HUMAN ERROR - MANAGING THE BLAME FOR INCREASING ORGANISATIONAL POLICE PERFORMANCE

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ABSTRACT

Every organisation that deals with hazards and people on a daily basis faces a simply and very profound choice: either it manages human error or human error will manage the organisation, always with great cost and often in great danger. Managers fail to understand that the biggest risk they are running into is to interfere with human error. There are also other risks to be dealt with, like trading or currency risk, but human error is really the big one. It has fantastic financial consequence. Companies from all over the world gone out of business because of human error, workers could be put out of work, managers could end their career, and it could turn the company's market value into nothing.

Police organisation is not exempted from mistakes. Police managers face the consequences of tactical and mental errors made by police officers during difficult activities. Effective decision and accurate judgement made by police officers under stressful conditions are skills that are degraded rapidly in the absence of ongoing practice and training. This paperwork discusses the causes of police officer mental or tactical error under conditions of stress and offers police managers tools they can use to fulfil excellence in law enforcement by taking good decision. Knowing where and when the error is highest allows proactive and effective deployment of resources, both human and financial.

Mistakes will always happen and must be accepted. The objective is not an organisational culture where police officers are not allowed to make mistakes, rather the objective is to learn from the mistakes that happen, and prevent their occurrence.

KEYWORDS: *human error, root cause analysis, risk management, organisational behaviour*

JEL CLASSIFICATION: *D23, D81, G32.*

INTRODUCTION

Human error has been cited as a cause of contributing factor in disasters and incidents in industries and companies as diverse as aviation, nuclear plants, space exploration, medicine, railway transportation. Across different organisations, error patterns remain constant and people doing similar jobs in widely different culture environments make the same mistakes, the same kind of error, time and time again.

Human error occurs very often in daily life and is frequent in all walks of life because people are different. People got different shapes, physical abilities, psychological aspects are all different depending on our previous experiences, physiological is different and it affects how our brain work and psychosocial as well. Managers try to build a process that delivers the same result every single time and they are dealing with people who are very variable and don't really want to change. It is almost impossible to change people, all managers have to do is to build the process that allows people to be people. So they must not look up in blaming people, they must do their best to update the poor business process that allows human error to multiply and magnify.

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This paperwork talks about the challenge police managers face when dealing with people and also about police organisation that deals with all kind of human factors. Every law enforcement agency in the world faces the possibility that one or more of its officers could engage in police actions that are found to be improper or incorrect. The consequences of these mistakes can be serious. Errors have led to the deaths of officers and civilians. Some have resulted in complaints and lawsuits alleging misuse or abuse of police power.

Police executives have not escaped the consequences of things going wrong either. The number of losses among police executives to health problems such as cardiovascular death and disease is high. The stress exposure experienced daily by police executives from social-political and organisational pressures can alter life.

The past years of economic crises coupled with increased demands for homeland security provisions have further complicated the life of police officers performing their duties. In todays police environment the consequences for error in performance or decision making have become increasingly severe.

Another aspect is that whatever reason, motivation or ability, social, organisational or environmental, there are many errors an officer can make and any of these errors can lead to the death, or serious injury, of law enforcement officers, their fellow partners or even civilians. These mistakes are: preoccupation or lack of concentration, tombstone courage, not enough rest, taking a bad position, not heeding danger signs, failure to watch the hands of a problem employee, relaxing too soon, improper use of handcuffs, no search or poor search, dirty or inoperative weapons or failure to maintain proficiency and care of equipment (Brooks, 1976).

A review of the literature on technology, suggests that human error is a primary cause of 60-90% major accidents. Accidents happen because of the operator's misinterpretation, wrong decision, lack of knowledge or silly mistake (Helander, 2006).

