

# Avoid blame and better understand human error

A 26-year-old farm laborer started her day working on the onion-peeling processing line where employees “rough-clean” onions and place them on a conveyor. They then go through a machine that trims and peels them.

Because she needed to finish early to go to an appointment, she asked her supervisor if she could clean the machine after the day’s production run instead of preparing onions for shipping with the other employees.

After getting her supervisor’s permission, she started the cleaning task by blowing down the machine with an air nozzle attached to an air flow line. Then, she washed the machine with a pressure washer.

When she finished, she noticed some grass wrapped around the drive shaft to the machine’s positioning chain. She walked around to the right side of the machine and opened a safety door to remove the grass. The safety door had a switch that turned off the machine if the door was opened while the machine was running, but the machine continued to run.

There was a gap of four to five inches between the two sides of the chain that connected the top sprocket on the drive motor to a slave sprocket on the drive shaft. She thought she could “just reach in and grab the small amount of grass” if she was careful.

As she reached for the grass, her sleeve caught the rotating slave sprocket, which pulled in her arm and severed her hand at the wrist.

This story is taken from the Safety Notes section of Oregon OSHA’s Resource newsletter, available here: [osha.oregon.gov/pubs/newsletters/resource/print/2850-2019-06.pdf#page=17](https://www.oregon.gov/pubs/newsletters/resource/print/2850-2019-06.pdf#page=17)

In a case like this, it’s easy to blame the worker for the injury because she opened the door and reached into the machine. However, it is the systems around the worker, the circumstances, and the culture of the business that led to this behavior.

*(Continued)*



## How was the worker set up for failure?

Workers interviewed after the incident said they were not authorized to open the safety door. Later they admitted that they had all done it, but the machine usually shut off. They were directed to get the foreman to open the safety door when needed, but the pressure to get the work done often led workers to skip that step. In addition, the company had no procedures for locking and tagging out the equipment.

All these factors make up the context—the circumstances that led up to the behavior and ultimately led to the injury.

## Blame doesn't fix the system

Even the best workers make mistakes. Successful systems are designed to prevent injuries, even when mistakes are made. They build in redundancies to ensure safety.

Blaming or punishing the worker doesn't allow system improvement. It makes employees less likely to report injuries, to speak up if something goes wrong, and it prevents learning from mistakes that are made so future injuries can be prevented effectively.

Todd Conklin, who consults on human and organization performance, says, "Workers themselves do not usually cause serious incidents. They can trigger latent conditions existing in systems, processes, procedures, and expectations on the job site."

## Summary

It takes more work and requires more thought to look beyond employee actions when analyzing a workplace incident or injury, but it's worth it. Creating a process that examines systems, rather than blaming employees, is the most effective way to create a safe workplace.

Sidney Dekker, from his book *The Field Guide to Understanding Human Error*.

"You can help change the way your organization thinks about 'human error.' This begins with asking questions, looking at things from another perspective, and using a different language."

"Underneath every simple, obvious story about 'human error,' there is a deeper, more complex story about the organization."

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## Activity ideas

- Think about a recent incident or injury at your location and discuss it. Did it involve employee behavior? Discuss the context that led to the injury.
- Look at investigation reports from the Oregon Fatality Assessment and Control Evaluation website: [ohsu.edu/oregon-fatality-assessment-control-evaluation](https://ohsu.edu/oregon-fatality-assessment-control-evaluation). Pick one and discuss as a group. Do you see the larger system issues?