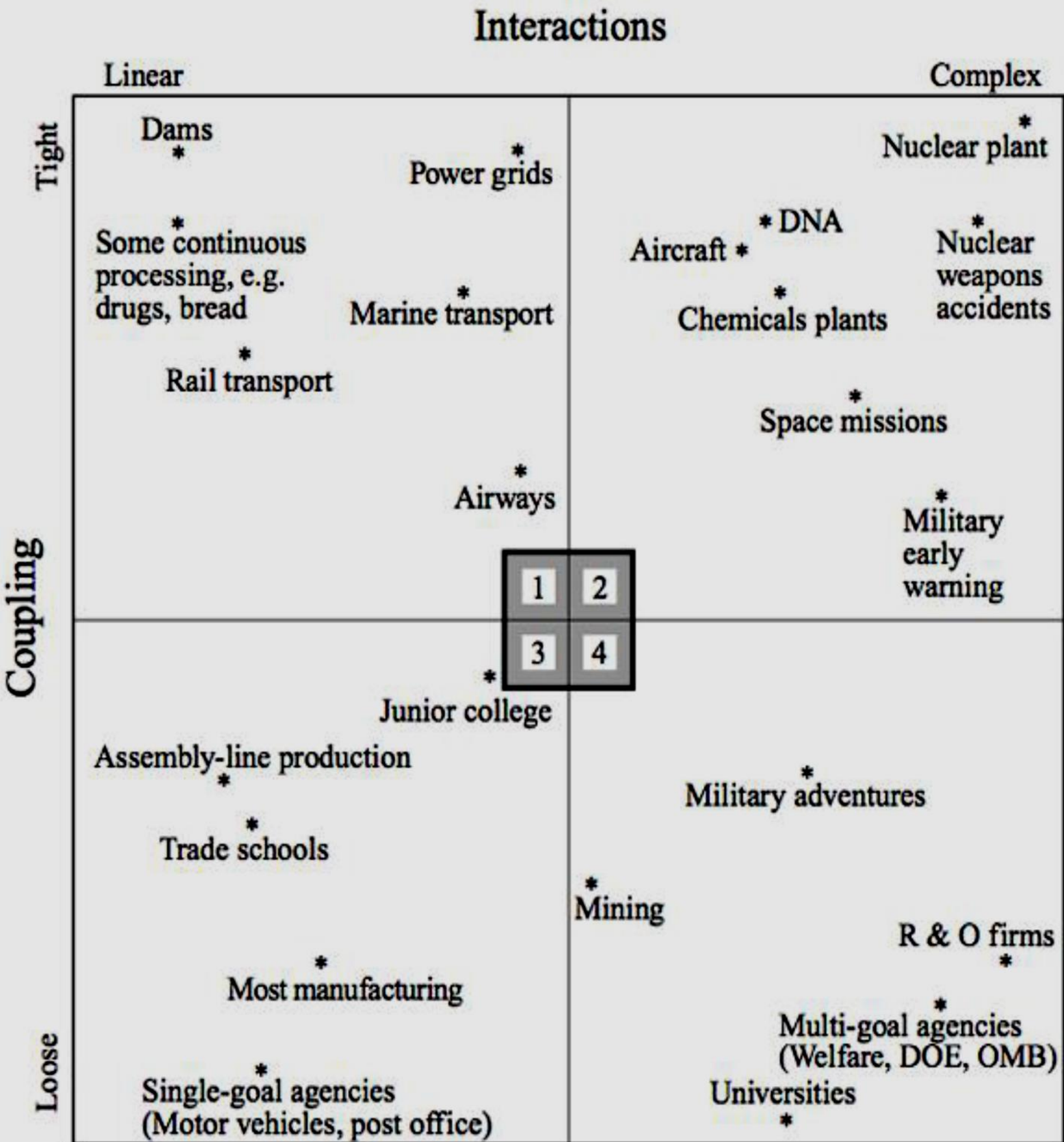


**Exxon Valdez 1989**



# 4 theories - models - metaphors

## normal accidents



so you want to understand an aircraft carrier? Well, just imagine that it's a busy day, and you shrink San Francisco Airport to only one short runway and one ramp and gate. Make planes take off and land at the same time, at half the present time interval, rock the runway from side to side, and require that everyone who leaves in the morning returns that same day. Make sure the equipment is so close to the edge of the envelope that it's fragile. Then turn off the radar to avoid detection, impose strict controls on radios, fuel the aircraft in place with their engines running, put an enemy in the air, and scatter live bombs and rockets around. Now wet the whole thing down with salt water and oil, and man it with 20-year-olds, half of whom have never seen an airplane close-up. Oh, and by the way, try not to kill anyone. Senior officer, Air Division



# **4 theories - models - metaphors**

**people make accidents**

**organisations cause them**

Safety is a dynamic property obtained by the systemic articulation of hazards, environmental, organisational and individual dimensions in high-tech-high-hazard sectors.

This property is obtained through the on-going interaction of in/external actors with technology, mediated by structures and power.

Balancing conflicting goals defined as trade-offs quandaries is at the heart of the vision of safety. The power of safety departments is one of the elements of the quality of these trade-offs.

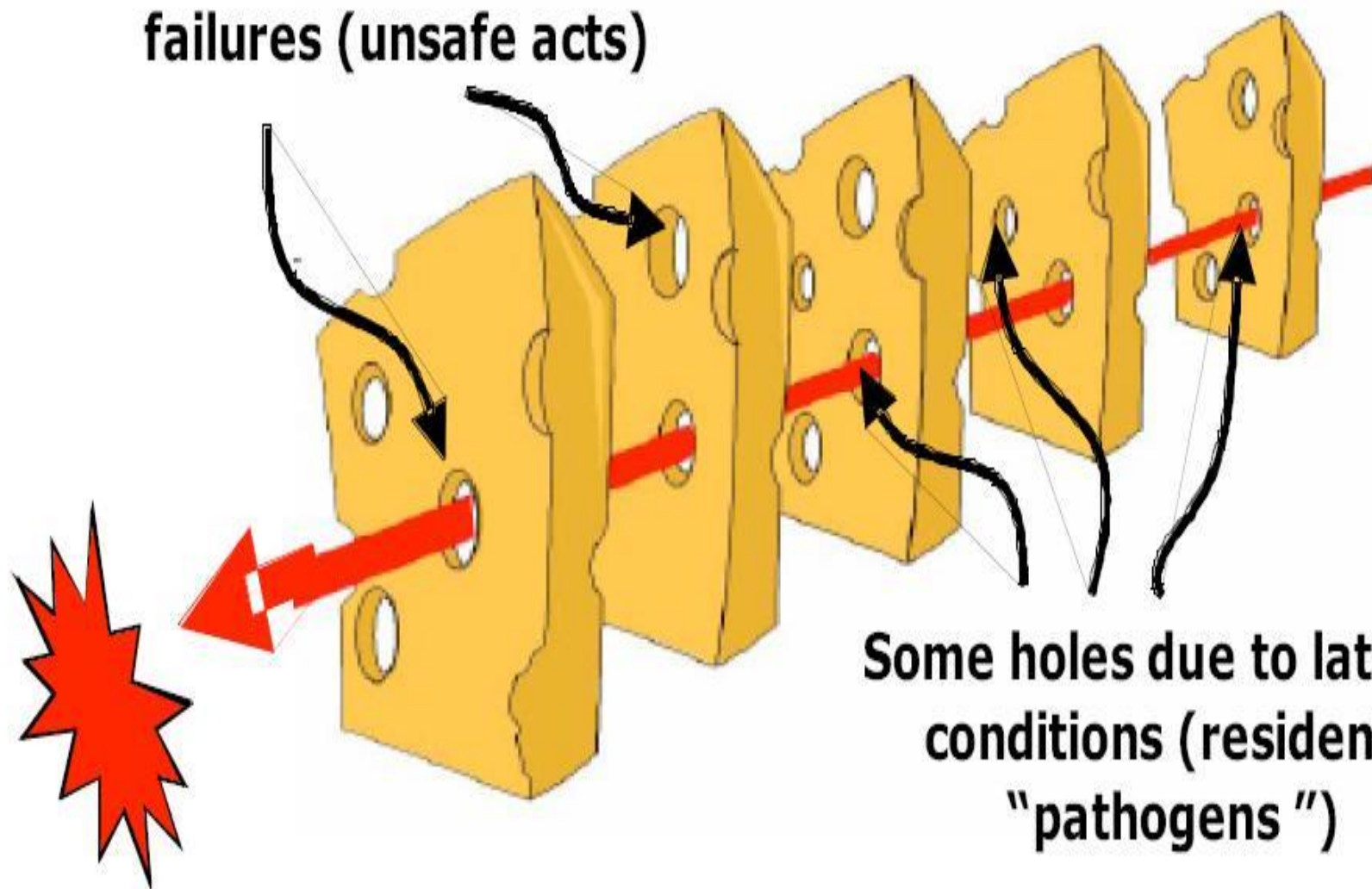
# 4 theories - models - metaphors

## Swiss cheese

Sharp End ←————→ Blunt End

Some holes due to active failures (unsafe acts)

