

# 2019-06 - High Potential Severity Incidents

Hello,

I found an interesting report from 2018 (Serious Injury and Fatality Prevention: Perspectives and Practices) from the Campell Institute (part of the National Safety Council in the US). At the beginning of the report, they talk about the evolution of the incident rates in the US, with overall incident rates declining, but the more serious incidents reducing at a much slower rate. The same is true for us if we compare our MTAR with our H-MTAR. Comparing 2018 to 2016, the MTAR has declined by 30% but the H-MTAR has only declined by 11%.

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The report is fairly aligned with what we are doing. If you recall, we say that most incidents/accidents are a result of a person's behavior (an action taken by a person). However, the environment that a person works in has a significant impact on the actions they take, so focusing solely on the person's behavior will not drive the performance we want. In this article, they refer to the part of the environment that the organization impacts as "management control". Their main hypothesis is that if we want to prevent Serious Injuries and Fatalities (SIF), we must look to the precursors of these types of events. The article mentions three indicators that are a sign you have a higher likelihood of having a SIF on your sites, : Normalization of Deviation, Uncalibrated Perception of Risk, and Data Collection and Analysis is not done in a Mindful, Targeted Way.

Normalization of Deviation: This is really about what is acceptable (mindset at the site level), examples include:

- We have always done it that way
- That has never happened here
- Workers have developed work arounds for the sake of efficiency (and worse - management accepts without a thorough assessment)
- The application of procedures is inconsistent

Uncalibrated Perception of Risk: We all have different perceptions of the probability and severity of a risk leading to an undesired outcome. It is important to be aligned and to have a shared perception of the risks (especially for the people involved in performing a task). In a way, this was the intent behind the SLSR and transversals - the idea was to create a shared understanding of the risk and the minimum requirements necessary to address those risks, with the intent of having everyone go home alive and healthy each day.

Data Collection and Analysis: This is about the data we collect and how we utilize that information. Once again, this goes to the culture of the organization. Do we collect data for the sake of data or do we collect relevant data, analyze it, and develop meaningful actions to minimize the precursors to SIFs? Data we collect from near misses, High Potential Severity Incidents, Culture (e.g. Safety Climate or equivalent) can help us identify opportunities within our organizations to improve. However, if we simply collect the data and report it without really using it to drive performance it will have very limited value and will not help you eliminate SIF.

The report also gives three ideas for creating intervention strategies to address the precursors for SIFs:

- (1) Educate everyone in the organization from senior leaders to the shop floor about the potential for SIF's and the precursors that could lead to a SIF.
- (2) Provide visibility throughout the organization on SIF potential (near misses and high potential severity incidents is a way to start)
- (3) Understand your gaps - examples: procedure implementation (are there work arounds? are they implemented consistently?), controls, employee behaviors, etc.

Ultimately, we need to accept that employees will make mistakes (we all do from time to time). Our job is to create the right culture within the organization to help employees take the right decisions. In addition, we need to find ways to eliminate risks or find ways to control the risks (e.g. guards, barriers). Finally we need to make it easier for employees to do the right thing (example: some sites have PPE vending machines in the units).

Hopefully the report will give you some ideas for things you can do within your GBU and some material to use for discussions.

[Take the report](#)

Be Safe,  
James