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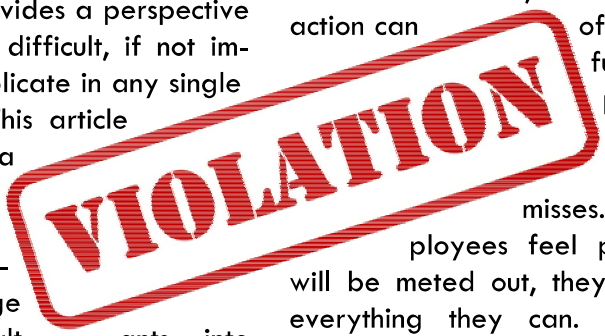
Learning from Incidents: Protips Part 3

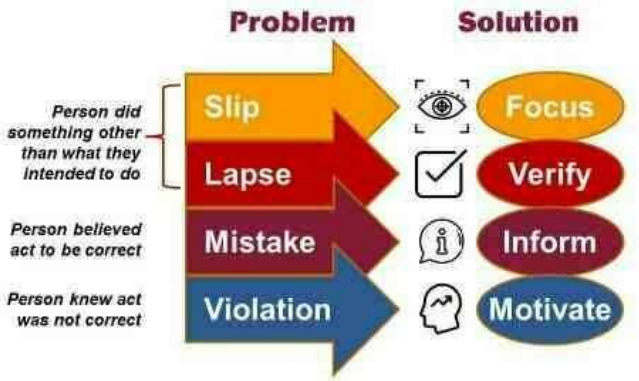
Over the almost 20 years that vPSI has been in business, the company's consultants have reviewed tens of thousands of incident investigations and have participated in many more. This perhaps unique experience provides a perspective that would be difficult, if not impossible, to replicate in any single organization. This article is the third in a series that will attempt to distill the accumulated knowledge of vPSI's consultants into "protips" that will be of value to those involved in investigating and learning from incidents.



The IOGP issued a report last year that points to human factors being involved in 80% of all unplanned events. Some of these human actions are due to error: slips, lapses, and mistakes. It's an unfortunate fact that some percentage of these incidents are due to violations. What's a company to do?

There are multiple issues at play here. The first is that many organizations use disciplinary action for any human-caused incidents, regardless if they were violations or not, to the point that they might as well pre-print "disciplinary action taken" on their incident reports. An organization's safety culture can be set back many years by responding illogically to things going wrong, and using disciplinary action for a mistake is one example of that.

Another issue with the standard organizational response to things going wrong is that even when there is a violation, disciplinary action can often inhibit future reporting of incidents and near misses. If employees feel punishment will be meted out, they will hide everything they can. Employers can't fix problems they don't know about, thus hiding problems is clearly bad for the organization. Often, it's more effective to respond to other aspects of what went wrong and handle the violation as a human resource issue versus as a corrective action, putting distance between the disciplinary action and the safety department.



Finally, the biggest issue with violations: there are many different "flavors" of violations, and determining which is at play is often difficult (especially in cultures where hiding problems is common), and yet knowing the flavor of the violation is integral to knowing the appropriate response.

One common type of violation is the unintentional violation. This is technically a violation but could also be a slip, lapse, or mistake. How do you take account of slips and lapses when lifesaving rules are non-negotiable? An example of this is an employee forgetting to clip his fall arrest system into place. Disciplining an otherwise good employee who simply had a lapse is a sure way to increase turnover with little to no effect on compliance.

Another violation category is situational; some violations occur because it is actually impossible to do the job following the rules/procedures. Discipline in this instance is clearly inappropriate. The solution here is to modify the work context to eliminate the "forcing" conditions.

Beneficial violations are those done for the real or perceived

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Inside this issue:

Weasel Words

"Should" is such a dangerous word that we ban its use in incident investigations. One of the most difficult transitions for actions coming out of incident analysis is from recommendation to reality. Aspirations and good intentions aren't enough to change the risk revealed by the unplanned event. Only when the action has become real (i.e. been implemented) can it have any impact on workplace risk, and only then if it is both relevant to, and effective against, the unplanned event in the real world work context.

It's not only the word "should" that's troublesome in the investigative context; we have a fairly long list of "weasel words" that are also to be viewed with great suspicion. If an activity presented as a corrective action is based solely on one of these phrases, you are likely still in the analysis phase of the investigation.

An investigation begins with data gathering immediately after the initiating event and ends with implementation of corrective actions and elimination or satisfactory reduction of the risk related to the unplanned event. If the organization has decided that an unplanned event should be prevented from repeating, it has decided that the risk associated with a potential recurrence is worth the time and effort it takes to do an end-to-end investigation. Such events are significant enough to require us to be thoughtful in what we do about them. Generally, if one of these weasel words is the main verb in an activity presented as a corrective action, it will fail the vPSI Test™ and be considered a Type 0, meaning that it's not a corrective action at all.