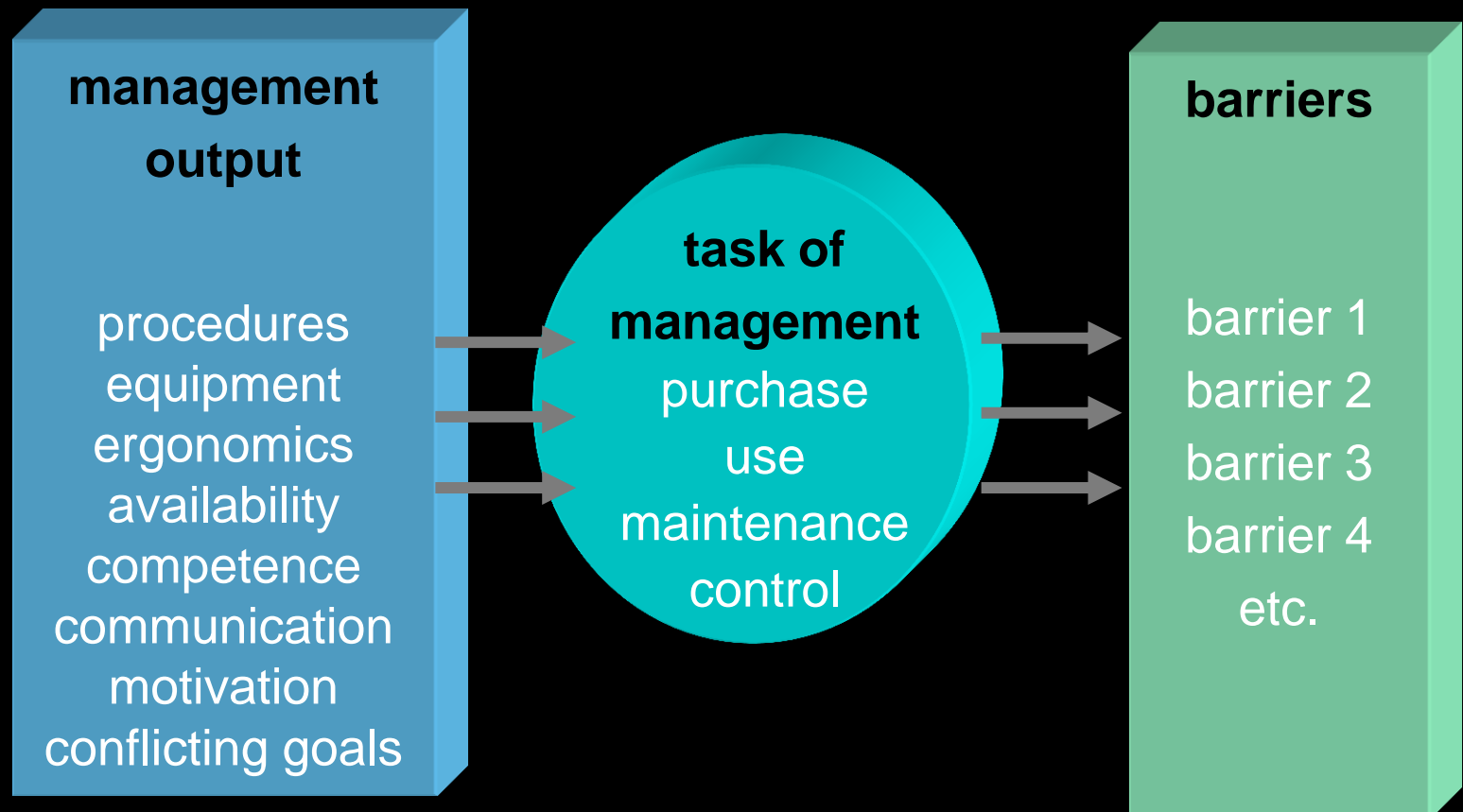
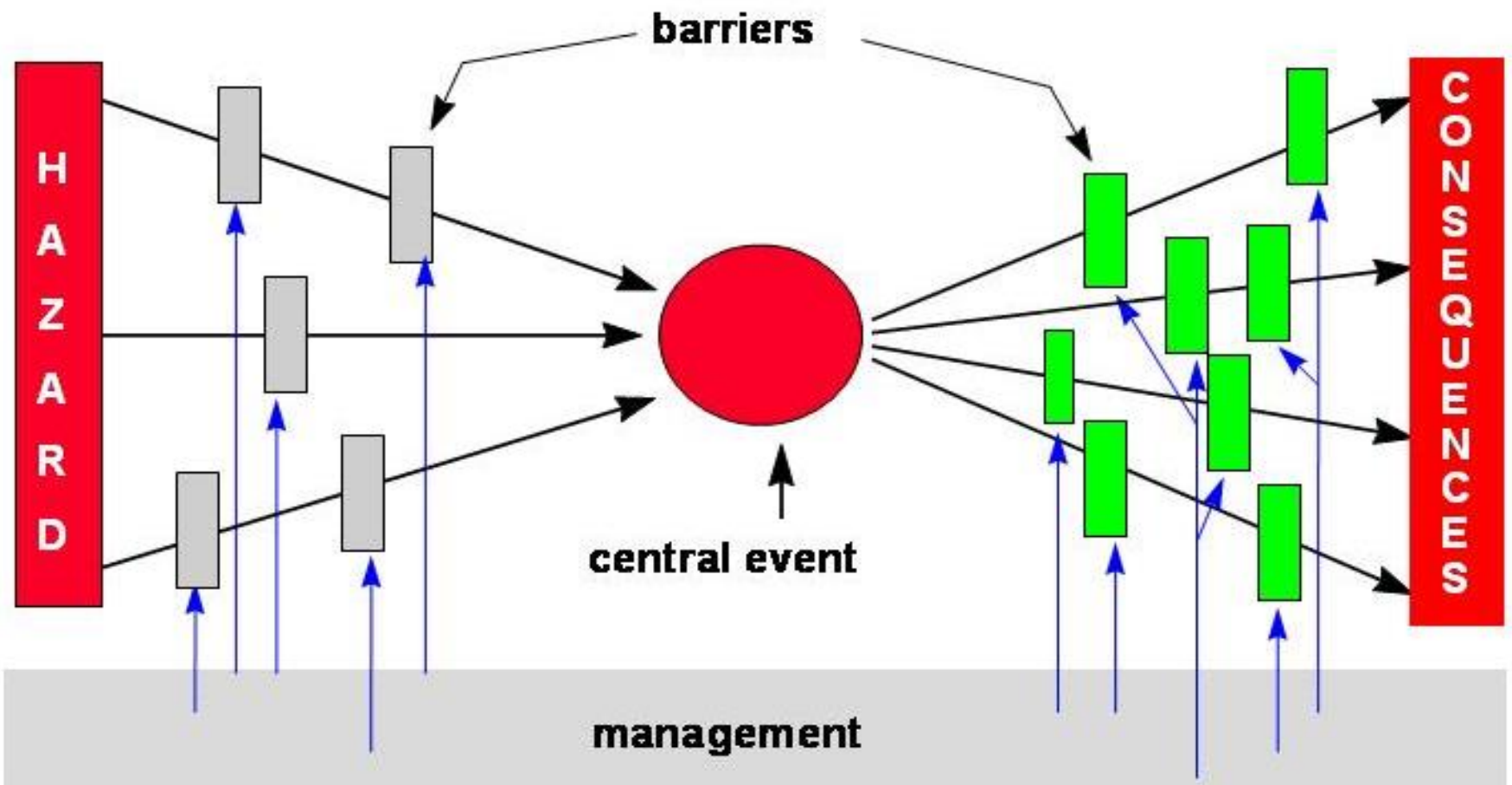
Hazards



