Failure and Human Error

When a project fails, a product is recalled, a chemical pollutes or a person gets hurt the natural human (and organisational) instinct is to place blame and move on. Far too often the conclusion of an incident investigation places human error as the significant root cause of the negative event. Reprimands and tighter procedures (controls) are the common reactions to a human error finding, however, more often than not, despite the organisation undertaking these actions, the failure reoccurs or manifests itself in a slightly different form.

Generally the decision (call in hindsight the 'human error') made reasonable and justifiable sense to the subject at the time. When an in depth review is implemented it is regularly uncovered that the same decision(s) had been made numerous times in the past with successful outcomes (i.e. increased productivity) and may have even been rewarded (i.e. praise for having a 'can-do' attitude or a monetary reward relative to increased product delivery times). If the incident or failure had not occurred then those decisions and the resulting actions would most-likely still be occurring within the organisation.

More often then not, rather than being the root cause, human error is actual a consequence of broader and deeper organisational issues. The interaction between competing influences (i.e. reduced resources, systemic complexity, shifting time-frames, outsourcing, conflicting performance measures and dynamic or poorly defined job roles) often explains the human logic behind decisions taken at a point in time.

Numerous and often extremely overly complicated business processes are the norm in many large organisations. Smaller organisations tend to have limited documented processes and often rely on unwritten process control, taught and communicated by word-of-mouth or by example from employee to employee. Intriguingly, despite the significant differences in how both large and small business systems are formulated and implemented there appears to be little differences in how organisations of all sizes portray human error as the main root cause of their failures.

All systems are open to failure. Too often the higher the consequence of a systemic failure then the more complicated and rigid the organisation makes the business system and thereby (and inadvertently) increasing the risk of future systemic failure. As mentioned earlier, when a complex system fails and human error is described as the root cause, reprimand and tighter procedures are generally established. When applied to address failure, these two actions tend to create a cyclic scenario where future systemic failure is more likely to reoccur or manifest itself in a different form. Often in advanced business systems a null response to a failure, instead of tighter procedures, results in a lower probability of future system failure and no significant increase in future failure rates.

To truly understand why failure occurs in their business, organisations need to actively seek the root causes which influence the decision their employees (and contractors) make. The simple allocation of blame tends to lead to a fear of failure and the concealment of future failures, while providing little benefit in reducing future incidents. Tightening controls and making processes more complicated can greatly increase the probability of future failures. The recognition of human error as often being a consequence rather then a root cause is a significant step towards recognising and addressing failure within an organisation.

Karza Pty. Ltd. can assist you by: removing complexity from your business systems; evolving your incident investigation processes; managing and assisting your internal incident investigation group through co-sourcing; or by running a fully outsourced internal incident investigation programme for your organisation.

Contact.Us@karza.com.au for more information.