Of course, significance is not the only factor in deciding whether an unplanned event should be fully investigated. The next question is about preventability. If the problem revealed is deemed preventable, again the actions that come at the back end of the investigative process should (ahem) actually change how the work is done in reality, not just be aspirational statements of what that reality "should" look like.

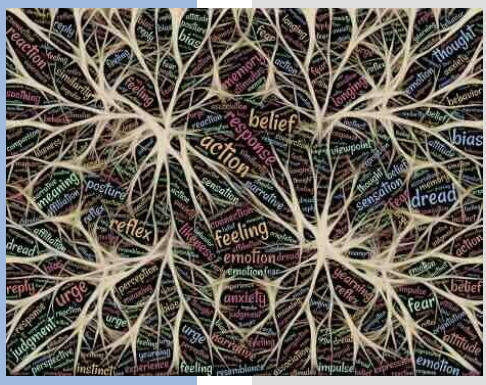
There is one instance where these weasel words can be useful... if an organization insists that an incident is both significant and preventable despite the opposite clearly being true, stringing together 3 or 4 weasel words can help the investigation team be good custodians of the corporate purse while still satisfying illogical expectations. For example, the activity, "Form a team to look into considering a new design for XYZ failed part" gives the impression of action but can be marked complete almost as soon as it has been written, and without any wasted expenditure of time, energy or effort!

- Analyze
- Assess Options
- Audit
- Brainstorm
- Call in an expert
- Call a vendor
- Check
- Conduct a "root cause" analysis
- Consider
- Design
- Determine
- Develop
- Discuss
- Engineer
- Evaluate
- Examine
- Find out about
- Follow up
- Form a committee
- Form a team
- Get quotes
- Hire a consultant
- Identify
- Initiate project
- Inspect
- Investigate
- Look into
- Observe
- Raise engineering query
- Raise an MOC
- Raise a work order
- Recommend
- Report
- Research
- Review
- Study
- Survey
- Test
- Troubleshoot

Food for Thought

We at vPSI Group are considered by many to be risk management radicals. Our concepts and processes challenge the status quo and make the sacred cows of safety extremely nervous. We are not content to accept conventional wisdom as we pursue making the world a better place, one company at a time. We invite you to put down the sudoku and stretch your mind with these vPSI-tastic thought experiments that may challenge some of your current mental models.

The well managed modern workplace is a low risk environment. This does not mean that there is no risk, there is some level of residual risk in everything that we do. It does mean that when an incident occurs it may be an inherently low probability event. Just because an unplanned event has happened does not (usually) mean that it's more likely to happen again in the future. It is still low probability, meaning that even if you do nothing in response to the incident it may never repeat. If your corrective action validation consists of waiting to see if the unplanned event happens again, how can you be sure that any actions you took were the cause of it not repeating? How can you know that you actually had any effect on the probability of its reoccurrence?



An incident has occurred but you can't decide if it's significant or not. Here's a thought experiment that will help… Pretend that you do nothing in response to the unplanned event that just happened. Now project yourself 6 months into the future where the same activity that gave rise to the incident is about to be repeated. Do a risk assessment of the activity, remembering that nothing changed as a result of the past incident. Where does the activity fall on your risk matrix? If it's deeply in the green, then the incident you are currently contemplating is not significant and can be recorded, filed, trended and set aside without wasting the organization's resources on corrective actions.

Learning From Incidents: Protips Part 3…

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benefit of either the individual or the organization. Taking a shortcut by clambering over a conveyor is a violation with mutual benefit, yet not the choice most organizations would prefer their employees make. If this is what happened and the employee fell onto the conveyor, would firing that employee cause others to think twice before acting similarly? Which would be more effective in the long term: firing that employee, or building a walkway that acknowledges the need for a faster crossover route?