Some holes due to latent conditions (resident "pathogens")

# 4 theories - models - metaphors

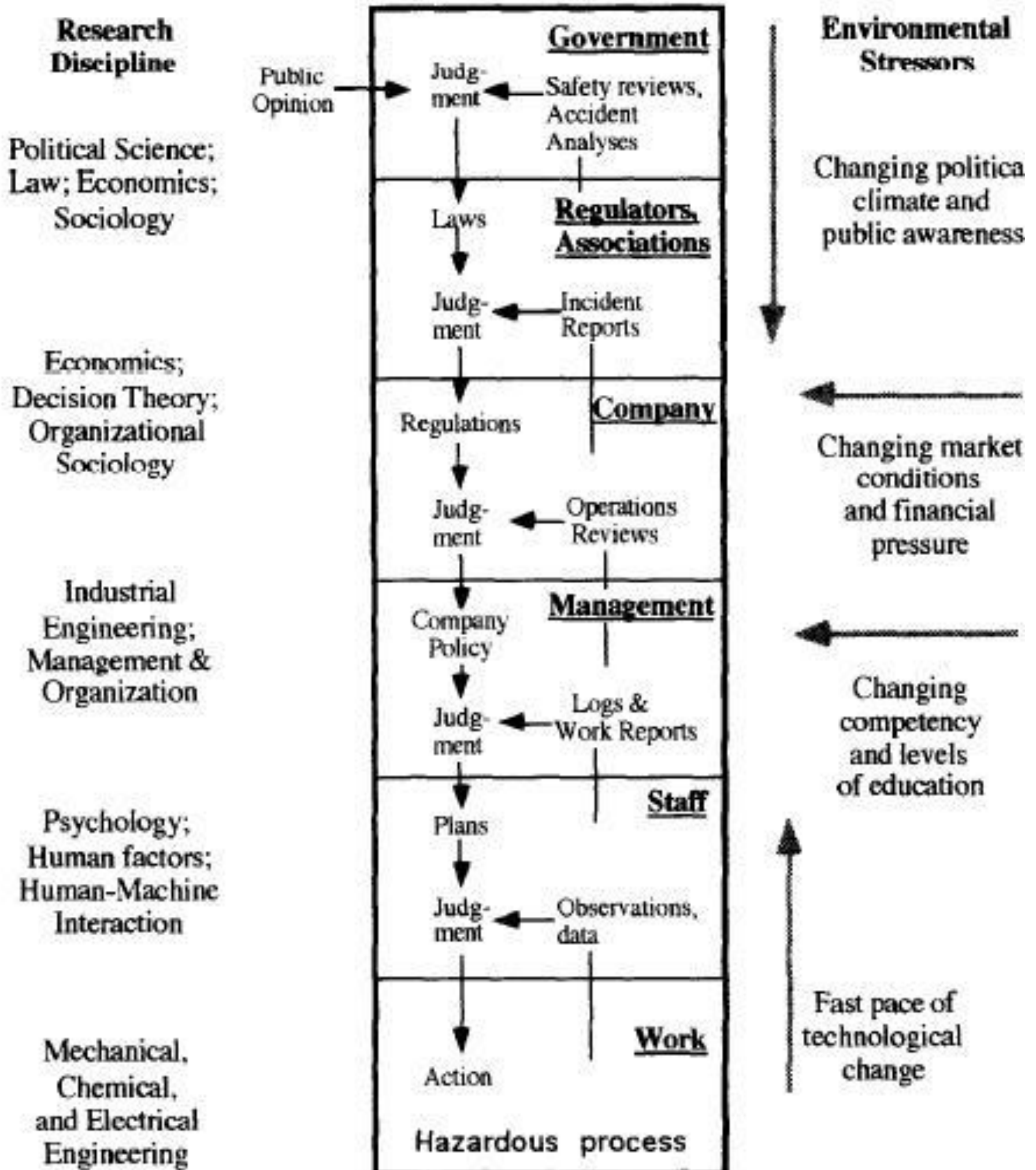
## process & occupational safety - bowtie



Visser K (1998). Developments in HSE Management in Oil & Gas Exploration, Production  
Guldenmund F Hale A Goossens L Betten J Duijn N (2006). Audit technique quality safety barrier  
management. Journal of Hazardous Materials 130(3)

