

How to keep history from repeating itself



Safety: Eddie Janson

Captain Eddie Janson of MariTrain AB, instructor and consultant in maritime safety, points the Shipgaz spotlight at safety related matters.

In the previous issue I elaborated on near misses and the importance of learning something from them. But how does it work in reality? Do we learn from our mistakes?

Many disasters have led to new regulations as for example MARPOL, which came into effect after the Torrey Canyon accident and have led to a reduction of oil spills.

But lessons learned from smaller accidents and incidents are just as important. A lesson learned from a smaller incident, if used correctly, can help avoiding larger incidents from happening and prevent loss of life, damage to property or the environment.

There are many systems in place for experience transfer, such as MARS, Insjö etc. Some companies also have regular safety bulletins describing incidents and accidents including Lessons Learned. The oil majors send out regular safety bulletins as transfer of experiences. But do we really take in this vital information and make use of it in order to avoid history repeating itself?

If we were really good at learning from our mistakes, two similar accidents would never occur. Have we for example learned anything from all groundings caused by fatigue? I would have to answer NO to that question because people still fall asleep on their watch and vessels are still running aground due to that fact.

If you study the adjacent diagram, it shows that we unfortunately are not so good at learning from our mistakes. The tanker accidents have doubled between 2005 and 2007.

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TMSA REQUIREMENT 8.3.2

→ "The incident analysis process ensures that the lessons learned from an incident or near miss are shared across the fleet."

So how can we become better at learning from our mistakes? Shall we wait for a disaster resulting in new regulations? I believe the correct way is to start in our daily work on board. When you have a near miss or an incident on board it shall be reported, but do not stop there.

Discuss the event on board and try to find out why it happened. On board, such events should be discussed with an atmosphere of trust,

i. e. within a no-blame culture. Try to do a Proper Root Cause Analysis and find the real causes behind the accident. Try to go one step further when finding the causes.

Many times we stop with for example the statement "The accident was caused by fatigue" – but we need to go a little bit further to find the real cause. Why was the officer tired? What were the causes for fatigue? Do not stop with Human Error. Ask why it was possible to make this human error? What were the conditions that enforced the Human Error and what can we do to prevent it from happening again?

If you find good answers to these questions and you can communicate them to your colleagues you may actually prevent an accident in the future.

It is now 15 years since the Estonia disaster. What we have learned from that is discussed on other pages in this issue. *

TANKER INCIDENTS BY TYPE SOURCE: INTERTANKO/LMIU/ITOPF/VARIOUS