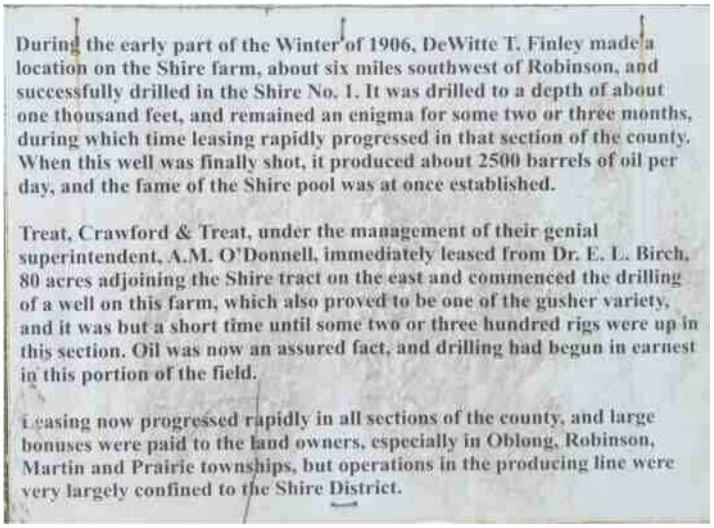
Some other non-disciplinary responses to violations include having engaged supervisors that increase the reward probability for desired behaviors and negative outcome probability for violations. This is essentially about changing behaviors by giving feedback, but that feedback has to be immediate and reasonably certain to occur. Eliminating unnecessary rules and bureaucracy is another route to a solution: unfortunately one of the challenges in the investigative process is we often go in the opposite direction and impose more rules or bureaucracy. Modifying employees' pre-act risk assessment is another valuable track for problem solving but can be difficult to do.

Of course, all of this is dependent on having a firm foundation of the data collected after an unplanned event occurs. See Protip Part 2 (the Data Quality Ladder) for more information about verifying the quality of post-incident data.

Combining Business with Pleasure

There are few opportunities for travel at the moment, so we're opening up the archive to take a wistful look at past adventures…

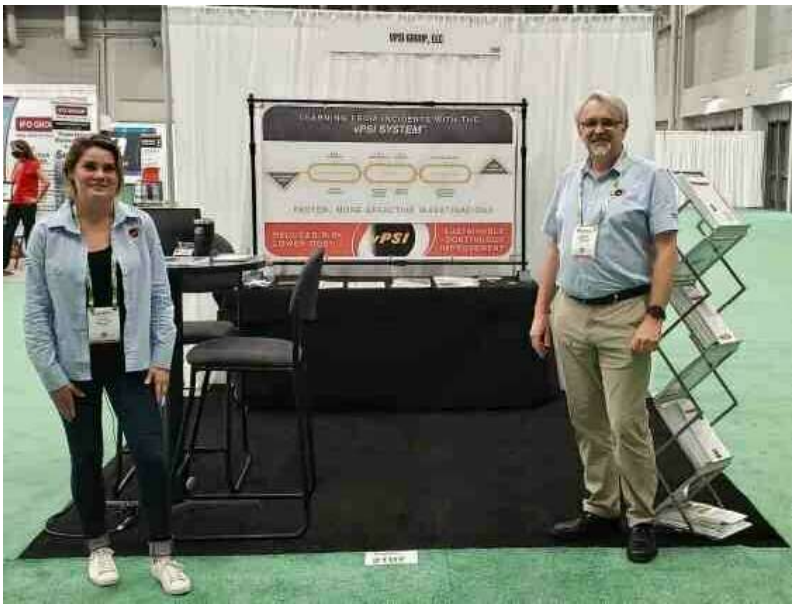
Seen in Robinson, Crawford County, Illinois while conducting training at the Marathon refinery: this wooden derrick which dates to 1906. Also seen, the canine docent pictured below who escorted our consultants as they toured the historic derrick.



During the early part of the Winter of 1906, DeWitte T. Finley made a location on the Shire farm, about six miles southwest of Robinson, and successfully drilled in the Shire No. 1. It was drilled to a depth of about one thousand feet, and remained an enigma for some two or three months, during which time leasing rapidly progressed in that section of the county. When this well was finally shot, it produced about 2500 barrels of oil per day, and the fame of the Shire pool was at once established.

Treat, Crawford & Treat, under the management of their genial superintendent, A.M. O'Donnell, immediately leased from Dr. E. L. Birch, 80 acres adjoining the Shire tract on the east and commenced the drilling of a well on this farm, which also proved to be one of the gusher variety, and it was but a short time until some two or three hundred rigs were up in this section. Oil was now an assured fact, and drilling had begun in earnest in this portion of the field.

Leasing now progressed rapidly in all sections of the county, and large bonuses were paid to the land owners, especially in Oblong, Robinson, Martin and Prairie townships, but operations in the producing line were very largely confined to the Shire District.



We exhibited at the ASSP Safety 2021 Professional Development Conference and Exposition in Austin, Texas September 13th through the 15th. Visitors to our booth had the opportunity to win two of our coveted Yeti tumblers (one of which can be seen in the photo).

Pictured are Charity Yauger, Creative Director, and Norman Ritchie, Co-Founder and Director.

We enjoyed the opportunity to see old friends and make new ones for the first time in person since the pandemic.

Look for us at the upcoming 2021 UTA Oil and Gas Conference in Houston, Texas, USA December 14-15.

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