

# Lessons Learned

## Introduction

Many of the accidents and near misses that HSE Inspectors investigate have similarities and could have been avoided by applying lessons from previous accidents, not necessarily in the same industry.

This is particularly true where the root cause of the accident has been identified as a failing in the safety management system, such as poor procedures, or human factors, such as slips, mistakes and violations.

## **HSE website:**

<http://www.hse.gov.uk/managing/delivering/act/learn-lessons.htm#common>

contains information regarding the lessons that can be learned from accidents it has investigated:

## **Common factors when things go wrong:**

Analysis of major incidents in high-hazard industries, with different technical causes and work contexts, has identified several common factors involved when things go wrong.

These factors are related to:

- leadership
- attitudes and behaviours
- risk management and oversight

When these aspects of an organisation become dysfunctional, important risks can become ‘normalised’ within it, leading to serious consequences.

## Organisational learning

Organisational learning is a key aspect of health and safety management. If reporting and follow-up systems are not fit for purpose, for example if a blame culture acts as a disincentive to reporting near misses, then valuable knowledge will be lost.

If the root causes of precursor events are not identified and communicated throughout the organisation, this makes a recurrence more likely.

In many cases, barriers within an organisation - where different departments operate in 'silos' - inhibit organisational learning.

# Human factors

Leaders and managers need to be aware of the people-related, cultural and organisational issues that may prevent lessons being learned effectively in their organisations.

## **Sign up to news bulletins**

<https://press.hse.gov.uk/2019/06/06/valero-energy-uk-fined-5-million-after-four-people-died-in-an-oil-explosion/>

## **ROSPA**

<https://www.rospa.com/rospaweb/docs/advice-services/occupational-safety/noshc/learning-how-to-learn-from-accidents.pdf>

## **Academic studies**

Trevor Kletz

<https://www.amazon.co.uk/Learning-Accidents-Trevor-Kletz/dp/075064883X>

ESReDA <https://esreda.org/wp-content/uploads/2016/03/ESReDA-barriers-learning-accidents-1.pdf> Barriers to learning from incidents and accidents

**HSE Videos** <http://www.hse.gov.uk/resources/videos.htm>

Gas Transporters Incident Review Panel - feedback report is given at GTOSG.

Link to tanker overfill video

<https://www.youtube.com/watch?v=TCIOy1gj-LY>

Hazchem info tag (the red sign on the back of the tanker ) Emergency Action Code 3YE = Use foam or dry agent, substance reacts violently/is explosive, BA use is essential, evacuate vicinity, contain spill and the 1203 code = Gasoline or petrol or motor spirit.