

SAFETY BULLETIN

Ensure your Team is Prepared!

Understanding Human Error

W. H. Heinrich's "Causation Theory" that dates back to 1959 on human error has been credited as one of the primary scientific studies on accidents. Heinrich's work involved over 75,000 accident reports and indicated 88% of those events were the result of unsafe acts. Recent studies indicate as many as 92.5% of all accidents are caused by unsafe acts.

It is easy to point to the injured employee and ask "What were you thinking". High Reliability Organizations understand the actions of an employee were logical at the time, it was the result that was undesirable.

The legendary educator and author Dan Peterson wrote in 1997 "If you want to improve your safety performance, put away your accident statistics and start listening to the real experts on safety - your employees".

Today's leaders understand safety is a people issue. However, High Reliability Organizations understand it is more than a people issue, it is both a cultural and an organizational issue. Employee's actions are logical at the time of the accident.

The flaws in work behavior are the result of many factors. Those factors are best identified by the employee. It is the employee that works within this environment on a daily basis. The 360 degree approach to safety enlists every employee in identifying problems and solutions. This is an evolved process that produces unequalled results.

It is easy for safety committees or managers to fix blame when reviewing an injury report. On the surface it is easy to identify an error that is a contributing factor in the injury. A firefighter is injured in an apparatus accident involving a collision with a civilian automobile. The firefighter was not wearing a seat belt and suffered injuries from impacting a side door inside the apparatus. An easy response to the error would be to end the investigation with the conclusion that the injury occurred from a policy violation by the employee for failing to wear a seat belt.

A High Reliability Organization would drill down on the obvious and repeatedly ask the question "Why". Why didn't the firefighter have their seat belt on? After a thorough investigation you might find the firefighter had worn their seat belt the entire call until just moments before the accident. The firefighter had been notified by the engineer that they were only seconds from arriving at the scene. At that moment, the firefighter unbuckled their seat belt and began to prepare for the emergency (a common practice in the fire service). It is somewhat ironic that the seconds just before arriving at the scene are among the most dangerous of the entire response.

A High Reliability Organization would identify the root cause of these firefighter's injuries and move to change the behavior of the organization through education and training.

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