Catalogue of errors puts man in way of a train

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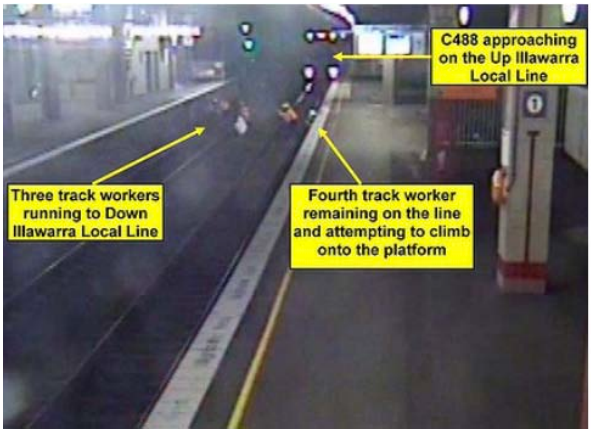


"Righto mate, blocks are on."
"Thank you."
"Ta."

THERE are a number of factors that led to the death of Tamati Grant, who was struck by a train on the morning of April 13, 2010.

But the above conversation, in which a RailCorp signaller told a man on Mr Grant's track cleaning team that "blocks" were on, is first among them. If the blocks really were on, the train that hit Mr Grant would not have been able to get near Kogarah station.

But they weren't, the signaller just said they were, and Mr Grant and three other men kept cleaning until just after 1.08am, when a Kiama service screamed into Kogarah, killing Mr Grant, 59, as he tried to climb onto the platform to safety. A report into Mr Grant's death was released this week by the NSW Office of Transport Safety Investigation.

It details a catalogue of errors, failures and breaches of process, by the signaller at RailCorp's Sydenham complex, by the leader of Mr Grant's cleaning team, and within RailCorp more broadly.

Speaking to the *Herald* from New Zealand yesterday, Mr Grant's brother, Ken Mihaere, said he was absolutely shattered and shocked to read the report into his brother's death. Mr Mihaere said he hoped the spotlight on the failures would lead to some improvement in safety conditions.

Mr Grant was in a five-man team employed by Swetha International to remove rubbish from RailCorp tracks. There was a 'protection officer' in charge of organising the safety of the men, and four cleaners.

At about 1.07am on April 13, the protection officer called a senior signaller known as an area controller working at RailCorp's signalling complex at Sydenham. He requested the area controller put up blocking signals for the tracks alongside Kogarah's Platform 1, to prevent a train moving into the area. That area controller, however, had been having a bad time. He had been on sick leave for 11 weeks until the middle of February, being treated for "psychological conditions and drug rehabilitation".

In that time he asked his manager whether he was fit for duty. But he had returned to work, even though wanting to call in sick on April 12. That day, he later told investigators, he had felt "crappy" and was suffering from headaches.

When the call came through from the protection officer at Kogarah requesting a blocking signal, the controller gave a "non-cognitive" response.

About 30 seconds later, the controller realised his mistake. He could have used RailCorp's so-called MetroNet Train Radio system to broadcast a more immediate warning message to the train that had just left Hurstville on the way to Kogarah.

But he was not confident he knew how. He instead phoned the station attendant at Kogarah to issue a loudspeaker warning that a train was approaching from Hurstville.

By the time the attendant broadcast the loudspeaker warning, just after 1.08am, the train was already fast approaching Kogarah station. The protection officer, who should have double-checked the signal block was on, moved into an alcove at the end of the station.

Three of the cleaners scattered to the parallel tracks. Mr Grant, who was about 1.5 metres tall according to his brother, tried to climb onto the platform.

After the incident, the area controller went to buy cigarettes and then was taken by ambulance to Royal Prince Alfred Hospital to be treated for shock. He no longer works for RailCorp.

In the Sydenham office, meanwhile, phone records show that signallers packed away laptops that they were not meant to use at work.

The OTSI issued 10 recommendations to RailCorp this week, and a coronial inquest is ongoing.

"My brother's life should not have to have been taken like that," said Mr Mihaere yesterday.