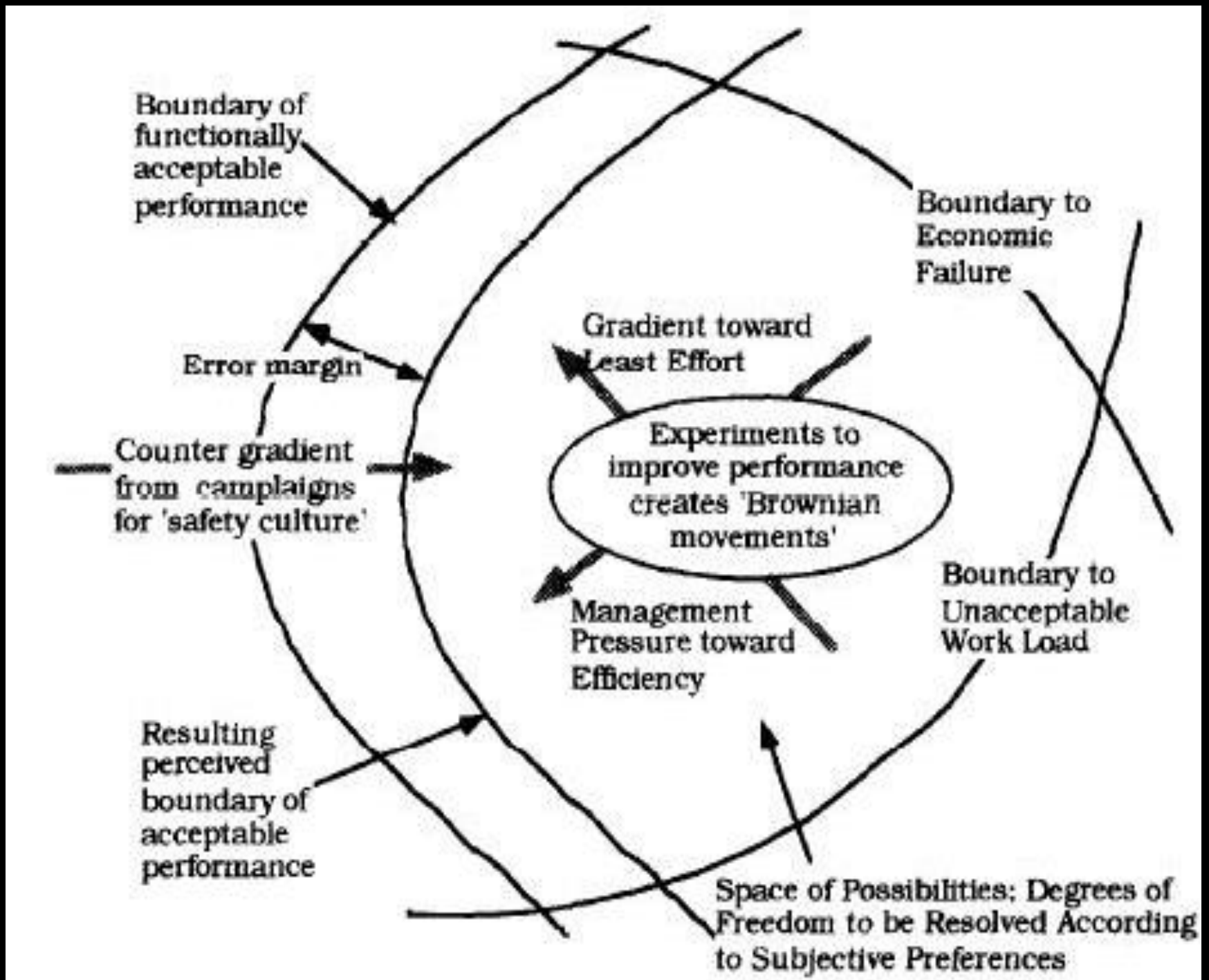
# 4 theories - models - metaphors

## Rasmussen drift to danger



# 4 theories - models - metaphors

## Rasmussen drift to danger



# 5<sup>th</sup> generation technology 2<sup>nd</sup> generation managers



Colombia 2003