For example, on our study conducted on 120 Romanian police officers, 83% of respondents believe others act unsafely because they don't want to make extra effort. In other words, others lack personal motivation. Being asked why they themselves act unsafely, only 41% of respondents said it was because they don't want to make the extra effort. So, when people see that others act unsafely, they usually blame it on personal motivation. Police managers' respondents say that they are usually stuck in the office behind a great pile of paperwork. If one of subordinate officers comes in and presents a problem, which requires a decision, without looking up from the computer and agenda, the police manager listens, evaluates, and takes a decision. Several days later this decision is wrong. By making a decision when you are very busy, it is unlikely that you gave it the thought it deserved. Social pressure can help or hinder the performance of the decision maker (Konz, 2008). Social pressure often is confounded with rank. Many cases in police activity have been reported in which lower rank officers did not want to challenge higher rank officers and the higher ranked officer's error was not corrected. In this study, almost 80% of police executives say that they don't allow other police managers to force their hand to make decisions out of their area of responsibility, because in many of cases, they consider that they might not have the resources or the information to make a successful, informed decision. Another identified issue is that many police managers in leadership positions spend numerous extra hours at work (between 6 and 10 hours) and, in many cases, mistakes made due to fatigue may not have fatal consequences, but they will certainly affect careers and the health of the police organisation as a whole.

Plausible-deniability tactics, poor morale, a "kill-the-messenger" philosophy, a large number of grievances, and a culture of distrust are some of the danger signs within any organisation (Brooks, 1976). 82% police managers responded in the questionnaire that they become so caught up in the everyday activities of running the organisation that they forget the big picture, they do not make themselves visible; they don't take the time to get out of their office and don't hear anything important from their staff.

Every police organisation has its bad apples. It is amazing how one problem employee can disrupt an organisation. Problem police employees are experts at creating assignments and work for police

managers. The study reveals that only 25% of police managers learn to know their problem employees, document all their activities as well as their interactions with them, and treat them exactly like the other employees. Most important is that they don't allow problem employees to take up their valuable time. Another problem identified is that police managers are relaxing too soon. Just 30% of police managers responded that when a critical incident takes place, they have many other pressing activities. They delegate a subordinate officer or a senior officer with the task, but they never delegate responsibility. When the error comes in what they may have thought was obvious may have been so only to them. Police managers become frustrated and hand out discipline to executive officers who make errors. In the Romanian police departments there is a concept that considers that if you want to discipline the problem officer, the one who makes mistakes frequently, you make a policy that restricts everyone in that police department. For example, concerning technology, early in the life of a nuclear plant we find that the failures, when we look at the cause of the failures, come down from design errors (35%). Errors made by such as material selection, misunderstanding the operational service and buying the wrong machine for a particular job. When it comes to operating area, the people and procedure problems cause half percent of the operational errors, some of the maintenance errors the people or procedures used, causing the failures.

The procedures that caused the errors are documents that the organisation has approved to use. Fabrication errors represent just 1% of the problem. 88% of the early life failures events in a nuclear power plant are rather people or business process caused by human error and human factors. Nothing to do with the machines, people's are business process.

There is nothing wrong with the organisation's machines and materials, with the engineering, with the science. The problem is that people's business process is poor and people don't know enough about the right thing to do. So if we are trying to improve a company, we must try to do some work on the machinery. The machinery are suffering because of people and their poor business processes. If we'd gone improve the organisation, we'd work on the processes, on the company's policy. If we'd do the processes improved and lift the people up to understand more and appreciate things more, we will get the results that we want from our employees. But there isn't a full proofed policy, because by definition, a "full-proofed" policy is a policy free of "fools". Who has never fallen in love and lost 50 IQ points, caught a flew or went to a party and go drunk, came into work the next day and made errors. There is no such thing as a "fool-proof" policy, because we humans are all acting like "fools" in some point of our lives. There are few of any procedures that cover every possible circumstance with complex operations and you can also find gaps in the procedural safeguards (Allen, 2010).

Having said this, most of police managers responded that they tried to avoid most types of unfair discipline by splitting the mistakes and errors into two categories, errors made by the mind and errors made by the heart. Officers who make a mistake of the first sort do so unintentionally, because they think they are doing the right thing, but it turns out badly, and police officers that commit errors of the second sort know that they are doing wrong, but they do it anyway. The first ones should be handled, whenever possible, as training issues or minor counselling sessions, but for the second ones additional training or minor counselling sessions will do little to stop these officers from continuing to make bad mistakes. All of the police officers questioned said that most of errors is due to apathy. If there is apathy at the top management level of the police departments, that department is doomed to mediocrity and failure.

