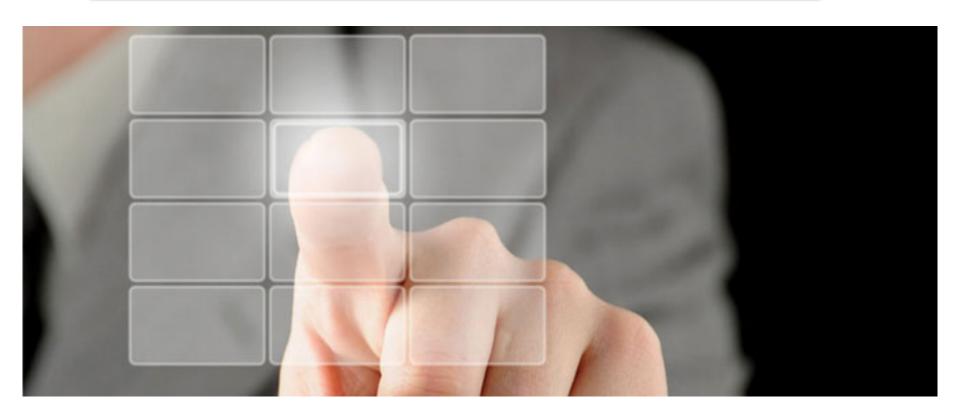
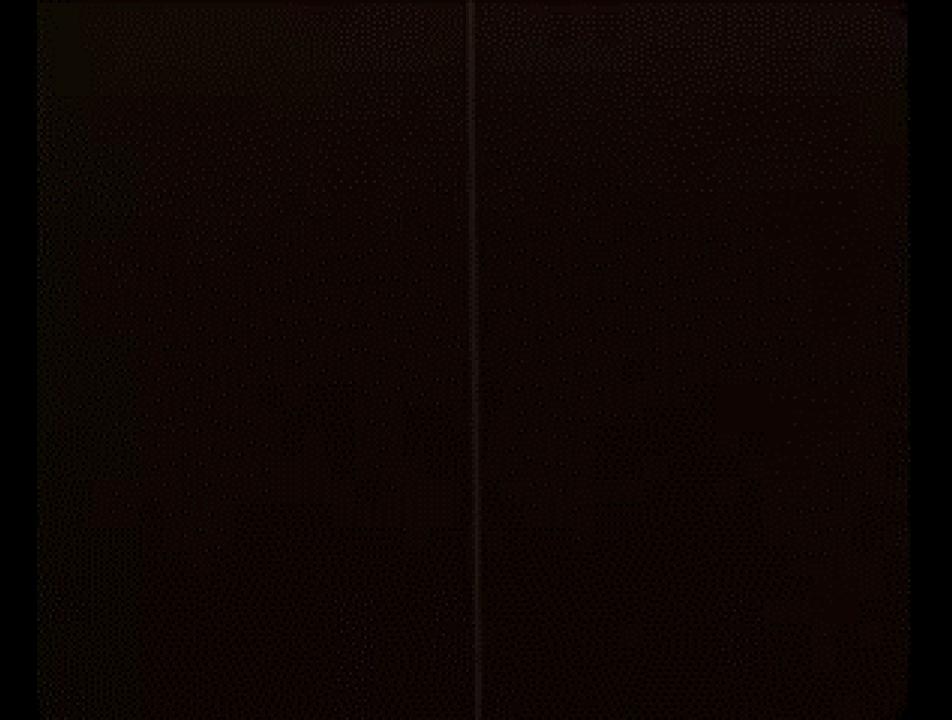






The Interface







Voluntary Protection Program

Recognition of Safety Excellence

Why Do We have Mishaps?

