

Investigating Organisational and Process Incidents “How not to blame the workers”

As is widely known, incidents involve organizational factors, workplace factors, and unsafe acts/human factors. Yet, management often attributes safety incidents to human error or unsafe acts, not accounting for the work environment that contributed to the worker engaging in risky behaviour. When management attributes safety incidents to unsafe acts without accounting for the work environment, leadership personnel communicate values to their employees that suggest safety performance metrics are valued over human safety. Although incidents occur because of a failure in the system, there continues to be a tendency to blame the worker. Factors that may not be evaluated by management include inadequate training/supervision, tight project schedules and budgets, extended work hours that result in sleep deprivation, and work-life balance stress caused by shift work, to name a few. Further complexities are added when injury-free project awards and monetary bonuses are tied to contract safety performance if a system values zero-incident targets. Safety performance bonuses may encourage workers to not report or minimize injuries for their benefit or when safety performance bonuses are tied to team performance.

A person who believes that most injuries are caused by employee behavior can be viewed as a safety bully. This belief could influence a focus on the worker rather than the culture or management systems, or many other contributing factors. As Deming warns, “Don’t blame people for problems caused by the system.” When safety programs are promoted on a premise such as “95% of all workplace incidents are caused by behavior,” one can understand why union leaders object vehemently and justifiably to such. Claiming that behaviors cause workplace injuries and property damage places blame on the employee and dismisses management responsibility. Most worker behavior is an outcome of the work culture, the system. It is wrong to presume that behavior is a cause of an injury or property damage. Rather, behavior is one of several contributing factors, along with environmental and engineering factors, management factors, cultural factors and person-states.

Many incident investigations do not go far enough. They identify the technical cause of the incident, and then connect it to a variant of “operator error.” But this is seldom the entire issue. When the determinations of the causal chain are limited to the technical flaw and individual failure, typically the actions taken to prevent a similar event in the future are also limited: fix the technical problem and replace or retrain the individual responsible. Putting these corrections in place leads to another mistake—the belief that the problem is solved. Too often, incidents investigations blame a failure only on the last step in a

complex process, when a more comprehensive understanding of that process could reveal that earlier steps might be equally or even more culpable. In this Board's opinion, unless the technical, organizational, and cultural recommendations made in this report are implemented, little will have been accomplished to lessen the chance that another incident will follow. Paraphrasing, for emphasis: If the cultural, technical, organizational and methods of operation causal factors are not identified, analyzed and resolved, little will be done to prevent recurrence of similar incidents.

Finally, when an employer focuses on prevention by using root cause analysis, public trust can be earned. Employers with an incident free record may be more likely to attract and retain high performing staff. A robust process safety program, which includes root cause analysis, can also result in more effective control of hazards, improved process reliability, increased revenues, decreased production costs, lower maintenance costs, and lower insurance premiums.

Getting to [the causal factors] should be the real reason for an incident investigation. Typically, the fault is often blamed on the employee that was involved. Be it 'mind not on task', 'in the line of fire', 'complacency', etc. This is just the easy way out, and not taking ownership of what the true issues are at hand. Fault tree, RCA, FMEA, or whatever tool companies use, if the investigator is not trained well enough to recognize what they are looking at, then the exercise is futile

We Investigate incident independently to assist the company to find all contributing factors (Organizational factors, workplace conditions, human factors) in order to determine the root causes of the incident.

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