Southern Company

FIX THE WORKER vs FIX THE SYSTEM

Jeff White
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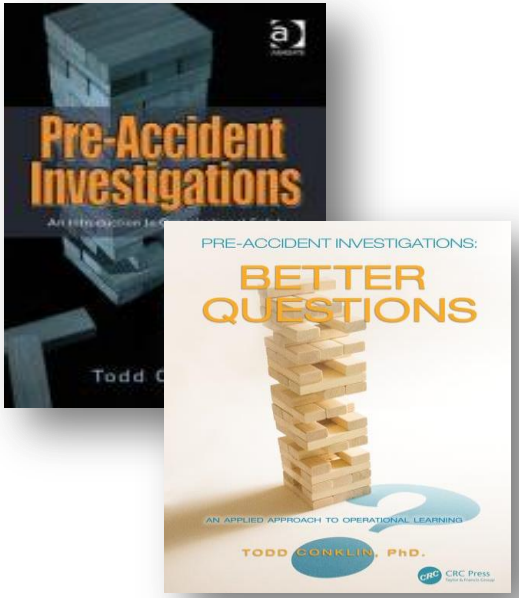
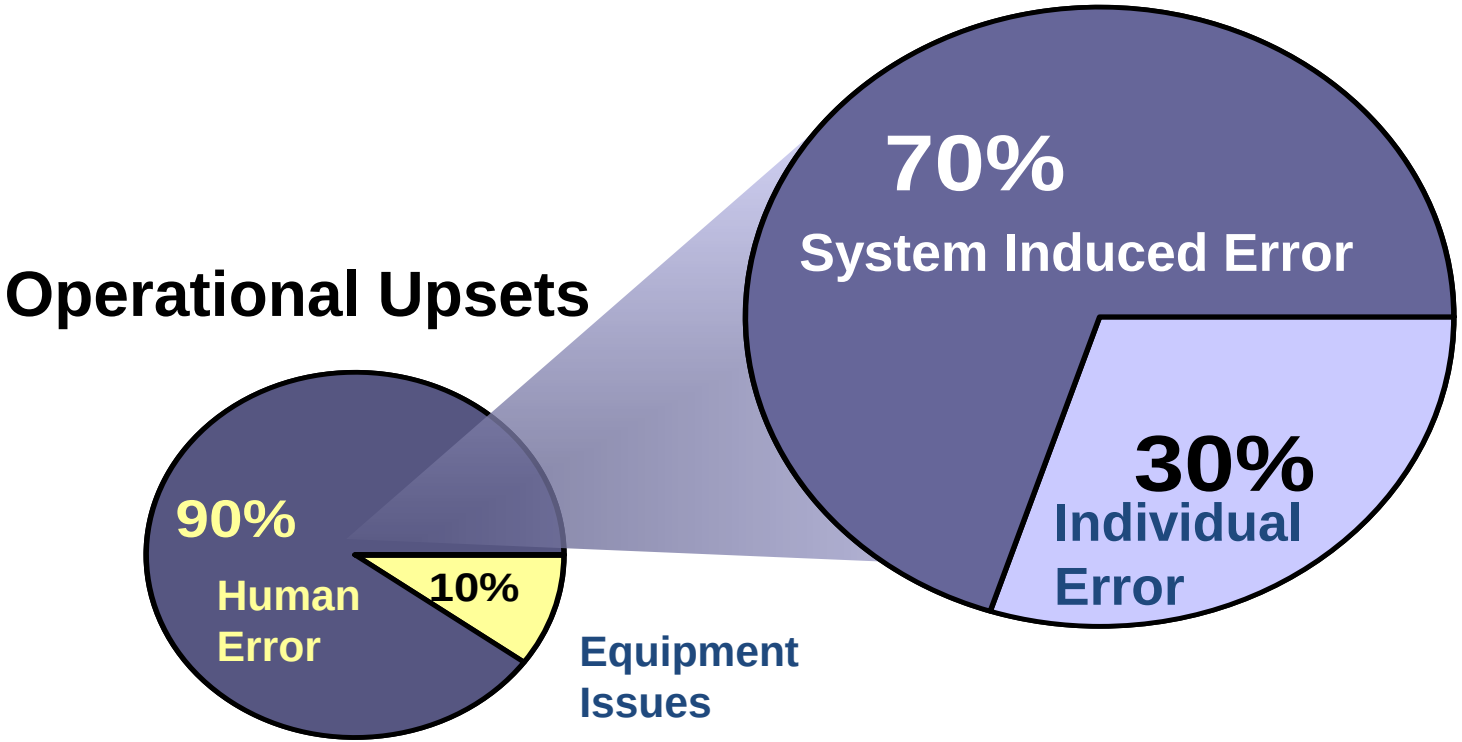
REFERENCES



Dr. Todd Conklin
PreAccident Investigation Podcast

Mr. Bob Edwards
http://hopcoach.net/

Origin of Human Error



Traditional RCA vs Event Learning Process

Root Cause: **Human Error**

Investigations found inaccurate assessments and bad decisions

Findings list what workers:

- ✓ should have done…
- ✓ could have done…
- ✓ failed to do…!

