FOCUS ARTICLE

Stopping the Cycle of Recurring Incidents

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Repeat occurrences of workplace accidents are regrettably not unusual. Prevention starts with understanding why they recur and taking concrete steps toward improving leadership, investigation processes, exposure prevention and human factors.

Reducing or eliminating on-the-job incidents is unequivocally a worthy goal and one embraced across industries and organisations. And while progress has been made through regulatory frameworks, organisational investment, research, technical and technological improvements and more, accidents not only continue to occur, but often at times reoccur–that is, the same scenario repeats itself, perhaps with more serious consequences the second (or third) time around. What's behind the recurring incident phenomenon? It comes down to failures in one or more of four areas: leadership and culture; accident investigation; exposure prevention; and human factors.

Leadership Missteps

Leaders set the tone and determine a company's culture by what they prioritise and reward. They have the means–by setting the budget, implementing initiatives, shaping processes, recruiting and more–to influence every aspect of their organisation. By comparison, a shop floor worker has relatively little control beyond their own behaviour. This power imbalance points to where responsibility lies when the issue is safety.

Leadership may inadvertently foster the conditions that lead to repeat incidents. It is not unusual, for example, to find organisations celebrating production speed and increased output and holding up those who achieve or exceed targets as role models for others in the company. If **safe behaviours** are not equally recognised and rewarded, the implicit message is that production takes precedent over safety. Short cuts may soon become how things are done, and a tolerance for cutting corners ends up ingrained in corporate culture. If an accident takes place with relatively minor consequences, but production is uninterrupted or even improved,

whatever led to the accident will receive little to no attention and will remain as a latent risk.
Neither does it make sense to penalise people when incidents do occur. The most likely outcome here is that accidents either go entirely unreported or are minimised or falsified. An unreliable reporting system undercuts its value, which is to describe accidents, uncover the risks and exposures that caused them and ultimately to learn from them so that they do not happen again.

Investigation Issues

A failure to learn from the past is a major driver of recurring incidents. In addition to the benefits of strong regulations and competent regulators, a robust reporting system that emphasises the opportunity to learn inherent in every incident is both rare and essential. Indeed, accident investigations should focus on future prevention, which requires a transformational process: an examination of the full context of the event in question, from failed defenses to cultural and environmental factors, leadership and beyond.

Unfortunately, investigations can be quite narrow, lacking context and focusing on outcome rather than exposure. A fall from a moderate height, for example, can result in mild to serious injury or even death, so that two or more individuals who take the same tumble can suffer vastly different consequences. Determining the level of exposure underlying the incident is both more meaningful in terms of prevention and more complex in terms of process.

Overlooking Exposure

Exposure to potentially fatal risks ought not to be obscured by an approach that favors attention to outcomes. There are disturbing signs, however, that is exactly what is happening. While the number of non-fatal accidents is trending downward, efforts to improve safety have done little to prevent or even reduce Serious Injuries and Fatalities (SIF). In fact, despite heavy regulation and some of the strictest standards on the planet, more people died in workplace incidents last year than in the preceding year in the UK, the US and Australia.

The NASA Challenger disaster tragically illustrates one of the ways outcome overshadows exposure. During a series of successful launches, scorch marks were observed on the space shuttle's o-rings. Although they pointed to a potential risk exposure and certainly constituted a deviation from ideal conditions, the burns became normalised as they coexisted with positive outcomes. Until they didn't.

A faulty approach to exposure prevention could also be to blame. In the hierarchy of hazard controls, prevention efforts should begin with elimination and proceed through substitution, engineering,

administration and PPE (Personal Protective Equipment). If leadership looks for ways to completely remove the hazard, substitute it with something less risky or isolate people from it with engineering solutions, the results will be more effective hazard control and exposure prevention. The most prevalent approaches, however, are administrative measures aimed at changing the way people work and providing PPE, another remedy that relies on human behaviour. Both are demonstrably inferior to elimination, substitution and engineering when it comes to reducing risk.

Ignoring Human Factors

The challenges of changing or adapting human behaviour are reflected in the hierarchy of controls, where the prevention methods most reliant on manipulating how people act are the least effective. In part, an ignorance of **human factors** is to blame for this lack of efficacy. The human brain is wired in ways that, if left unaddressed, can undermine safety efforts. Humans are prone to both risk blindness and risk tolerance–either they simply do not perceive certain dangers or, despite seeing them, discount the real risk they pose. These tendencies often arise through habituation to repeated tasks and those more experienced are naturally less alert to possible hazards than novices. With targeted training and consistent reinforcement that take brain science into account and includes calibration, people can be taught new patterns of behaviour. An organisation that is unaware of or chooses to ignore human factors, however, may be primed for repeat incidents.

Breaking the Cycle of Repeat Incidents

Fortunately, there are proven ways to correct the errors that lead to serial accidents. **Leadership coaching and interventions** aimed at improving organisational culture make a difference in "how things are done." Companies can implement effective incident reporting systems and overhaul investigation processes so that learning from experience actually takes place and translates into fewer accidents, injuries and fatalities. New technologies can support organisations' efforts by tracking data such as which types of controls are adopted for exposure prevention–more elimination and less PPE, for example. Finally, there are solutions to strengthen awareness of human factors and improve human performance reliability in the service of safety.

DEKRA Organisational & Process Safety

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In terms of behavioural change, we deliver the skills, methods, and motivation to change leadership attitudes, behaviours and decision-making among employees; supporting our clients in creating a culture of care and measurable sustainable improvement of safety outcomes is our goal.

The breadth and depth of expertise in process safety makes us globally recognised specialists and trusted advisors. We help our clients to understand and evaluate their risks, and work together to develop pragmatic solutions. Our value-adding and practical approach integrates specialist process safety management, engineering and testing. We seek to educate and grow client competence to vide sustainable performance improvement; partnering with our clients we combine technical expertise with a passion for life preservation, harm reduction and asset protection.

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We have offices throughout North America, Europe, and Asia.
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