Safety by accident

Performing tasks during routine operations on board is often automatic, without thinking, leading to behavioural safety complacency and sometimes unnecessary accidents

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Why do seafarers still get injured during mooring operations? Why do seafarers still suffocate when entering into enclosed spaces and carrying out other standard operations? Luckily, in most cases they are safe – but they are safe by accident. As a result, we tend to think that a good safety record mirrors a safe work process. Therefore, ship managers and officers must be aware of the dangers of behavioural safety complacency and over confidence. Some time ago Green-Jakobsen was asked to carry out an accident investigation after a very serious incident. This article sets out some of its post-investigation reflections on how crews can be misled in their risk perception.

Hazards of standard operations

On a lovely May evening in a Northern European port, a gas carrier crew were engaged in a tug boat and mooring operation. The crew were well trained and experienced - perfect conditions for this type of operation. Nevertheless, before the vessel was properly moored a rating had lost the lower part of his left leg, ripped off by the tug boat messenger line. What went wrong is always the question that follows - but more importantly how can officers and managers in the future recognise the mind-sets, behaviour and attitudes which need to be corrected before they lead to an accident?

Overrating own performance

One of the main and recurrent findings when assessing safety behaviour, is that crew members predominantly rate their own performance as better than, or at least equivalent to that of their colleagues. In other words, they believe, "my colleagues can do better but I'm ok".

Why is this? Some argue that we assess ourselves in this way to avoid losing morale - on the basis that the poorer our performance, the more we highlight our own infallibility. Others argue that humans are influenced by previous occurrences or behaviour (antecedents) - the consequences of this behaviour either enforce or discourage repetition of certain behaviour patterns. If the way we do things has a positive result – "I wasn't hurt when I did it that way" – we tend to repeat this specific behaviour next time we are in a similar situation.

We forget the process and look at the result – complacency and overconfidence

The consequence of this mind-set is that we forget to reflect on the process but focus on the result. Although a ship might not have experienced any serious incidents before, this does not mean that the way its crew conducts itself is safe!

From a safety perspective, this attitude often leads to behavioural safety complacency and self-satisfaction. A Master once said, "I must be better than my colleagues and be doing a safe job! Just look at my safety record". This is a performance evaluation based only on results, not on how the processes leading up to the results were managed. Maybe the Master had been safe only "by accident". This approach can potentially lead to the downfall of an individual with disastrous consequences.

Ship managers and officers must challenge behavioural safety complacency

When the rating got his leg torn off during a standard mooring operation, the accident investigation clearly indicated that a mooring and tug boat operation was not perceived by the crew as a task demanding thorough risk management. "We have performed this task so many times so there is no need to discuss the process beforehand". Despite the fact that the tug boat's conduct was a major contributory factor, there were numerous examples of crew behaviour and mind-set which were clearly controlled by earlier experiences and results, rather than constant reflections on the process in hand. Potential risks have to be identified before they result in an accident. The only way to do this is through constant, dynamic, on-going evaluations of the processes involved - not getting hurt does not necessarily mean that a good job was done. Officers and managers are important role models to drive the crew safety mind-set and behaviour in this direction.

It would be wrong to conclude that the rating who suffered the serious injury in the case we investigated might have avoided the accident. However, the fact is that the crew members on board made a superficial evaluation of a very dangerous work process. This was a problem.

Recommendations

Since seafarers continue to suffer serious injuries during standard operations the approach to safety needs to change. A number of recommendations can in this respect be made but for Green-Jakobsen the three most important are:

1. *Debriefing* – Discuss how the job was carried out – good and poor performance. Do not wait for an incident before you do this - the result is not irrelevant but it is the process that needs to be discussed. Instil a sense of "chronic unease".

2. *Risk Management* – this is more than risk assessment. Train crew and shore staff in risk management skills enabling them to recognise, motivate and give feedback on safety mind-sets, situational awareness, behaviour and attitudes.

3. *Fight overrating of capabilities* – Human beings overrate their own capabilities, which leads to complacency. When crew become complacent a down-ward spiral starts, which can end up in sloppiness and poor performance.

While understanding behavioural safety complacency will not change every decision they make, knowledge of its effect can improve the risk management process.

Remember good safety statistics do not mean that you are working safely. Maybe you have been safe by accident!

Our thanks to Erik Green, Managing Director of **Green-Jakobsen,** a group of consultants based in Denmark, specialising in safety, leadership and human resource management in the maritime sector.

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