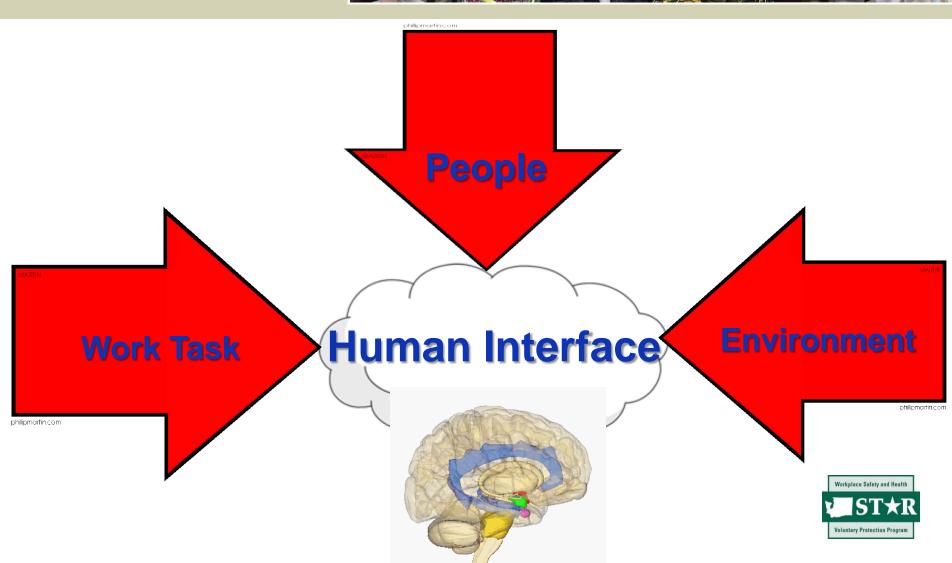
















John Geppert (360) 902-5496 gepp235@lni.wa.gov



Cooperative and Outreach Programs Manager Education and Outreach Services Department of Labor & Industries Division of Occupational Safety & Health (DOSH)







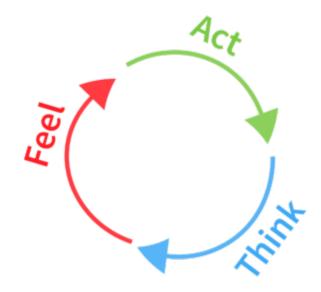








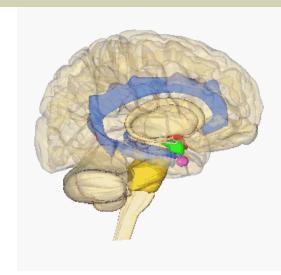
Human Behavior







Objectives

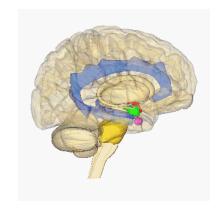


- You will explore the human task interface
- Know the importance of human factors in safety
- Understand your cognitive limitations in the workplace.







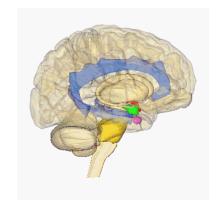




Why do we get injured in the workplace?