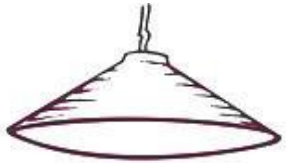
Human error is a symptom of trouble deeper inside a system

Don't stop at where people went wrong...

Find out how peoples' actions and assessments **made sense at the time** given the circumstances that surrounded them.

The Old View Approach

- Starts with the worker
- Focuses on “why”
- Looks for a “root cause”
- Tries to fix the employee
- Crime and Punishment
- Makes the worker feel guilty

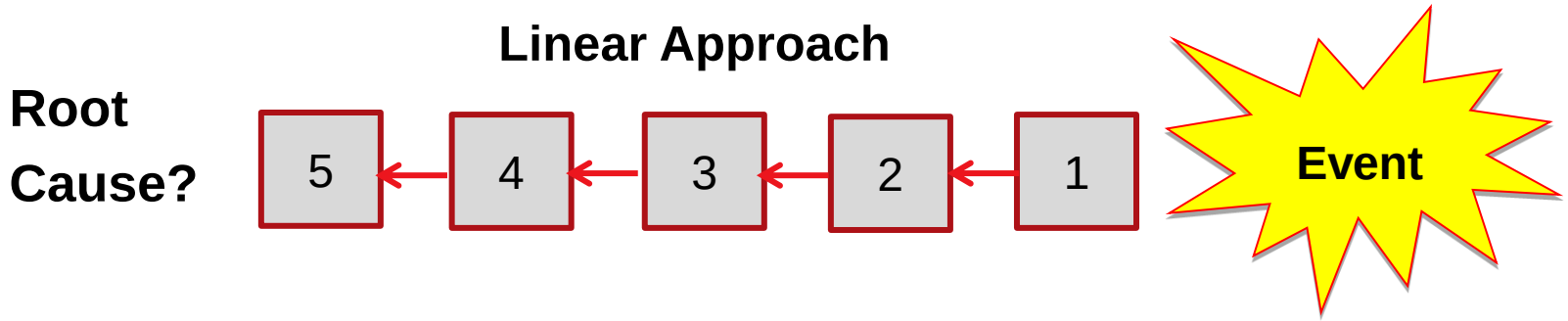


The New View Approach

- Starts with the Process
- Tell the story of “how”
- Identifies latent conditions
- Fixes the process, build defenses
- “Diagnose & treat”
- Makes our organization better

Our traditional approach . . .