Texas City 2005



Buncefield 2005



AF 447 2009



Deepwater Horizon 2010



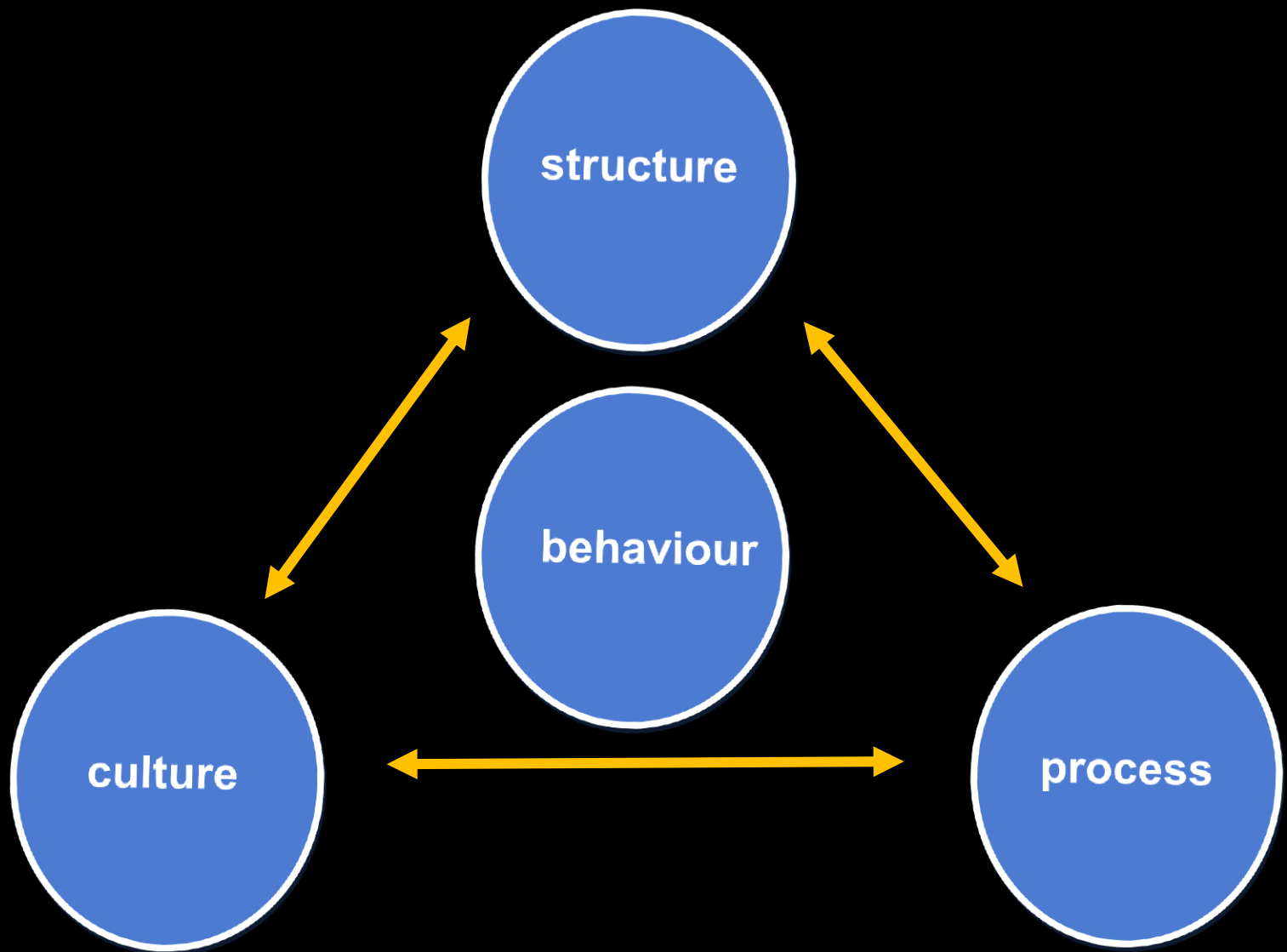
Fukushima 2011



# 5 management

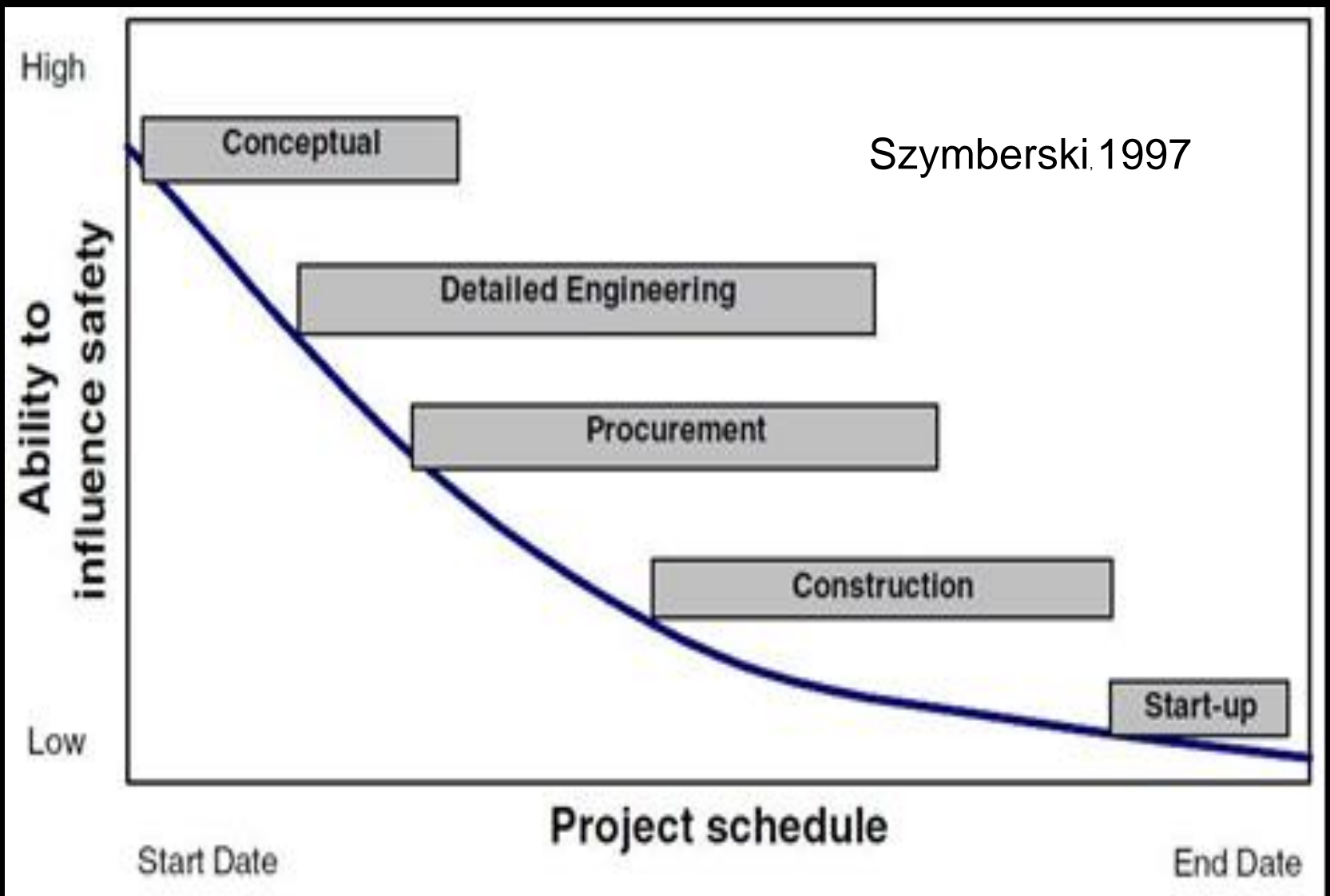
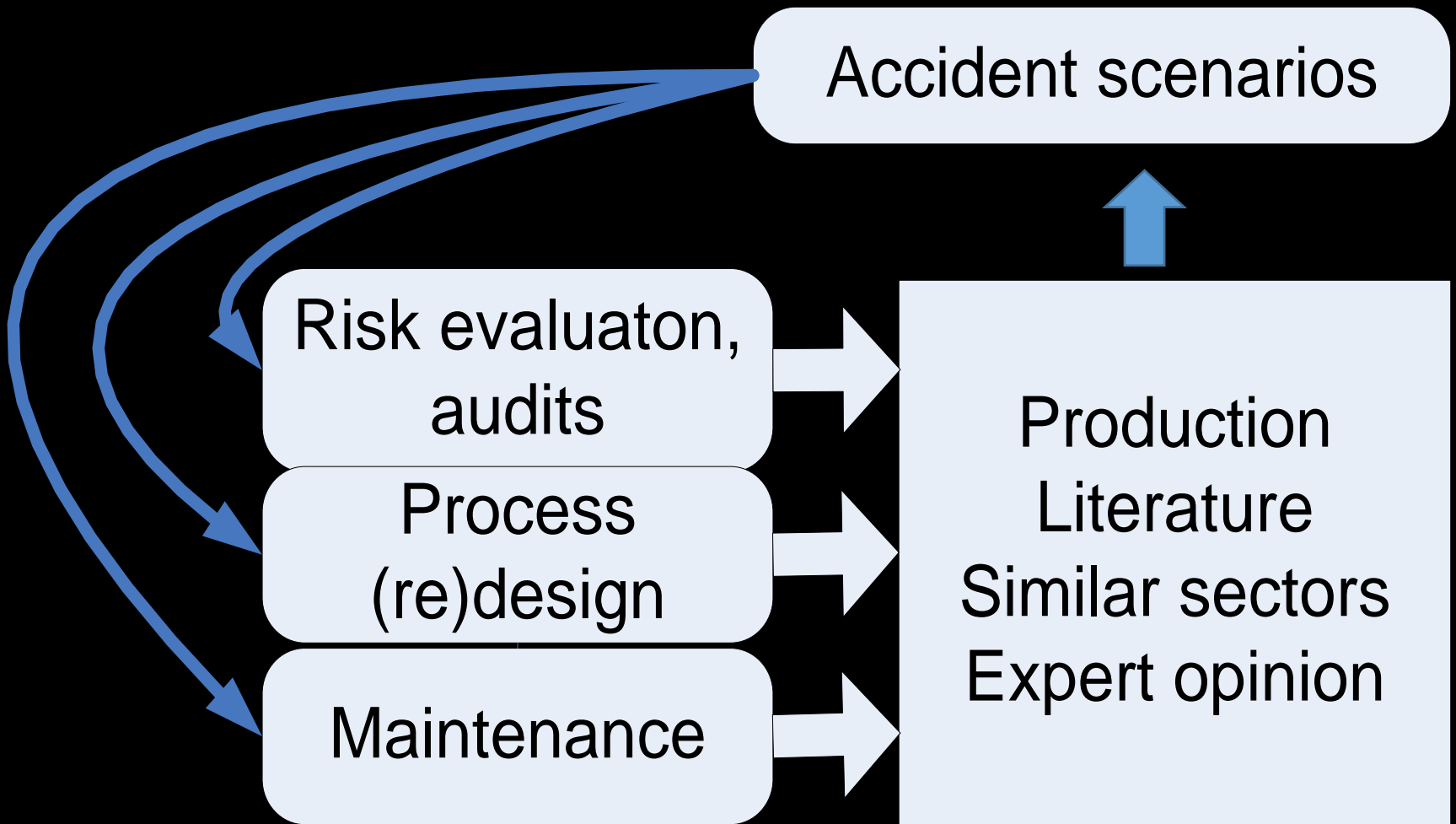