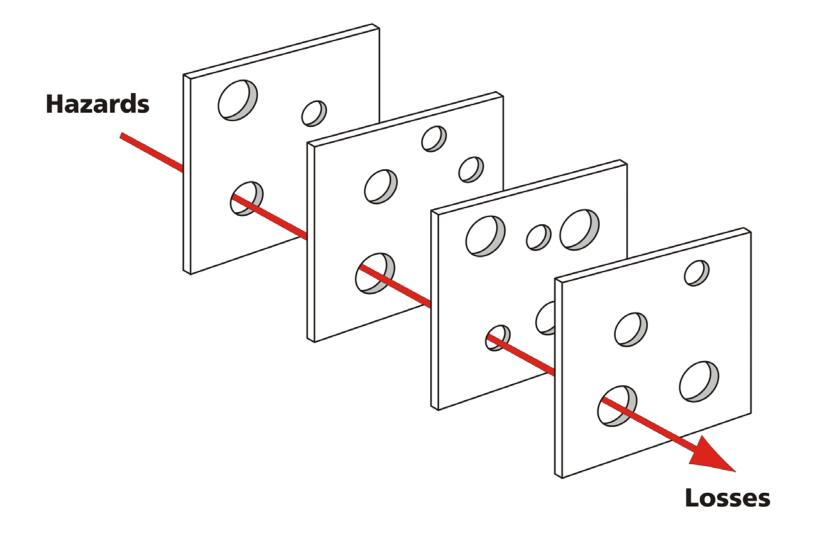


Possible Reasons

- You are exposed to hazards in the workplace.
- There is risk of injury and illness when you interface with work equipment or task.
- Workplace conditions or the environment changes
- Equipment or systems can fail



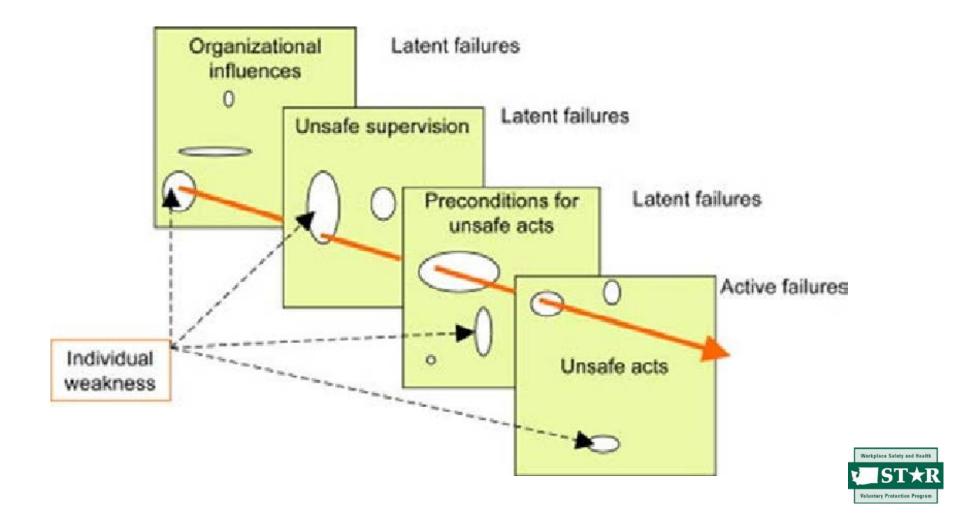








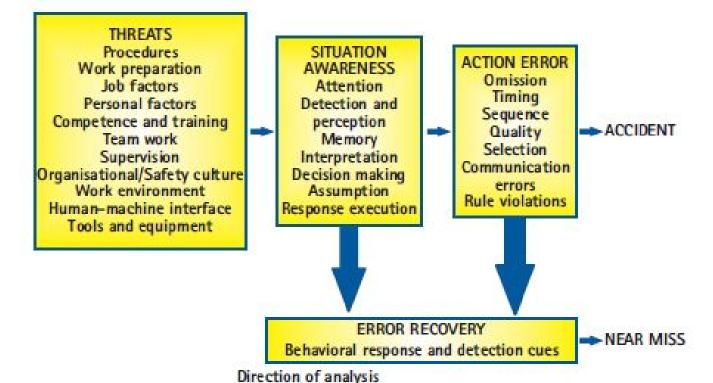








Direction of causation



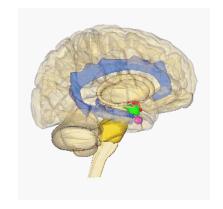
Workplace Safety and Health

STXR

Voluntary Protection Program









Five Most Common Incidents

- Slips trips, and falls.
- Being Caught In or Struck by Moving Machinery.
- Transportation and Vehicle-Related Accidents.
- Fire and Explosions
- Overexertion and Repetitive Stress Injuries