Source – adapted from
http://www.smh.com.au/nsw/catalogue-of-errors-puts-man-in-way-of-a-train-20120208-1rf16.html#ixzz1msXlisPJ

Case Study 1

Analysis

There were many 'small' things involved in this tragic accident. Many of them happened well before the actual accident, and all of them were of little importance on their own. Your task is to discuss this reading and use it as a background document to develop comments and notes on the following issues.

Once you have competed this task, you will be leaving this group to join other groups – so it is important that each member of the group has their own comprehensive notes to take with them.

The Actors and the Stage

There are always a lot of individuals involved in any story of events in an organisation. This is because *organisations* are collective entities. There are hierarchies of authority and decision-making, broad bands of similar jobs and tasks, and differentiation along lines of roles and responsibility.

While all these are designed to reduce complexity and increase the likelihood of getting the job done efficiently, they can also make it very difficult for individuals to actually.

1. Who are all the actors in this story? Do not stop at the people mentioned in the article. Think beyond the immediate event. Who else will have been directly involved after the events of this tragic evening?
    a. What is the environment?
2. What words will you use to describe the setting of the whole organisation. Is it in a relaxed and carefree state? Or taut and often criticised? Is it doing a simple job? Or a very complex one?
    a. What might conditions be like at Kogarah – or any railway station - at 1.08am?

Intention

One of the key issues in learning to understand and operate effectively within any workplace culture is the perception that no one intends to harm another person. Can you assume that everyone has a conscious intention to behave with due care for self and others?

3. List ways in which good intentions were evident but insufficient in the way they were carried out – on this occasion.

Awareness

The University of Wollongong Engineering Graduate Capability continuum lists the following as a vital capability for engineers

- *Be flexible, thorough, innovative and aim for high standards.*
- *Work collaboratively and engage with people in different settings.*
- *Recognise how culture can shape communication.*

Engineers Australia lists as a key **Attribute of Graduates from an Accredited Program**

- *Understanding of professional and ethical responsibilities and commitment to them*

These are neither simple nor easy to sustain. This unit of study is designed to help you consider your own present state of awareness.

4. While it may be 'easy' to blame all/any of those whose actions are described in the article, what factors might have inhibited their respective abilities to attend to these capabilities on that night?

Recommendations

The NSW Office of Transport Safety Investigation final report makes fifteen separate recommendations for the two organizations to implement. If you have access to the Internet you can read the report at

http://www.otsi.nsw.gov.au/rail/Investigation-Report-Kogarah-Fatality-final.pdf

5. **List at least six actions** that either/both organisations could take to improve attitudes and behaviours around safety in their workplace cultures.

Use the following page to record your answers to each of these questions.

Worksheet for Engineering Across Cultures 3 – Case Study 1

The Actors and the Stage

1. Who are all the actors in this story?

2. What is the environment?

Intention

3. List ways in which good intentions were evident but insufficient on this occasion.

Awareness

4. What factors might have inhibited abilities to attend to the key safety factors on this occasion?

Recommendations

5. Regardless of your access to this report **list at least six actions** that – in your opinion - either/both organisations could take to improve attitudes and behaviours around safety in their workplace cultures.

Work together to complete these tasks.

Task	For your notes
Report. The teams are working on different Case Studies. First each group member introduces your case study and describes the discussion, summarising key elements you recorded on Part A of this worksheet. Use this space to make notes.	Use this column to make notes.
Identify. There are similarities and differences among the case studies. Working together construct a comprehensive summary of all the factors you can find. Where new ideas emerge from this discussion list them also.	
Cues and Actions. The information you have now complied can be used to develop a list of cues and actions to help identify aspects of underlying workplace culture. You can also being to construct a list of actions you might employ to ensure you enact good practice in regard to the organisational culture issues examined in each case study.	
Presentation. Knowing *about* such things is not enough. By presenting this information in an attractive and memorable manner you demonstrate what you have learned and assist others to learn with and from you. The next page sets out options for collating and presenting the data. The choice of what to do is all yours.	

