MANAGING THE RISK OF PEOPLE NOT PAYING ATTENTION
By Cristian Sylvestre, Managing Director of SafeStart

Can all hazards be eliminated in a practical sense? Of course not, things are always changing one way or another.

Although human error is a part of everyday life, there has been a reluctance to look at reducing the unintentional mistakes we all make that can get us hurt. It’s much more popular to try and “fix” something.

While “blaming” someone doesn’t achieve anything, doing nothing “accepts” that the injury was not preventable. Fixing something that doesn’t contribute to the injury or re-training someone that doesn’t need to be isn’t going to get you anywhere either.

Of all the examples that come to mind, the most extreme (in terms of fixing something that didn’t contribute to an injury) was of a worker who was walking backwards in the car park telling co-workers a joke. He tripped on a concrete parking divider, fell down and broke his wrist. As a result, the employer decided to paint all of the concrete parking dividers yellow. Even the most devoted safety supporters recognised the ridiculousness. “What good would painting the dividers any colour achieve? Unless the workers have eyes on the back of the head, they are not going to see it, no matter what colour it is …..”

So, can human error be minimised? Yes, by understanding what causes people to make errors or mistakes – and working on those human factors.

When 20,000 people in 300 organisations were asked what type of mistakes they made without meaning to, the number one response was “eyes not on task”. The top four responses (referred to as ‘critical errors’) were:

- eyes not on task
- minds not on task
- (being in or moving into the) line of fire
- (loss of) balance/traction/grip

Those 20,000 people were asked then what causes people to make one or more of the four critical errors, the number one response was “rushing”. The top four responses (referred to as ‘states’) were:

- rushing
- fatigue
- frustration
- complacency

People reported that they were most likely to make one or more of the four critical errors whilst in one or more of the four states.

In your own experience, can you think of an injury that you’ve had where you were not actually in at least one of the four states (rushing, tired, frustrated or...
 complacent) looking at what you were doing, thinking about what you were doing, aware of the line of fire and conscious of losing your balance, traction or grip? When the 20,000 were asked that same question they came up with very few legitimate scenarios that didn’t involve equipment malfunction (an event like a flood or a cyclone) or someone else doing something to cause the injury - but these contributed to less than 5% of all injuries.

What that tells us is that people making unintentional mistakes is a significant factor in people getting injured. It also tells us that the four states and four critical errors are involved in over 95% of incidents people have.

What this research established was that when people are in one or more of the four states, they are most likely to make one or more of the critical errors. When they make one or more critical errors, they increase their risk of getting injured. We refer to this as the universal ‘state to error’ pattern of human behaviour.

Incident Causation

If we look at our personal injuries, what we notice is that when someone gets injured, either the person came into contact with the hazard or the hazard came into contact with the person. The two parts of this “interaction” are the hazard and the person.

Historically, we have focussed on the hazard at work. Most organisations use the hierarchy of controls in a Safety Management Systems framework to deal with the hazard. These include inductions, risk assessments, take 5s, training, procedures, rules, permits, incident investigations, audits and other aspects which are all useful in managing the hazard and reducing injuries.

What we haven’t focussed a great deal on is the person – either doing or not doing something to put themselves ‘at risk’.
When we started looking at the ‘at risk’ behaviours of people in detail, we noticed that there were two types:-

- deliberate – things people do on purpose, for example, someone choosing to take a short cut or not following a procedure/rule
- unintentional and/or habitual – things people do without meaning to or when they are in ‘autopilot’ mode

Most people recognize that not paying attention contributes significantly to people getting injured.

Deliberate ‘At Risk’ Behaviour (Judgement)

However, the tendency is for organisations to address behavioural causes of injuries by assuming that our behaviour is always deliberate - that is, whether we get hurt or not depends on the ‘choice’ we make for ourselves. If someone got hurt, it is because they:-

- made the ‘wrong’ or a ‘bad’ decision, or,
- don’t have the right belief when it comes to safety, or,
- don’t have the right safety attitude, or,
- don’t have their values aligned with those of the organization.

If the ‘at risk’ behaviour of an individual was deliberate, then we can understand why organisations would focus exclusively on ‘safety leadership’ and ‘peer to peer safety observation’ programs. When something is deliberate, another person can influence the individual to make a different decision (i.e., safer) next time. This has been the approach advocated by safety consultancies including those with a psychological background.

But if it is always about the ‘wrong decision’ why do so many people still make these ‘wrong’ decisions so often.

Could there be something else at play here?

Unintentional and/or Habitual ‘At Risk’ Behaviour (‘Autopilot’)

Our view is that there certainly is and it has been ignored so far by the safety profession. That is, there is something ‘automatic’ about how we interact with the environment around us (including hazards) that does not always mean a decision was involved in how we behave.

What is that? We believe it’s the universal state to error pattern of human behaviour. For example, have you ever received a speeding ticket when you didn’t mean to be speeding? Or have you ever gone through a STOP sign or red light because you didn’t notice it or noticed it too late to do something about it? Most people tell us that they have had experiences of this kind that did not involve a deliberate decision – it was a temporary moment of mindlessness.

The issue is that when the state to error pattern is in play, we are putting ourselves ‘at risk’ without even realizing it. We are not being mindful. It is not that we made the ‘wrong’ decision, it is that we weren’t even thinking about what
we were doing.