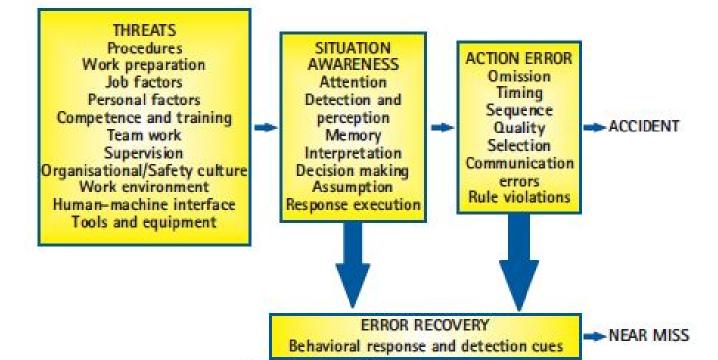






Direction of causation

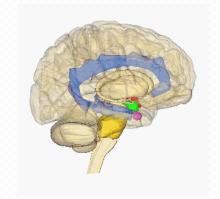
Direction of analysis













Seven Most Common Causes

- Workers take shortcuts at work
- Workers are overconfidence.
- Inadequate Housekeeping.
- Starting a tasks before getting all necessary information
- Neglecting safety procedures and rules
- Mental Distraction
- Lack of Preparation











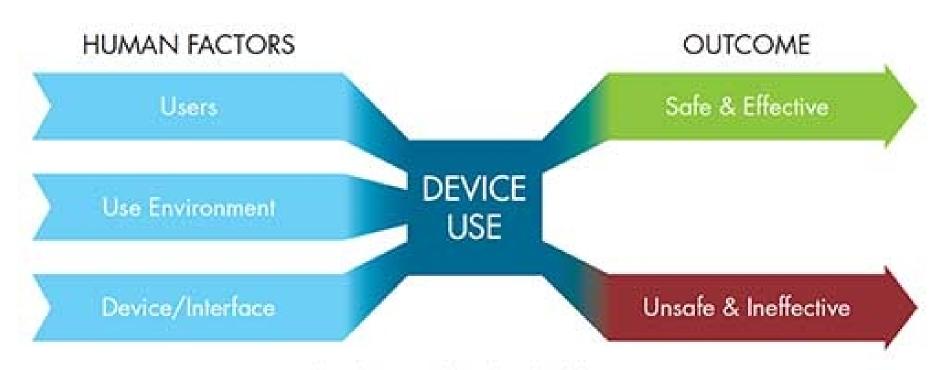












Human factors considerations for industrial designers.





AUTOMATION/ ROBOT FATALITY NARRATIVE





Warehouse Worker Crushed by Forks of Laser Guided Vehicle

INCIDENT FACTS

REPORT #: 71-171-2018s

REPORT DATE: 5/10/2018

INCIDENT DATE: 12/9/2015

VICTIM: 45 years old

Employed at facility for approximately one year

INDUSTRY: Bottled water manufacturing

OCCUPATION: Warehouse dock coordinator

SCENE: Water bottling plant warehouse

EVENT TYPE: Crush









FATALITY NARRATIVE (FACE)







Photo of the automatic laser guided vehicle (LGV) involved in the incident.









The victim was working in the warehouse when an LGV alarm was activated. Shortly after, another worker heard noises over the radio and looked into the warehouse to investigate.

He saw the victim slumped over one of the LGVs. The LGV then started moving again, and the other worker hurried to it and initiated an emergency stop. He could see that the victim had severe injuries to his chest and jaw.

He called for help and called 911. Emergency responders arrived within minutes and transported the victim to a local hospital where he was pronounced dead.

