# In high-reliability organizations, error can have devastating consequences on people, operations, and the environment.

Nothing is more frustrating than taking the time to conduct a thorough investigation, accurately identifying the lessons to be learned, and publishing these lessons in a report detailing how to prevent this from happening again, only to have a similar incident occur a short time later.

We once helped a client with an incident investigation involving an employee that failed to properly install isolation protocol resulting in a loss of containment of chemical products. Fortunately, no one was injured, and the spilled product remained within the secondary catchment facility. However, the site was frustrated because this was the third isolation-related incident in the past 18 months. Although different people from different areas of the plant were involved, the question that kept coming up was "Why aren't we learning from this?" A valid question which many leaders face on a regular basis.

From our experience, we find that operationally resilient organizations do the following three things well:

**1. Learn and Grow**

This learning and growth do not happen by accident. Exceptionally reliable organizations are deliberate about learning. The first step is to identify the actual problems. This requires a process that not only identifies the immediate failures but one which looks beyond the surface to find those latent, systemic conditions that existed and contributed to the incident. In other words, it is not enough to simply say "the cause of the accident was that the operator did not follow the procedures." We must understand why the operator did not follow the procedures and include that in our learning process.

**2. Communication**

The next step is to effectively communicate these findings to the organization. We find that without the explanation of why the bad idea seemed good at the time, people within the organization will tend to view the lapse in judgment as a character flaw of the individual involved. But if we can explain the latent conditions that existed at the time and provide context to the bad decision, people within the organization are more likely to relate to the identified lessons and apply those lessons moving forward.

**3. Human Factors Training**

The Human Factors Analysis and Classification System (HFACS) provides a framework to assist in the investigation process and identifies the human causes of accidents. HFACS has its roots in military and commercial aviation communities seeking to understand the human influences in failure. Due to the exceptional success in improving safety and operational performance, this approach to human factors has become a model for all industries seeking to achieve reliable and resilient operations.

Are you frustrated that your organization's safety performance is not improving, even though you have a robust incident investigation program in place? Learn more about Vetergy Group and how we can bring more power and success to your Human Factors training.

**To learn more about Vetergy Group's HFACS program click here.**

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