Usually, there are many people whose actions and decisions contributed to the incident over time. Identify these individuals and their actions.

* 1. At the scene, reconstruct and walkthrough the incident sequences. Pay special attention to:
* What was the task they were trying to accomplish
* What was the purpose of the behaviour that triggered the event or contributed to the event
  + What people could (not) see from their locations
  + Their body and hand position and what they were trying to achieve with it
  + The equipment and people they interacted with
* What was their understanding at the time of what the correct action to take is (what information they had at the time)
  + Where did that information come from (other people – who and how, documents, training etc.)
* What did they NOT know at the time of taking the action and why
  + WHO should have provided that information and HOW (e.g. engineer via X, training via Y, supervisor via Z)
* What were the constraints they had to deal with
* WHO else was part of this process (e.g. supervisor, another engineer, supplier, another operator etc.)
* Review how this task was performed in the past. Was there anything different?

For each person and their behaviour:

• Step 1 – Identify a single, well-defined behaviour which is represented in the cause map.

• Step 2 – Identify Assumptions / decisions / mind-set which underpinned the behaviour (why it made sense to them)

• Step 3 - Identify the Error Traps that may have influenced the person to make the error.

• Step 4 – Identify Management system causes / organizational which were behind the error traps.

Example 1: “*The operator continued filling the storage tank (behaviour) because he believed the tank was half-full (belief - why it made sense to them) due to an incorrect level indication from the level instrument (Workplace-level error trap) due to reduced maintenance budget in last 3 years which reduced the frequency of preventative maintenance (Error trap precursors).”*

Example 2: *“The operator used a wrong tool for the job (behaviour) because she believed it was the right tool for the job (belief – why it made sense to them) because the procedure was incorrect (Workplace-level error trap) as there was no process in place for managing updates to the procedures (Error trap precursors).”*

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| **Types of error traps** | **Workplace-level error traps** | **Error traps precursors** | **People to interview** | **Other activities to gather evidence** | **Industry standards, guides and additional tools** |
| **Procedures / work instructions** | * Inaccurate / Out of date * Unworkable in practice * Made it more difficult to do the work * Time consuming / quicker way possible * If followed to the letter, could not get the job done in time * Does not describe the best way to carry out the job * Difficult to know which is the right procedure * Too complex and difficult to use * Safety related information (hazards & controls) and warnings are not presented in operating procedures * Difficult to find the information you need in the procedure * Difficult to locate the right procedure * Not aware that the procedure exist * Not aligned with the training provided * Use of suppliers’ / clients’ procedures * Many procedures for the same task / activity? Are there any conflicts between them? | * There is no process in place to:  1. Monitor the use of procedures and provide feedback 2. Systematically evaluate error traps in procedures 3. Promptly redesigning or scrapping bad or superfluous rules  * The software used doesn’t allow for quick finding the needed procedure. * Workers don’t receive training and feedback on how to use the procedures. The use of procedure is not part of competency verification. * Workers are not involved in writing procedures. * Leaders don’t proactively seek non-conformance to address them ASAP. | Operators who use the procedure / work instruction.  Supervisors – are they aware and monitor the use of procedures.  Engineers and others who co-wrote the procedure.  Person responsible for the procedure management system and software. | Do a site walkthrough/ talk through with the selected procedure and operators and ask to show you how the steps are executed.  Ask users to show you how they access procedures.  If there are references or links to other documents ask users to show you how they access it. |  |