Unit 3 MOS 5101

Kathryn Campbell

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# Introduction

I had served as mechanical support assistance in a manufacturing company which was famous for its sportswear. It was my routine to experience many new inductees taking charge of their duties. At times, I was surprised how these inductees were well-trained to perform their tasks, but sometimes, some unfortunate incidents shook my whole body and I could not sleep for the next complete week. I still remember when John Duggan, the twenty-year-old worker, felt from the height of fifteen feet. He was trying to climb the storage rack, which fell over him, due to his slight negligence. He had to land on his knee which caused extensive damage to his muscles. After the incident, the first aid worker of the facility took him to the rescue center where he was given medical aid. The facility where this incident happened, was a three story building, which was equipped with multiple sewing equipment, along with storage tanks of fuel placed at the left corners. The storage tank, which fell over Duggan, was placed at the right corner, which was fifteen feet tall.

#  Steps Required to Investigate the Accident

The steps that I would take to investigate the incident will involve:

## Arranging First Aid

 Taking the corrective measures in terms of preventing more damage to human sufferings will be my first priority. For this purpose, I will arrange the first aid equipment available in the vicinity.

**Securing the Incident Place**

After removing the injured people from the workplace, I will secure the place of incident and will not allow any further movement near or toward that area.

## Collecting Evidence

 I will collect evidence which I think, will aid in further investigation. Though, this phase is a bit technical, but a thorough understanding of the workplace environment adds to ease in this process.

## Conducting Consultations

 I will consult other eyewitnesses of the event and will seek their advice in order to cope with this situation.

## Identifying Root Cause

 When done with the initial consultations and observation, I will search for the root cause of the accident. In this case, I believe his slight negligence was the cause of the accident.

## Preparing the Report

 I will prepare the report based on my initial observations and findings after consulting with other eyewitnesses.

## Recommending the Corrective Measures

 I will propose the corrective measures in my final report based on the situational analysis and the resources available.

# Theory applicable to the accident

 The ergonomic theory of the human factor is applicable to the incident. As this theory suggest that human interaction with other elements in a system might cause any incident, therefore, by this way, the ergonomic theory of human factor falls best to case of John Duggan (Garcia et al. 2015). The ergonomic theory is just not related to proposing the incident causes, rather it proposes the rudimentary measures, which include optimizing human wellbeing etc. It also talks about making effective overall system performance as well (Yoshifumi, Premkumar, and Manzuma-Ndaaba 2017). Based on such propositions of this theory, I will recommend the corrective measures as well.

# Conclusion

 John Duggan incident, although quite explainable, but invites different perceptions when it comes to analyzing it with a view of the workplace incidents. This incident was the result of human interaction with the equipment which was vulnerable to human interaction. A careful approach to setting the equipment might have avoided this incident. The reports which include the situational analysis often include such incidents as well. The only remedy these reports suggest is avoiding the unnecessary interaction with equipment at the workplace.

# References

Garcia, Patricia Petromilli Nordi Sasso, Ana Carolina de Araujo Gottardello, Cristina Dupim Presoto, and Juliana Alvares Duarte Bonini Campos. 2015. “Ergonomic Work Posture in Undergraduate Dentistry Students: Correlation between Theory and Practice.” *Journal of Education and Ethics in Dentistry* 5(2): 47.

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