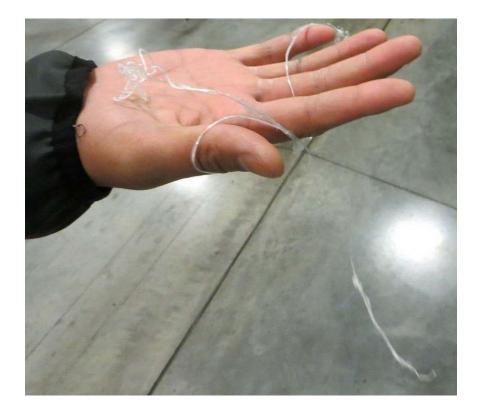






FATALITY NARRATIVE (FACE)





Example of a plastic "stringer" that would often tear off of the wrapping around the pallets of water bottles during loading and unloading and become caught on LGV forks. Stringers hanging from the forks that entered an LGV's safety detection field would trigger an alarm and pause automatic movement.









The manufacturer's manual required workers to initiate an emergency stop before removing an obstacle detected by the LGV. An LGV would then have to be manually reset before restarting its task. Without initiating an emergency stop, the LGVs would resume automatic function immediately after an obstruction was removed.

There were warning signs affixed to the vehicle indicating that workers should avoid standing beneath the elevated forks.













Sticker on the LGV indicating that working underneath elevated forks was prohibited.

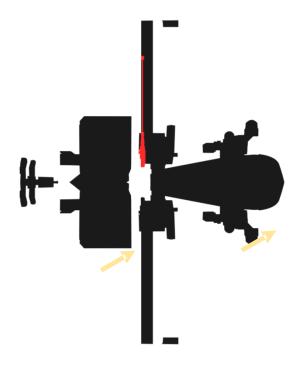


Diagram indicating the location of the emergency stop button and rope pull. An identical set was present on the other side of the LGV.







FATALITY NARRATIVE (FACE)









After the incident, the company trained employees to initiate an emergency stop before clearing an obstacle from an LGV's path, and to use a long-handled snipping tool to remove plastic stringers instead of reaching or bending under the forks of the LGV.









Requirements

Employers must protect workers around PITs (powered industrial trucks), and not allow them under the elevated part of any PIT, whether it is loaded or empty.

See WAC 296-863-4005(2)(a).









Recommendations

FACE investigators concluded that, to help prevent similar occurrences, employers should:

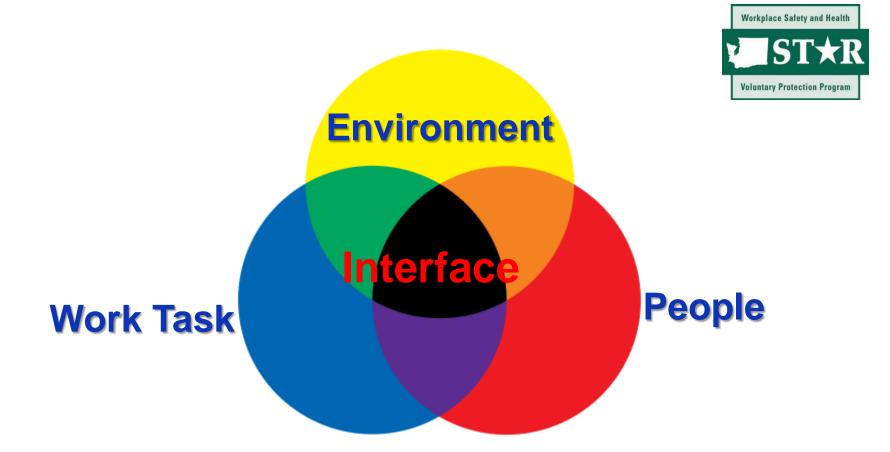
Train workers about the specific hazards associated with automated guided industrial vehicles, like LGVs. Emphasize that workers are expected to follow required safety procedures every time, and ensure compliance through periodic refresher training and spot checks.