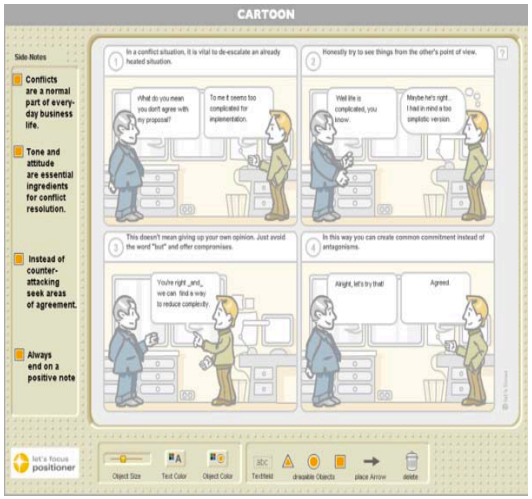
Presenting your agreed Cues and Actions in a visual mode.

The graduate attributes addressed in this Unit include communication skills. In this final activity you will exercise your ability to develop a visual representation of your discussion. Signs, symbols, images, diagrams and words are all forms of communication.

On the following page are four ways in which you could so. However if you know of other ways, or someone in the group is proficient in any from of visual representing of information you may prefer to use that.

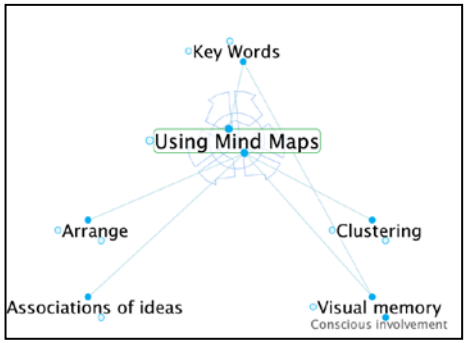
You have 20 minutes to use one or more of the A3 sheets of paper to prepare your summary for display to the whole class.

Comic/cartoons



This works likes this–

1. *First – decide a 'story' to share.*
2. *On the left hand side list key messages you want to convey. As this example says keep it simple. Have only 4 to 6 steps or items.*
3. *Draw a 4 to 6 stage process using cartoon figures. There are no prizes for drawing – everyone is interested in the content not how the figures look.*
4. *Engage the actors in a conversation - each adding new ideas to the story.*

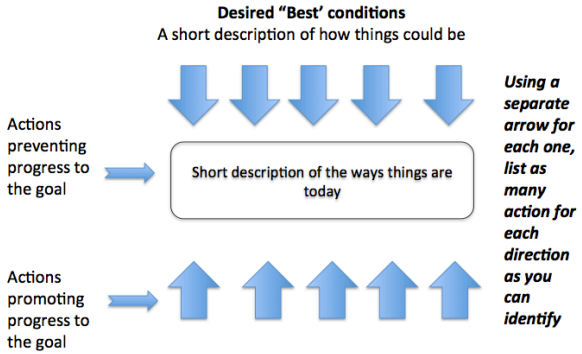


Mind map

A Mind Map is a picture showing connections and relationships among ideas. Begin with a key, organising idea in the centre of the page. Then draw lines out ending in circles where you write the ideas and connections you want to illustrate.

A Mind Map can have several layers when each idea has related ideas connected to it moving further out from the centre. The main ideas to remember are listed in this Mind Map – use Key words, Arrange new items to allow you to show relationships, Cluster like ideas, use any means you like to show Associations among ideas, and draw images to help with recall of the concepts.

Force Field Analysis



This image tells the viewer about four important variables in a situation:

- *Where things are now*
- *Where it is hoped to be*
- *What is stopping/slowing progress*
- *What is creating/causing forward momentum*

To help your audience list as many factors on both sides of the equation. What are all the possible factors causing the movement towards change?
What are all the possible factors holding things 'is stasis' at this moment, and therefore causing a lack of progress towards change?

An 'iceberg diagram' shows the visible factors that can be seen by everyone, and 'below the water line' factors that create and support the 'above the water line' barrier. As in maritime disasters, it is often the hidden factors that create the most damage.

Iceberg diagram

This kind of image is intended to illustrate the relative size of elements in a complex situation.

In developing a "Tips and Actions" visual image, using an Iceberg, you could list the visible and hidden elements, which your Tips And Actions are designed to help you respond to. Then you can – for example - include a boat carrying the cargo of your ideas [remember to list them in some way] navigating safely past the iceberg.

The key factor in such an image is forcefully reminding your viewers of how much may be hidden from view and therefore even more dangerous.