# 5 management

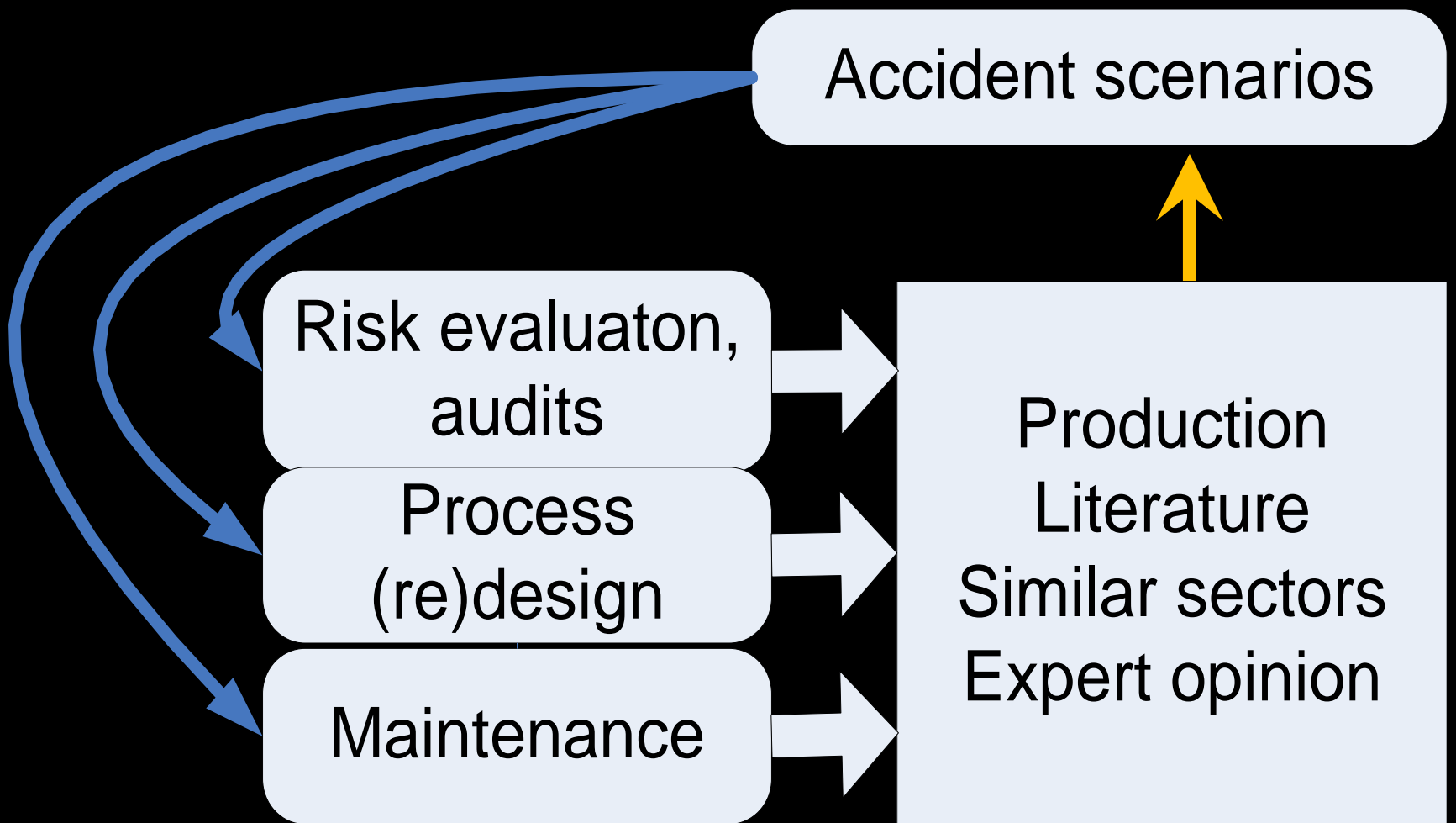




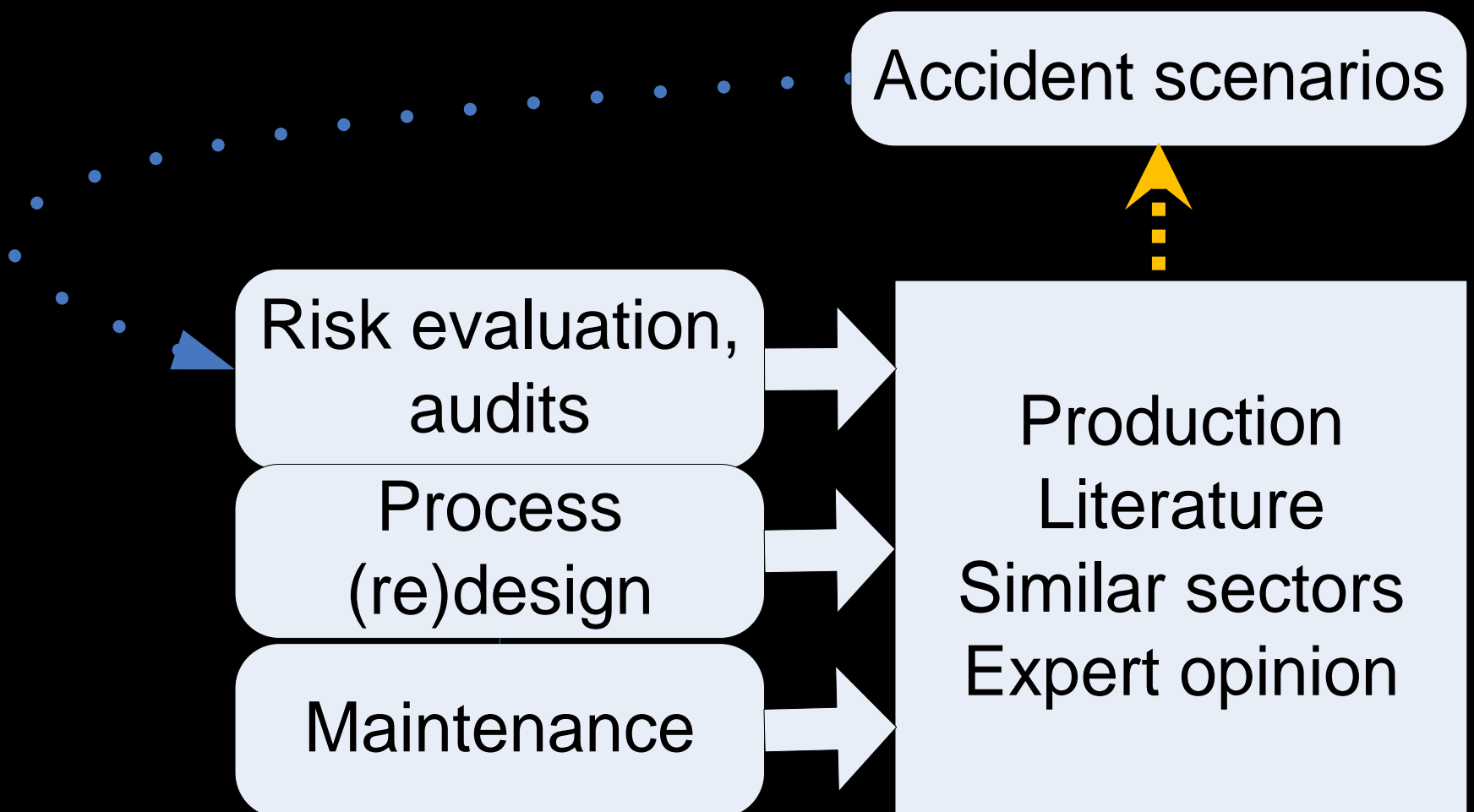
# 5 management and design



# 5 ideal feedback



# actual feedback



# 6 construction is 'organic'



Ford Madox Brown 1852-1865



Fernand Léger 1950

# 6 construction shocks and vibrations

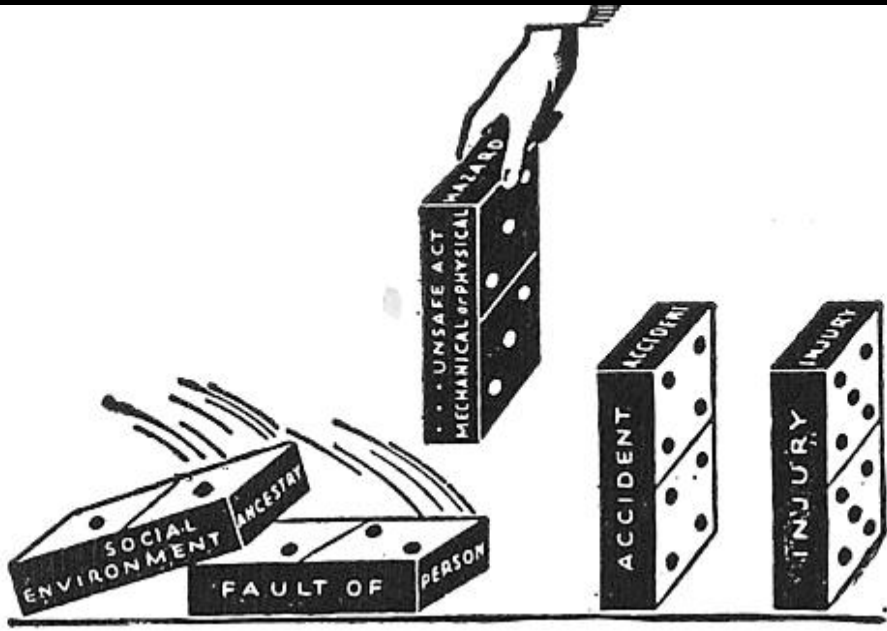


# 6 construction accident process

## direct and latent factors in construction

direct factors	latent factors
disturbances in materials	safety-production conflict (time)
disturbances in process	production bonuses
inadequate monitoring	not familiar with scenarios
prime focus on human factor	indifference to safety
inadequate accident analysis	no link to safety policies
labour, low level of education	distant from mother company
language	not adequate safety managem.
macho behaviour	relation design – unsafety
	low safety knowledge architects
	separation design – execution

# 7 are accidents predictable?

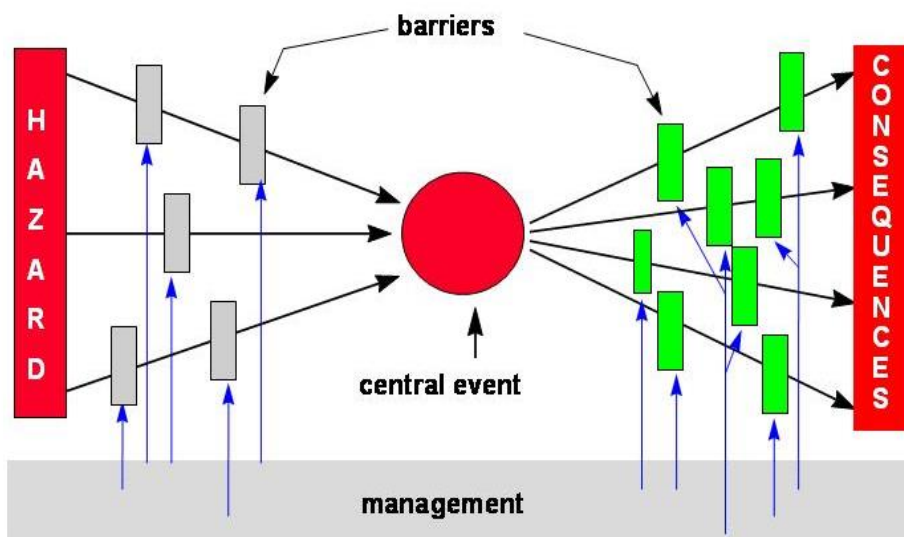
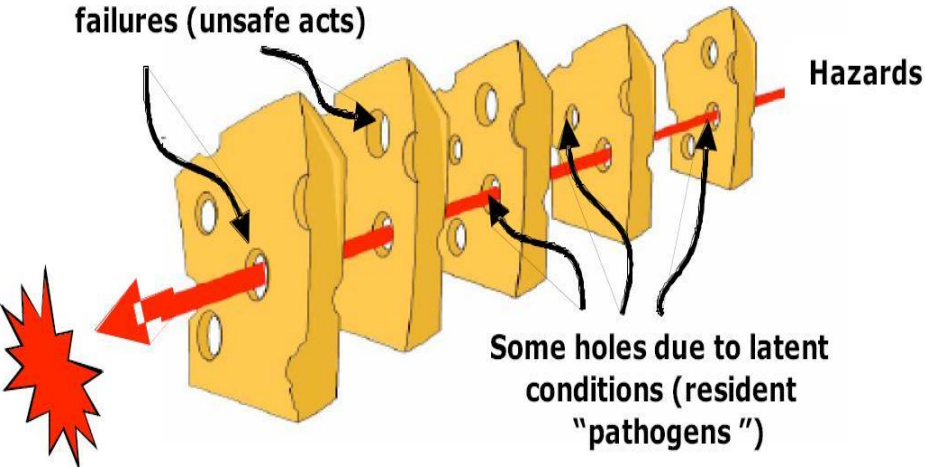