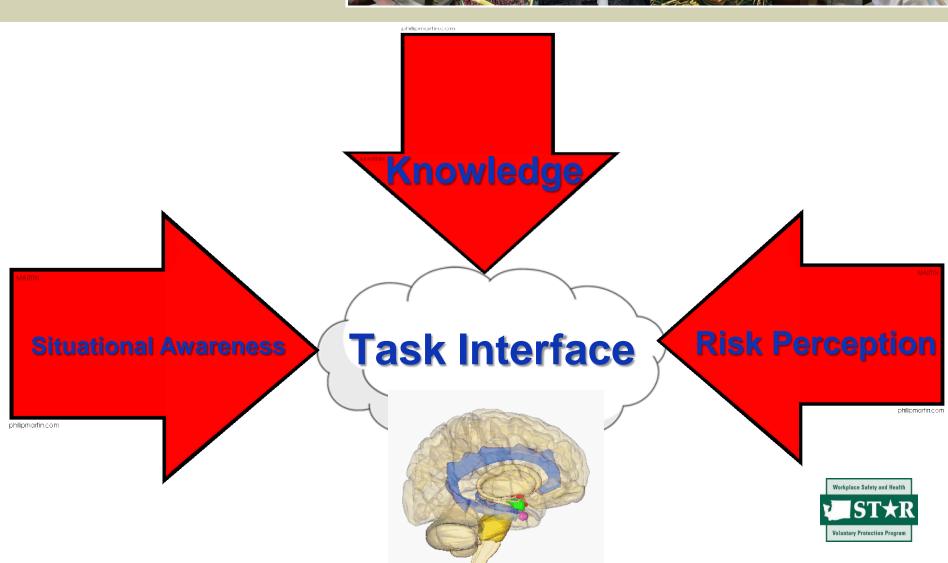














FATALITY NARRATIVE (FACE)







Photo of the automatic laser guided vehicle (LGV) involved in the incident.









Causes of USE ERRORS

- Perception
 - Failure to see or hear information
- · Cognition (Processing)
 - Forget information or step
 - Forget or apply rule incorrectly
 - Misinterpret information
- Action
 - Inability to reach a control
 - Use incorrect control
 - Use a control incorrectly
 - Failure to activate control

Information Processing

Information Perception

Interface

Interface

Input

Processing Reaction

Source: FDA Draft Guidance: Applying Human Factors and Usability Engineering to Optimize Medical Device Design, 2011

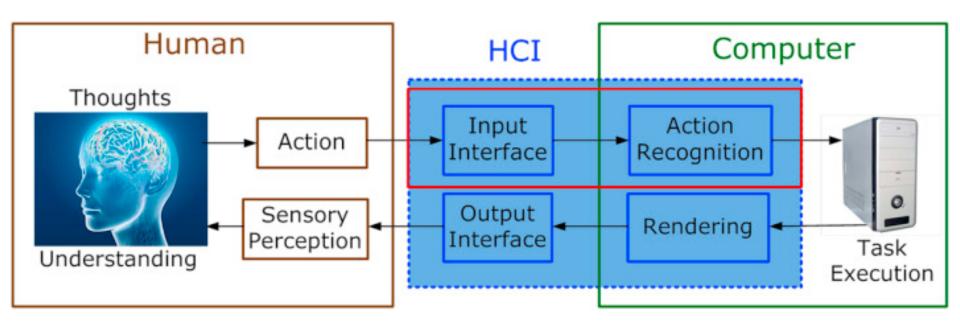




Voluntary Protection Program































FATALITY NARRATIVE (FACE)





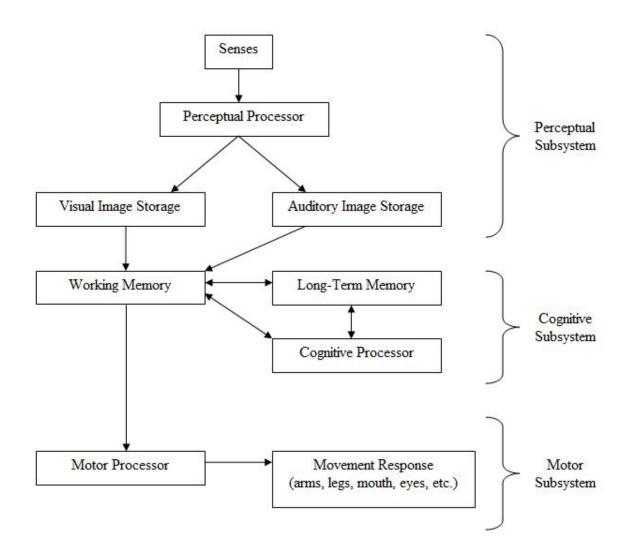
Photo of the automatic laser guided vehicle (LGV) involved in the incident.

















