

existed (Oakley uses a hexagon).⁴ Thus, events and causal factors charts provide considerable flexibility for sorting out the sequence of events, conditions associated with the events, and the causes of the conditions and events. All this information will directly help the investigators understand how and why the incident occurred.

An example of an occupational fatal fall is offered to illustrate how the events and causal factors chart can be used to clarify the sequential events. Figure 9.3 uses three rows to organize events into three phases. The top row contains the preliminary events that set up and allowed the man to fall. The second row contains the sequential events from loss of control to injury. The third row contains the relevant response events subsequent to the injury.

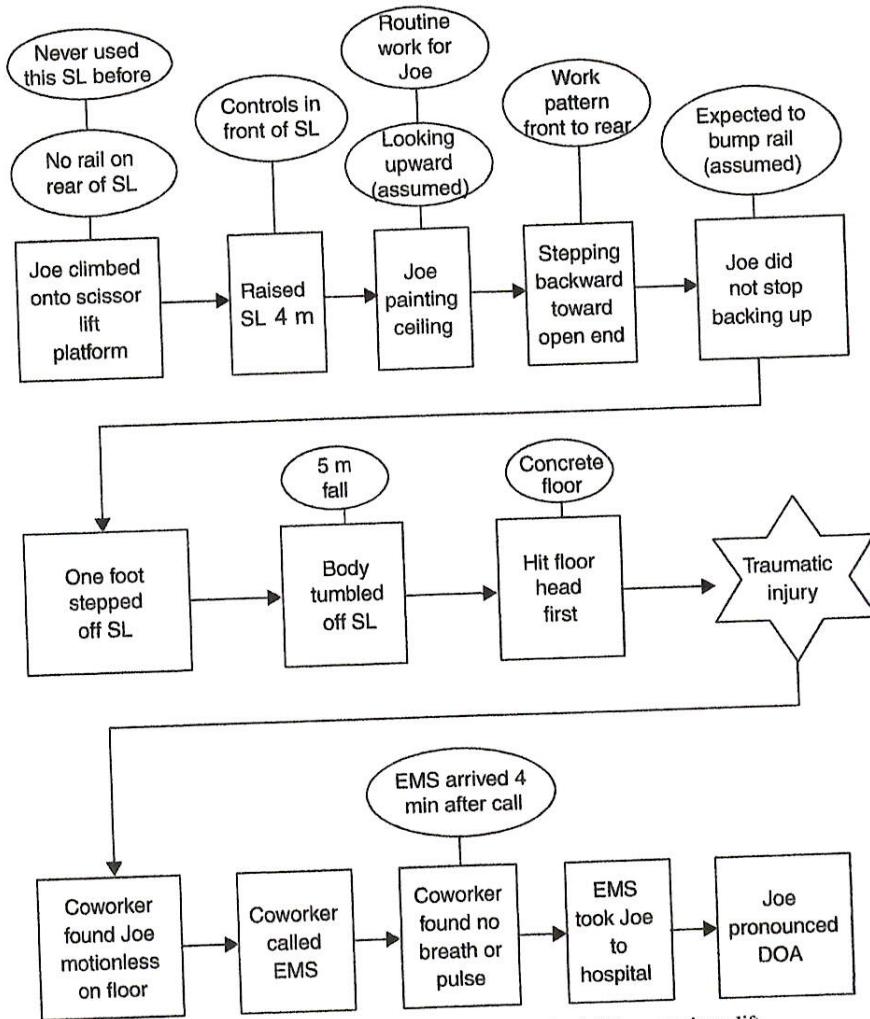


Figure 9.3 An event and causal factors chart for fall from a scissor lift.

A painter named Joe was painting working from a scissor lift (SL) elevated about 5 m above the floor. The SL was crew at the site. The railing on the lift platform had a swinging, self-closing rail at approximately midrail. Workers could enter the platform rail as a door. However, the old borrowed a chain.

Information obtained from other investigators to determine the normal method of painting a ceiling involves constantly then start in the front of the platform and then the back rail. They even call this a "burst" front to begin another cycle. After obtaining a coworker, and interviews with other painters as shown in Figure 9.3.

The chart begins with Joe climbing the scissor lift to start further back in time in order of using one owned by his employer. The chart shows a SL he could easily see was lacking a rail. The point where investigators should begin is where the rail was missing.

Benner proposed a place to begin the investigation for an event that started an uncontrolled function of a system. A brief explanation of the rationale. Think of the daily activities of a person in a controlled manner or in homeostasis. The person deals with the occasional deviation from normal (caused by human response or engineering error) and occurs and fails to be detected and initiating of a potentially uncontrolled event to various outcomes ranging from minor to fatal. Investigators know what events led to the injury and try to determine why the injury happened afterward.

In the illustration, the deviation was caused by the unfamiliar SL with a missing guard rail. The event sequence deviated from his normally successful use of the company's SL. Thus, the event sequence starts with the deviation event and ends with the fatal event. The mental focus on his body position relative to the scissor lift is a single-channel processing task. Joe was focused on his position and the roller brush applying