**APPROACHES TO ‘HUMAN ERROR’**

Comparing the ‘traditional’ and ‘new’ views of human error

The traditional view of human error in many industries is that “the facility would be safe if it wasn’t for all the people”.

The traditional view looks like this:

- People are seen as hazards, a threat, a liability
- People are the weakest link
- The less of them the better
- People need to be closely managed
- We need to protect the system from people
- Things sometimes go wrong
- Less thinking, more procedures
- People are told to “be careful out there"
- Investigations assign blame
- Investigations focus on the last person to touch the equipment
- Human behaviour is seen as binary - humans either fail, or they succeed
- Human errors and near-misses are often covered-up.

A new way of thinking about human error would be to turn this traditional approach on its head and take the view that “the facility wouldn’t be safe if it wasn’t for all the people”.

These principles summarise the new view:

- People create safety and success (in other words, things usually go right, because of people)
- People adapt to imperfect systems and match the conditions
- Human performance is not simply 'fail/succeed', but is variable
- We need to support people and make their life easier
- Identifying 'human error' is just the start of an incident investigation – it's not seen as a cause, but a symptom of deeper issues
- Investigations aim to understand why people behave (and think) the way they do
- Investigations ask 'why things made sense' to people at the time of an event
- Human performance may be influenced by people distant in time and space from the front line
- Human errors and near-misses are more likely to get reported.

If we take a routine task, let's assume that a human failure occurs once every 10,000 times that the task is performed. The traditional view may focus on that human failure, the one time that something goes wrong.

Alternatively, the new approach would recognise that there are 9,999 'non-failures' every 10,000 times that the task is performed. In other words, the human is successful almost all of the time – possibly despite sub-optimal conditions. The new view would look at this normal, successful work and ask "what went right"? and "why was the person successful"?

"The majority of accidents and incidents are not caused by 'careless workers' but by failures in control … which are the responsibility of management“ (UK HSE, 1997)