

Arbeidslag-spilletets estetikk og evnen til å forutse (The aesthetics of teamwork and the ability to foresee)

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Introduction

Safety is an ambiguous word and still we all know what it means. A process or activity is safe if no one is hurt and no losses incurred, as it happens or as a result of it. Safety is a quality, like success, and a component of the quality called success. Such qualities are easy to recognise both when they exist, and when they are absent. This is both a benefit and a problem when researching safety. It is a benefit because it is easy to agree on what the goal of the research should be: To increase safety. It is a disadvantage because the ability to identify a quality is not the same as being able to understand how the quality is generated.

The dominant opinion among safety administrators and researchers alike has, for quite some time, been that the best (and only?) way to achieve and improve safety is through standardised control mechanisms in the form of mechanical and organisational barriers. The latter term is a synonym for procedures. This consensus is starting to fray, however. An increasing number of practitioners and academics are realising that procedures do not guarantee safety, and may even, in some contexts, be obstacles to safe operations. They are now broadening their inquiries to try and achieve richer, more nuanced and hence more realistic understandings of how safe processes and outcomes are actually achieved during complex operations such as offshore work. The article by Røyrvik, Skarhold, Lamvik and Jonassen (2015): *The Balance between control and autonomy* (ISBN 978-1-138-02681-0), presents one example of how to understand how safety is achieved when procedures are not adequate, and the present research is another example of the same.

Setting

The topic for this article rests on the observation of a spontaneous and successful incident that unfolded on an anchor handling vessel during a pre-lay operation somewhere in Norwegian waters sometime in the period 2013 to 2015. The vessel was in the middle of the operation when one of the rollers got stuck. The rollers reduce the friction on the wires and chains when they are fed out to put the 15 000 kg anchors exactly where they need to go. Six more anchors remained to be placed, and the roller had to be freed to continue with the operation. The tensions on the chains gliding over the non-rotating roller was visible – a puff of smoke and a few sparks flew every time a chain link slid over. The rest of the operation could not be completed without freeing the roller.

The ship was one week's journey from the depot, and two days journey from the nearest mechanical workshop. If the stuck roller could not be freed the ship would have to break off the operation, go to shore and return. At least four days would be lost.

The observed phenomena

The researcher happened to be in the dirty mess when one team of AB's signed off and another signed on. Not long after the change, one of the bridge officers informed the AB's, over the radio,

about the roller that was stuck and asked them to have a look at it, at their leisure. Soon after the three AB's began the task of investigating how and why the roller was stuck, and in the process they invented a way free it. The entire procedure; finding out what was wrong, trying out different ways to free it, and then succeeding, took approximately half an hour.

In some ways this is not extraordinary; seafarers solve practical problems all the time. In other ways it is an intriguing incident because it did not contain any of the elements found in the dominant way of ensuring a safe outcome. The AB's did not talk about the problem before they set out to investigate it. They did not have a "tool box talk", did not discuss how to approach it, no plan was made, a "risk assessment" was not conducted, and no document was prepared and ticked off. The bosun just got up out of his chair, donned his work gear, seized a ladder on the way, leaned it against the stuck roller and climbed up; 4 meters above the deck. He did not say much and did not ask the other AB's to help. They watched him intently, and the moment he signalled, even without saying anything, what he needed, they brought it. The second AB then climbed up on the wall next to the roller, and assisted the bosun, while the third AB moved the cranes into position. One unsuccessful solution was tried and abandoned, then another. The AB and Bosun working on top of the roller moved gracefully and smoothly together, 4 and 5 meters above deck, one standing on a ladder leaned against the roller that was stuck, the other riding on a protrusion of the wall right next to where the roller had jammed. The bosun then came up with another solution, the AB climbed down, and started working the second crane. Together they managed to free the roller.

I observed and tried to keep out of the way. As an observer I was struck with how the success, and the safety of the operation depended on two things: Highly competent practical skills combined with an acute ability by the AB's to observe, and correctly predict, what the other AB's would need assistance with at any and every moment.

What it means

Analytically the article explores the interactional flow among team members who carried out the operation. My concern is with foresight as a necessary condition of social organisation and I argue that in this type of social organisation (anchor handling operations) the actors need to approach the future in two mutually exclusive ways at the same time. On the one hand they build foresight through crating and employing procedures, and on the other hand through participation in each other's work performance. The latter means that they continuously try to foresee (or forecast) what will happen and what the others will do. I argue that when something unexpected happens successful solutions of the problems depend on teamwork that flows smoothly and gracefully because team-members are able to assume each other's positions and anticipate what the others will do without verbalising it. In this process the act of imagining the future, and the acts needed to be executed in the future, cannot be explicitly conceptualised and formulated because the aesthetic qualities of flow and grace demands that actors never linger with that which has happened, but continuously shift their attention towards the future, what will happen, and what the others will do.

Conclusion

The first point of the article is to demonstrate the details of how safety is achieved when something unexpected happens. The second point is to show that sometimes safety is achieved because procedures are ignored because they are not relevant.