Sharp End ← → Blunt End

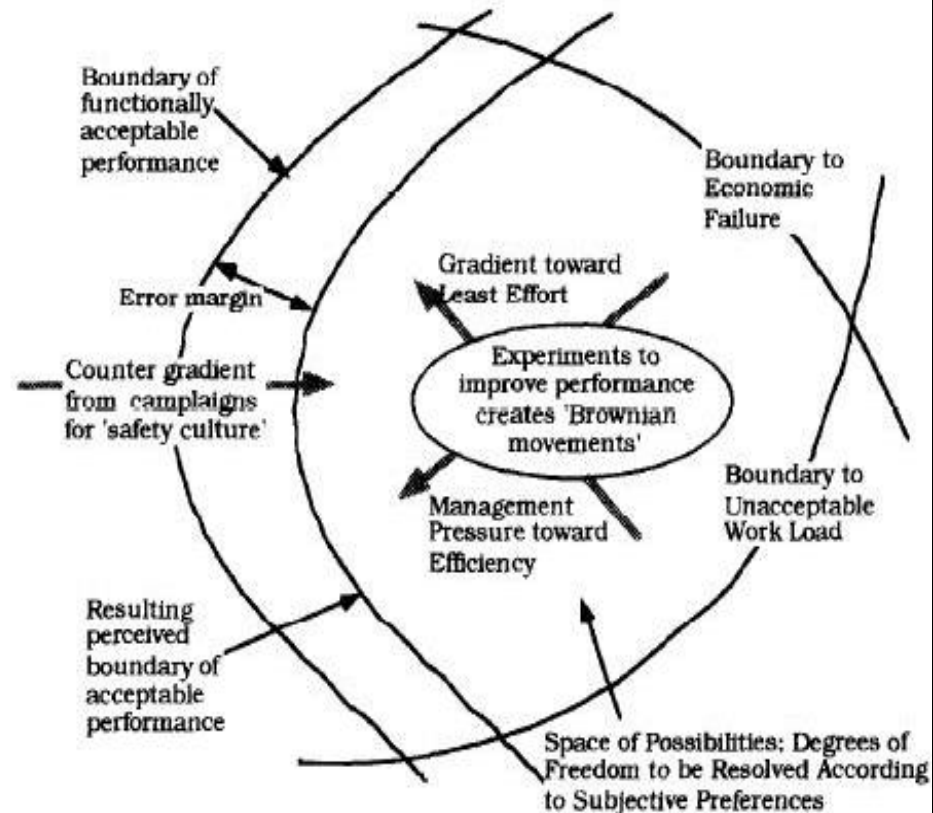
Some holes due to active failures (unsafe acts)

Hazards

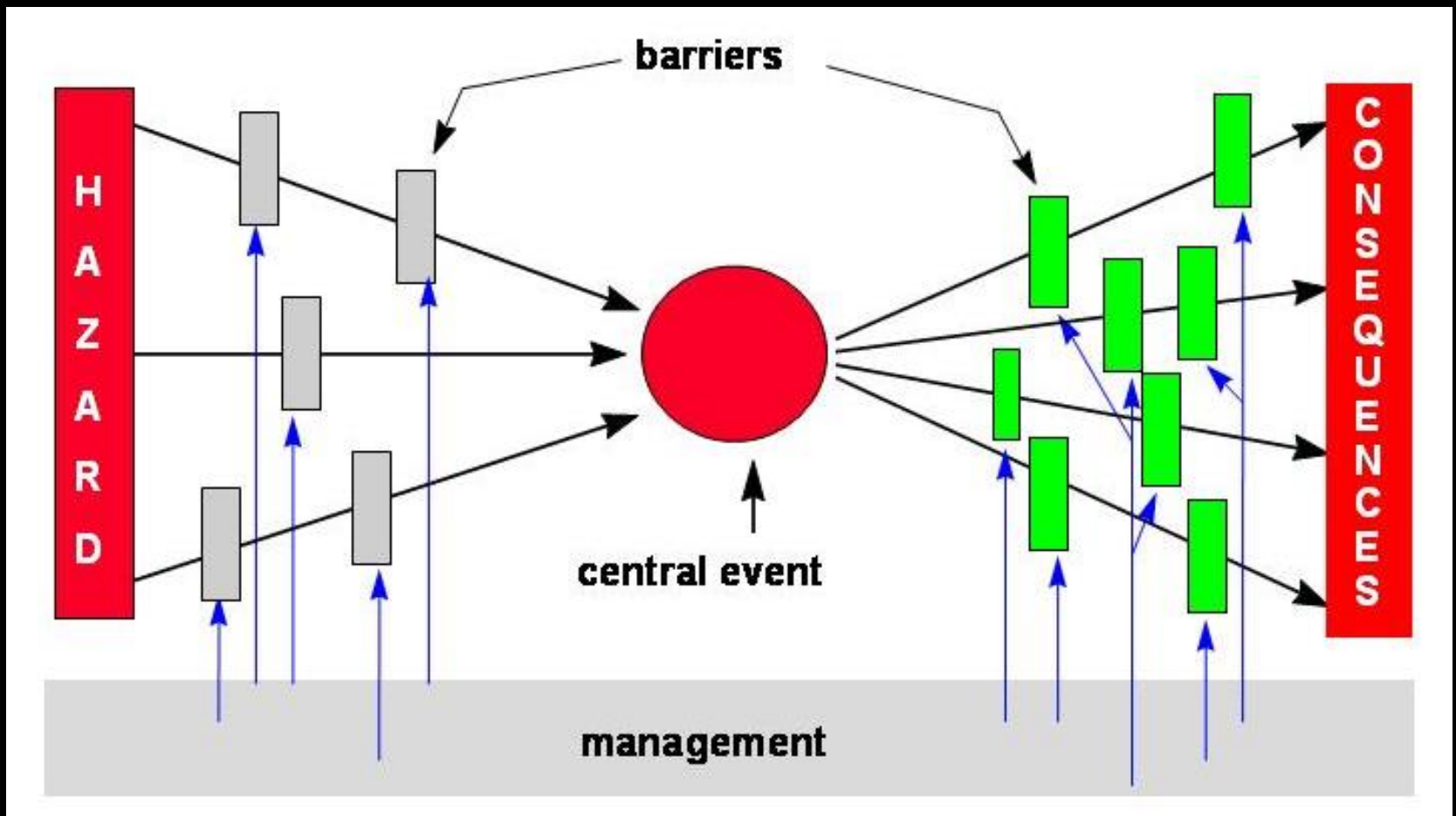
Some holes due to latent conditions (resident "pathogens")



		Interactions	
		Linear	Complex
Coupling	Tight	Dams * Some * continuous processing, e.g. drugs, bread Rail transport * Power grids * Marine transport * Airways *	Nuclear plant * Aircraft * *DNA Chemicals plants * Space missions * Nuclear weapons accidents * Military early warning *
	Loose	Assembly-line production * Trade schools * Most manufacturing * Single-goal agencies (Motor vehicles, post office) *	Junior college * Mining * Military adventures * R & O firms * Multi-goal agencies (Welfare, DOE, OMB) * Universities *