When there is no decision involved, other people cannot really influence the person’s ‘at risk’ behavior. In order for the person to make less mistakes, they need to be given the tools so that they can influence their own behavior. That’s what Human Error Prevention Skill Training does.

A holistic view of incident causation and the tools available to deal with all factors is illustrated below.

If safety culture is defined as ‘the way we do things around here’ – then this not only includes deliberate ‘at risk’ behaviour but also the unintentional and/or habitual ‘at risk’ behavior that needs to be included.

In other words, safety culture is a combination of organizational mindfulness (what influences deliberate ‘at risk’ behaviour) and individual mindfulness (what influences unintentional and/or habitual ‘at risk’ behaviour).

Which Tool for Which Problem?

We have thought about identifying the specific problem each of these tools are trying to solve. Our view is as follows:

- Safety Management Systems are for a Lack of Knowledge. The assumption is that people get hurt because they don’t know what can harm them and what controls they need to have in place. If they knew, they wouldn’t have been hurt.
Safety Leadership, Peer to Peer Observations and/or Cognitive Behaviour Programs is for the **Presence of ‘Incorrect’ Thinking**. The assumption we make is that people get hurt because they didn’t think correctly about safety (non-aligned values, inadequate beliefs, wrong attitude, bad decisions, etc). If they had thought about it properly, they wouldn’t have been hurt.

Human Error Prevention is for **Lack of Thinking**. When people get injured, it is not often because they didn’t know (<1% for personal safety at work, home and on the road combined) or because they weren’t thinking correctly (varies but usually approx. 10% for most workplaces). The reason they get hurt is because they weren’t thinking about what they were doing.

The problem that each tool is trying to address is illustrated below.

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**People Are Still Getting Hurt**

If you are finding that injury rates have plateaued or they seem to oscillate irrespective of what initiative is in place or how well it is being rolled out, ask yourself if you have identified the right problem and if you are using the right tool.

Ask yourself, are people still getting hurt because:

- there isn’t enough paperwork in place? Probably not.
- there isn’t enough commitment to safety or enough observations been made? Unlikely.
- people are not being ‘careful’ enough or paying enough ‘attention’? Most organisations report that >80% of incidents involve human error.
The most common indicator that human error was a significant cause in an incident is a report where the corrective action made was along the lines of:

- person to ‘take more care’ or ‘be more careful’ or ‘pay more attention’
- person needing counselling or coaching
- person to re-familiarise his/herself with procedure, risk assessment or JSA/Take 5
- re-training or re-inducting of someone who already knows what to do and how

If the real problem is human error, then reviewing or streamlining the Safety Management System won’t do much - neither will safety leadership training or a peer to peer observation program or cognitive behaviour programs. People need to be learn **what to specifically think about** when it comes to safety. This is what Human Error Prevention Skill Training does.

We do not advocate that organisations throwing away their efforts to improve their Safety Management System or stopping safety leadership or peer to peer safety observation programs or other initiatives. Everything we do to keep safety at the top of the agenda helps to reduce injuries. We just noticed that there was a “missing piece” to the injury prevention puzzle that everyone knows about intuitively (we know we all makes mistakes) but no one is addressing.

Because organisations are full of people that make mistakes they never wanted to make in the first place, helping them make less mistakes improves safety culture significantly and gets everyone closer to Zero Harm.

James Reason even states:

> **‘If human error could be managed through applied common sense, better rules and firmer discipline how is it that across different industries error patterns remain constant and people doing similar jobs in widely different cultural environments make the same kinds of errors time and time again.’**
About SafeStart and More Information

SafeStart believes in challenging the status quo by thinking differently about safety.

We help people discover that they are ultimately responsible for their own safety through their behaviour. We teach them how their behaviour facilitates how they interact with the world around and to acquire 'vital' skills that are:

- applicable at work, at home and whilst on the road
- simple to understand
- easy to apply

We do this by helping organisations implement human error prevention programs that are thought-provoking, educational and entertaining.

Organisations that have implemented the SafeStart program typically achieve 60-90% reduction in incident rates within 6-12 months irrespective of where they are culturally. Almost 2 million people have been trained in this human error prevention program world-wide.

Organisations that have implemented the training have also reported flow-on effects such as increased productivity, considerably less waste, better product or service quality and reduced property damage.

Introductory seminars into human error prevention are conducted periodically in capital cities on an annual basis. To register for a seminar or to obtain more information, please contact SafeStart on (02) 9354 0333 or visit our website www.safestart.com.au.

About The Author

Cristian Sylvestre is the Managing Director of SafeStart.

He is a human error prevention specialist – not from an academic or psychological perspective but from a practical one.

He is currently leading safety initiatives in a number of organisations by developing and implementing leading edge behavioural programs focused at the employee level.

He makes keynote presentations at conferences, runs human error prevention seminars & workshops and conducts training programs for clients in various industries.

Cristian has held various senior safety and environmental positions in ICI, Shell and other corporate organisations over a 20 year career where he has acquired a different way of thinking about safety.

Cristian holds Chemical Engineering Degree and a Masters Degree. He has been a past Vice President of the Safety Institute of Australia (NSW Branch).

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