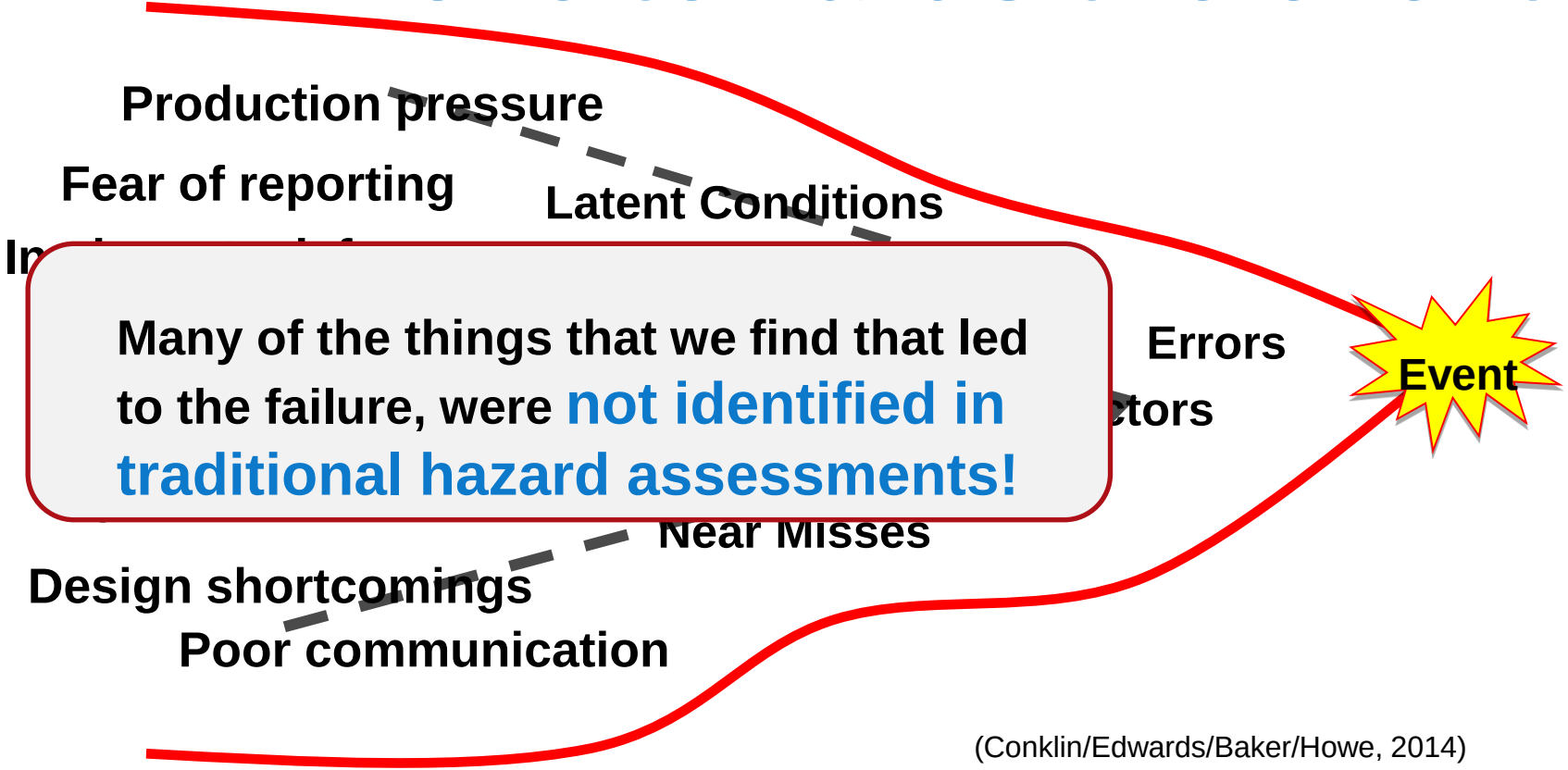
. . . looked for root cause



The problem is, the failure was not linear . . .

. . . and there almost NEVER is one root cause.

Start back in process . . .
. . . move towards the event.



(Conklin/Edwards/Baker/Howe, 2014)

Shift the question from **“why”** . . .

. . . to **“how”**....

“Why” drives us to examine worker’s intentions or motivations and “How” drives us to examine system weaknesses and sustainable solutions.”

(Conklin)

EXERCISE

Choose an injury, incident or an event that occurred at your place of work where it appears that human error is the root cause. Give a brief explanation on what happen and then:

1) **FOCUS ON THE WORKER:**
   First discuss and list on a flipchart what the worker could have done, should have done, or failed to do that could have prevented this injury.

2) **FOCUS ON THE SYSTEM:**
   Then on a separate flipchart list what could have been done addressing the system, tools, equipment, procedures, processes, etc.


YETI
4x4

Old View Comments and Suggestions

- Could have asked for help
- Failed to use proper lifting techniques
- Should have followed instructions
- Should have stretched before lifting
- Should have known better than to lift
- Could have used back support (belt)
- Failed to estimate weight before lifting


YETI
4x4

New View Comments and Suggestions

- Metal barrel should not be used as garbage can
- Use truck with tommy-lift
- Replace barrel with lightweight plastic or rubber garbage can with handles
- Insert & remove trash bag from barrel
- Utilize tool or equipment to lift barrel
- Hire service company to remove garbage

Old View Comments and Suggestions

- Should have worn gloves
- Failed to maintain three-point contact
- Should have held on tighter
- Should have dismounted slower
- Could have removed bulky clothing
- Failed to keep “eyes on path”
- Should have asked for assistance

New View Comments and Suggestions

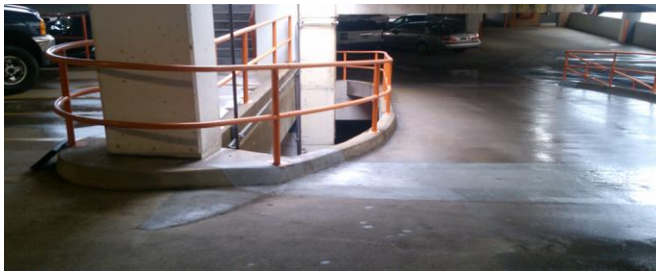
- Add fold-down, boat-type or removable ladder
- Add additional handles
- Design handles with non-slip surfaces
- Enhance/enlarge steps
- Paint step indicator on platform
- Change the design of steps
- Add rails and ladder to platform


TRANSFORCE AT


SPEED LIMIT
15

Old View Comments and Suggestions

- Could have requested different vehicle
- Should have a called a timeout
- Should have been more focused
- Should have slowed down
- Should have called supervisor
- Should have been more aware of surroundings
- Failed to use mirrors
- Should have understood turn radius of vehicle



New View Comments and Suggestions

- Large vehicles should not be parked in deck
- Large vehicles should be parked on lowest level
- Only small cars parked in last spaces
- Park storm vehicles in exterior parking lots
- Revisit process of assigning storm vehicles
- Re-designing the railing system in the deck

Closing Comments

- **The purpose of this breakout session was to demonstrate the difference in the old view approach to analyzing unwanted events compared to the new view approach.**

- **Fixing the System is much more successful in preventing recurrence rather than simply fixing the worker!**

Workplaces and organizations are easier to manage than the minds of individual workers.

You cannot change the human condition, but you can change the conditions under which people work.

Dr. James Reason

In Summary…

“Why” is a good question…, but “How” is a better one!

It’s important to determine “what influenced the actions or decisions of workers”

Incident recurrence is prevented through “Learning” not “blaming!”

QUESTIONS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