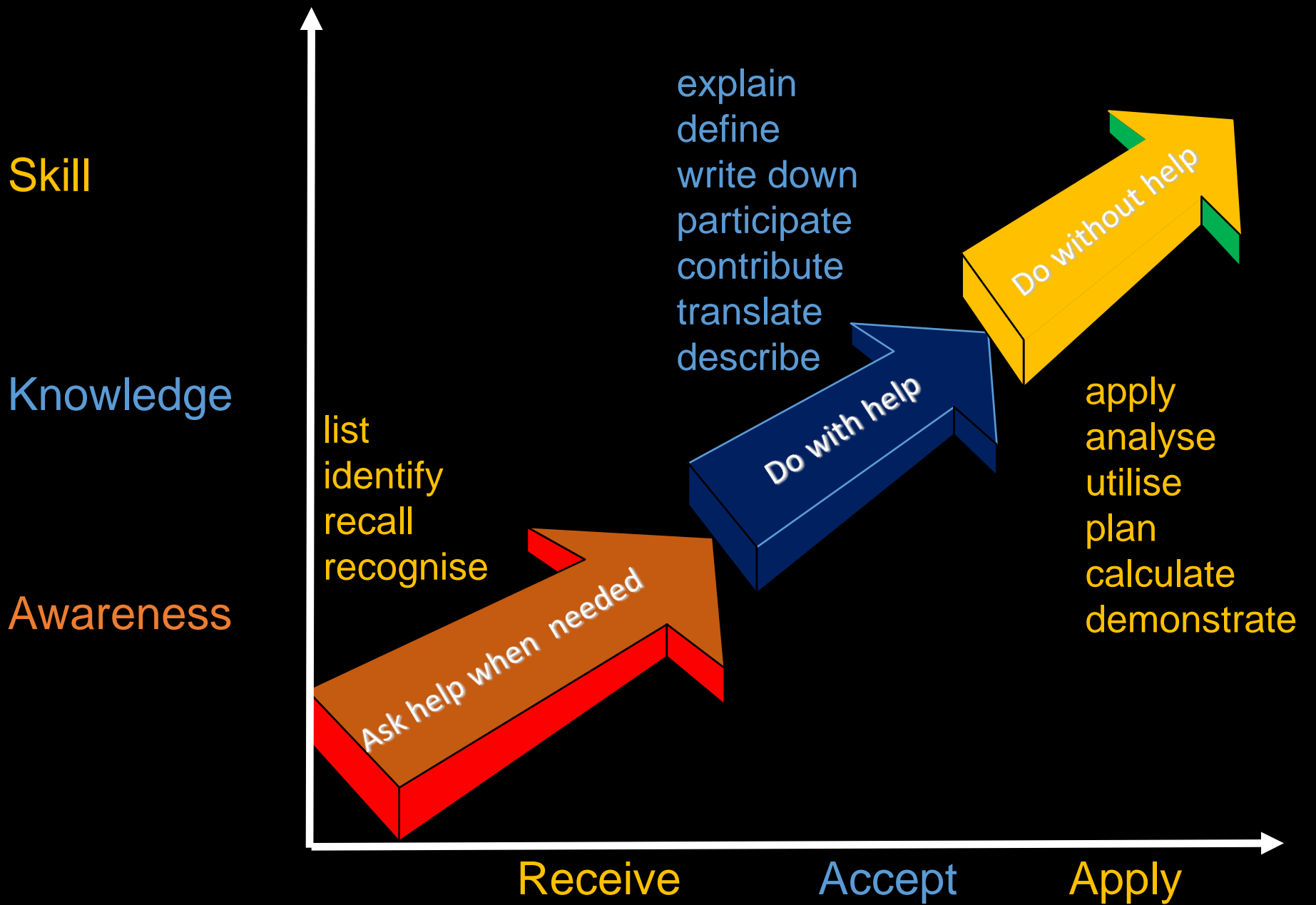
## 7 recent research



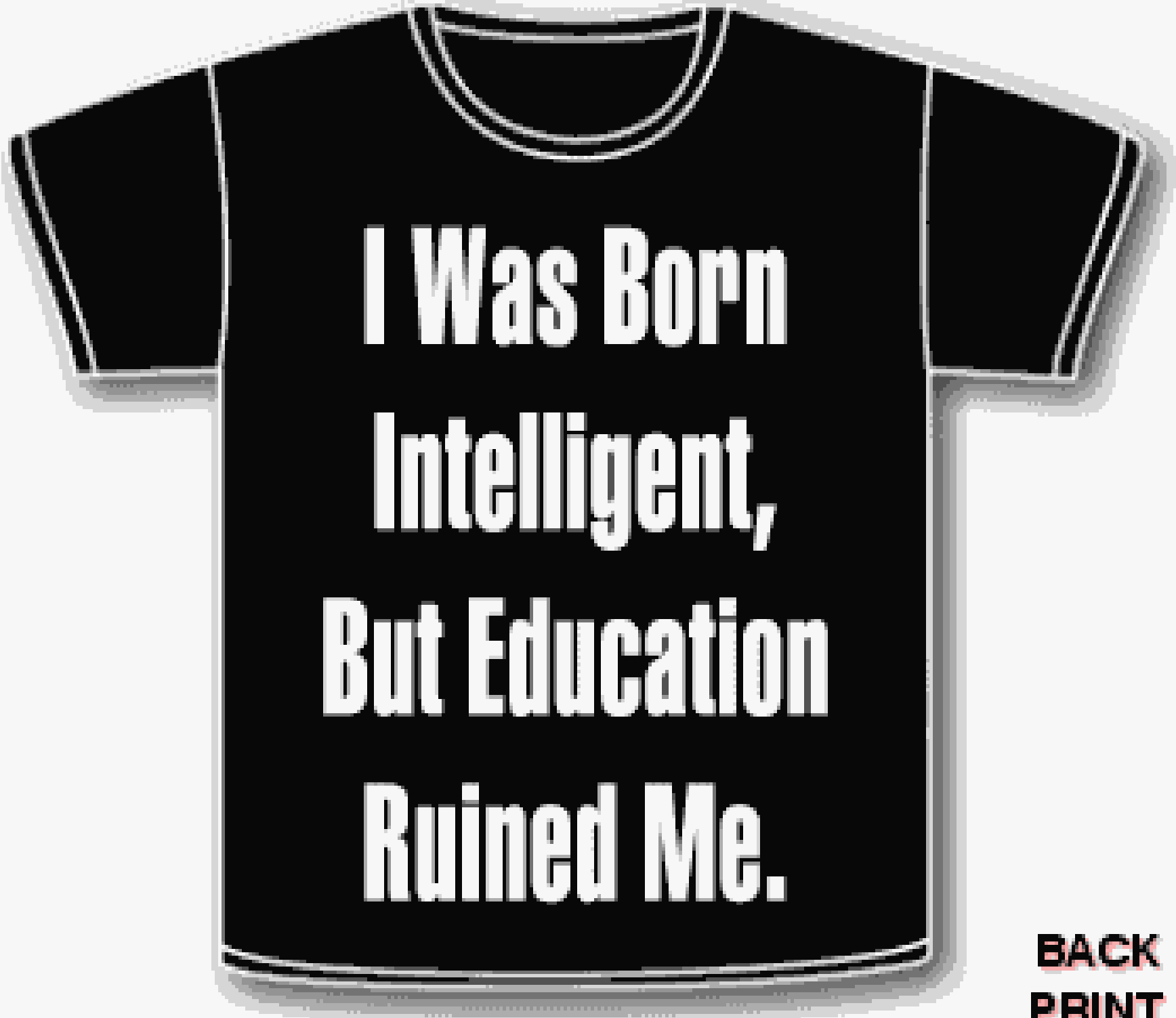
1. start with hazards and scenarios, observations, interviews workers & managers, literature, accident reports
2. determine central events, many scenarios, few central events
3. which barriers are present to stop, reduce effects of scenarios
4. how effective are barriers, interviews, accident reports
5. does management control the effectiveness of barriers

# 8 education

## competence levels







**I Was Born  
Intelligent,  
But Education  
Ruined Me.**

**BACK  
PRINT**

## red thread of presentation

- from mechanism to risk assessment
- from hazard to culture
- from human factor to socio-technique
- from technology push, cost reduction to disasters
- from risk assessment to design
- from management to accidents
- from rule following to critical reflection