Conscious 10%

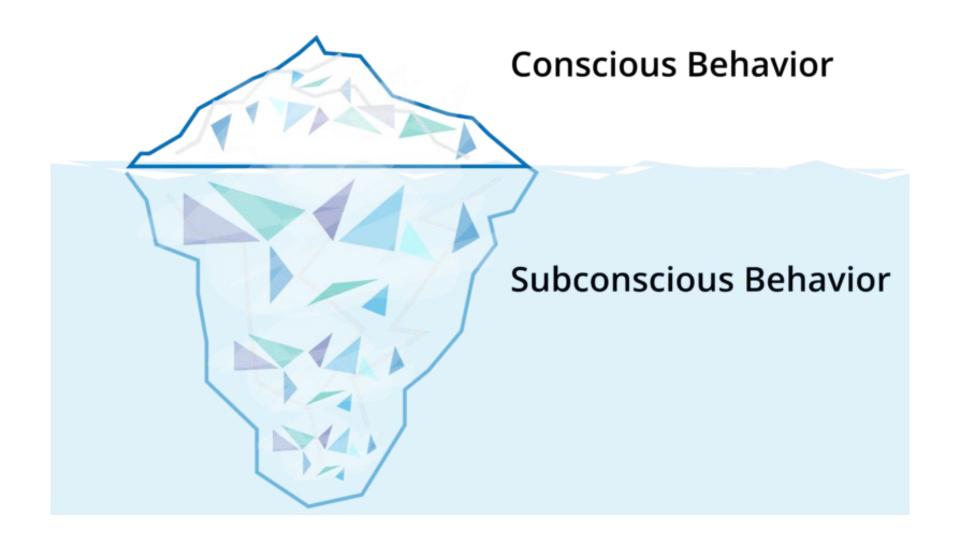
Subconscious 50-60%

Unconscious 30-40%













System 1

System 2

Fast



19

Slow

Unconscious





Conscious

Automatic



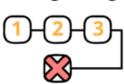
Effortful

Everyday Decisions



Complex Decisions

Error prone





Reliable







The intension is correct but it is not carried out

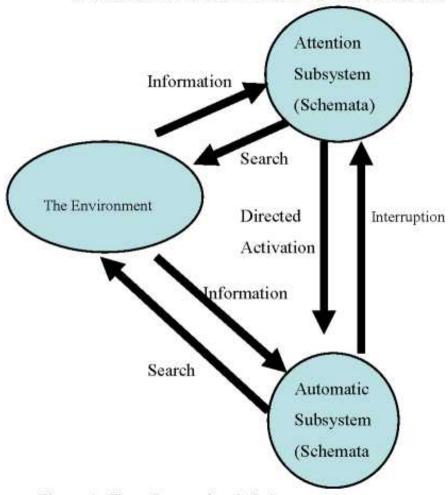


Figure 1: Three Interacting Sub-Systems.

Change Blindness (using flicker)
(from J. Kevin O'Regan -- http://nivea.psycho.univ-paris5.fr)









