

## “All the rules were followed, yet our workmate was killed”

Far too frequently, incidents occur when rules are bypassed. We all tend to take shortcuts - causing management to devote a lot of time and energy into ensuring compliance with rules. “Failure to follow rules” (or procedures, standards, guidelines) is often listed in reports as the prime cause of a mishap.

But are rules enough? Can management be assured that by following all rules and complying with all standards they will avoid unwanted incidents? Can such a heavy focus on following rules actually induce more risk?

Consider the following: *Hard & Fast Pty Ltd* is strongly focused on rules, standards and compliance. Supervisors work hard to make sure that every task, every routine job, has a set of standards that must be adhered to. For the non-routine tasks, comprehensive analysis takes place beforehand, where work teams prepare the detailed steps, hazards and control measures. And, should anybody think of transgressing, they need only recall what happened to poor old Bill last week when he was found to have not followed the written rules. Could it be that *Hard & Fast* has actually made things less safe by the application of this policy? Is it possible that workers, supervisors and managers believe that “If all rules (standards, etc) are followed, it must be safe”?

This is the paradox of rules:

*People come to believe that following the rules is enough, yet fail to realise that rules (procedures, standards, etc) can never fully anticipate the circumstances that might unfold during the course of the work.*

Simple solution, you say – make the rules more comprehensive. This brings us to Paradox Part 2:

*“The more comprehensive the rules, the less they will be referred to and the less they will be understood”.*

*Progressive Pty Ltd* has adopted a different approach. Sure, it has rules, procedures and standards – but they are simple, understandable and readily available to people who need them. More importantly, *Progressive* recognises that rules are a **minimum standard**, and need to be supported by a **risk assessment culture** where everyone is trained to think about situations that may emerge in the course of the work. People are mentally asking “What if?” at every step, alert to changing circumstances and on the lookout for situations that could harm themselves or their workmates.

## Two Tragic Case Studies

At Bell in the NSW Blue Mountains a railway track worker was struck and killed by a passing train. He was one of a gang of five working on a track where strict rules were applied to train movements. Flag operators were located 2.4 and 1.2 km on the approaching side, stopping all trains and then only allowing them to proceed at slow speed and under the control of the site supervisor. All rules in relation to “protecting” this track were followed. Inexplicably a second track, parallel to the first and only about two metres away, was not required to have any protection. A train travelling in the opposite direction at full track speed struck the worker as he was bending down using a power tool.

The track crew believed that all the rules had been followed. There was no rule requirement to protect the second track, yet any commonsense assessment would have highlighted the risk from passing trains. Rules were later changed.

At Glenbrook, also in the Blue Mountains, an electrical fault caused signals to fail to red indication as per design. Procedures permit trains to go past red signals, so long as particular precautions are taken. In fact, 84 chapters of rules governed these operations. Owing to confusion, misunderstanding and other factors, the driver of a train believed that he had verbal (radio) authorisation from the control centre to pass a red signal, and that there were no further problems ahead, at least up to the next signal. As it happened, a preceding train was moving very slowly and was not sighted in time to avoid a collision. Seven people died.

A subsequent judicial inquiry<sup>1</sup> reviewed both accidents.

With Bell, it criticised the way in which “slavish adherence to rules [was used] as the primary mechanism for preventing injury and accident”.

Regarding the 84 chapters of rules at Glenbrook, witnesses described them as “incredible waffle,” “ambiguous and constantly changing”, “trainers not clear as to the intent”.

The inquiry observed:

- “[There are] many areas where rules do not take account of human factors such as fatigue, perception and understanding.”
- “Rules should be simple, clear and unambiguous, tailored to the level of education and experience of the people who have to apply them.”
- “Rules should be part of system of safety management and not an end in itself.”
- “None of the employees [involved with the immediate actions at Glenbrook in passing the red signal] was risk aware.”

In later *Risk Aware* bulletins we will describe simple ways in which organisations can become more like *Progressive Pty Ltd*.

## References:

1. McInerney, AJ: Special Commission of Inquiry into the Glenbrook Rail Accident, 11 Apr 01.

## For more information, please contact:

Advitech Pty Limited  
1 Elizabeth Street  
Tighes Hill Newcastle NSW 2297

Tel 02 4961 6544  
[mail@advitech.com.au](mailto:mail@advitech.com.au)  
<http://www.advitech.com.au>