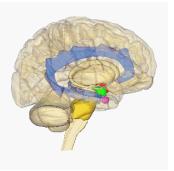




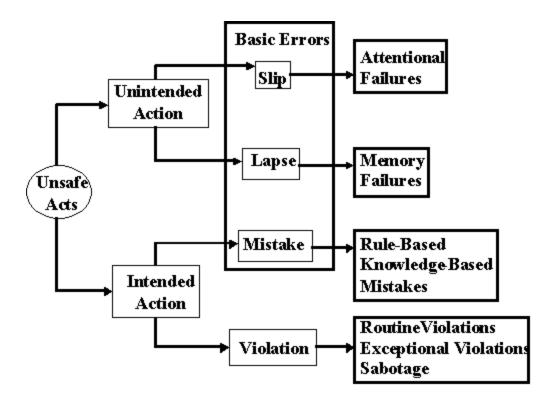
















Unsafe Behavior





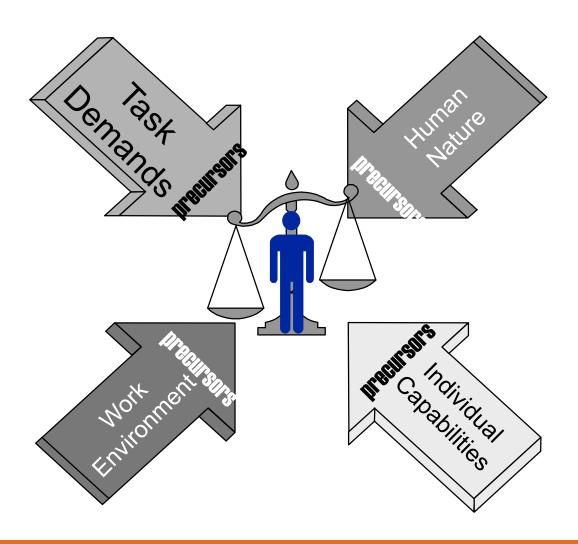


Failures in Attention









An error at the task interface can deduced by error precursors





Error Precursors (short list)

Task Demands

- High workload (memory requirements)
- Time pressure (in a hurry)
- Simultaneous, multiple tasks
- Repetitive actions / Monotony
- Irrecoverable actions
- Interpretation requirements
- Unclear goals, roles, or responsibilities
- Lack of or unclear standards

Work Environment

- Distractions / Interruptions
- Changes / Departure from routine
- Confusing procedure / Vague guidance
- Confusing displays / controls
- Work-arounds / OOS instrumentation
- Hidden system response
- Unexpected equipment conditions
- Lack of alternative indication

Individual Capabilities

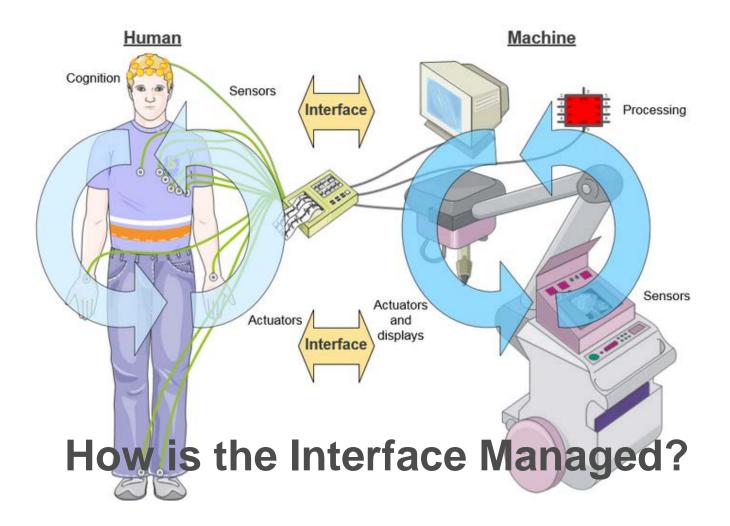
- Unfamiliarity with task / First time
- Lack of knowledge (mental model)
- New technique not used before
- Imprecise communication habits
- Lack of proficiency / Inexperience
- Unsystematic problem-solving skills
- "Can do" attitude for crucial task
- Illness or Fatigue

Human Nature

- Stress
- Habit patterns
- Assumptions
- Complacency / Overconfidence
- Mind set (intention)
- Inaccurate risk perception
- Mental shortcuts (biases)
- Limited short-term memory

























Summary









Workplace Culture