Another issue underlined by the study was that it should be obvious to most police managers that their role as leaders is quite different from that of patrol officers. Police executives said that they held their superior officers in contempt when they show up for work with old equipment or no equipment at all or that these police managers could barely qualify with their firearms or pass the physical exams. They admitted that no matter how good the advice was that their superior ranked officer offered, it was never given the attention it may have deserved because of the source, and doing so, they committed several mistakes.

1. HUMAN ERROR IN POLICE CROWD CONTROL PROCEDURES – CASE STUDY - PUBLIC DEMONSTRATION IN BUCHAREST UNIVERSITY SQUARE

This paperwork explores a police procedure during a public manifestation and is described in terms of organisational incident theory, which suggests a single unsafe act, in this case a wrongful decision, is facilitated by several latent interconnected conditions. The analysis shows the risk of errors committed by acts of omission were significantly more likely than errors committed by acts of commission.

Protests over austerity measures in Romania were marked by violence on Sunday after at least 30 people were injured in clashes with police forces. On 14 January 2012, in Bucharest, protestors rallied at University Square and outside the gates of Cotroceni Palace. To avoid clashes, there were installed protective fences, and police officers have created safety devices. During the day, everything was going fine. The University Square was full of peaceful protesters. But around 6 p.m. local time, protesters blocked the Nicolae Bălcescu Boulevard. After the intervention of police forces, the boulevard was liberated and people were pushed to the sidewalk. The violence was sparked by a small band of young people that separated from the larger group of peaceful protesters. Around 9 p.m. local time, protesters threw stones in the police. The protesters started breaking store windows, setting fire to tires, and throwing rocks at the police. They even threw Molotov cocktails. They were clearly prepared, and appeared to be out for a fight. The behaviour and field procedures of the police forces were quite strange. Though they greatly outnumbered these rioters, the police backed away and watched as the violence grew. The police did form a line to keep the violent protesters away from the peaceful ones, however. The police eventually used tear gas to disperse the demonstrators. Ambulance crews intervened for medical care for 30 people. Of these, five were police officers. The police picked up 29 protesters, after they threw blunt objects and have disturbed public order.

Whether the police act or fail to act when necessary can precipitate an incident. As such it is important to unpack where acts of commission and acts of omission may occur and who commits them to determine what presents the biggest risk. Although we are most interested in knowing where the risk lies before an incident occurs so it can be prevented, it is also important to know where the risk lies after the accident occurs to help mitigate the effects. While the proximate cause of an accident may be either an act or omission, they may not be equally distributed.

In the quantitative analysis, the investigative stage, the error type and the organisation role are each separated but have the same result. The investigative stage was split with twenty errors during the preliminary and follow-up investigation of the incident. Whether an act of commission (28,5%) or omission (71,5%) was committed shows that acts of omission are predominant. Errors committed by officers in top management levels (42,6%) were slightly lower than errors committed by the field officers (57,4%). An important principle of assessing risk is that a disproportionate share of errors is likely concentrated in a few categories of failure, which represent the riskiest types of errors. This implies that focusing attention where errors are concentrated may have the greatest preventive benefits and that focusing on the individual indicators only addresses symptoms, not the underlying problem. Just three categories of failure (24,8%) contribute over eighty percent (75,2%) of the risk of an error. Failing to observe proper field procedures is the most frequently occurring error (83.3%), followed by communication errors (12,5%) and poor-choice decisions (4,2%).

We summarized the error types based on the error stage leading to the incident, which are classified according to the organisational accident framework. There are twenty errors identified, where 25,6% of errors are acts of commission and 74,4% of errors are acts of omission. Unsafe supervision clearly emerges as the leading error point (80,5%) followed by organisational factors (20,5%). This suggests two possibilities. First, the supervisor during the preliminary intervention may have had a active role which may divided his attention at a time when he should have been controlling, directing and communicating among his subordinates to accomplish the task and to ensure it was following the established standards. Second, the supervisor may have been working against pressure in an environment that did not supply him with the tools like operating policies and training. There is direct

evidence the supervisor did not have a show-up policy available, delegate tasks to subordinates and communicate instructions to subordinates, which may have contributed to his poor decisions.

There where some error types by organisation role following the incident occurred. There were twenty errors, where 20,7% of errors are acts of commission and 79,3% of errors are acts of omission. The largest portion of errors (96,7%) resides with the lead field officer followed by his supervisors (3,3%). This finding is consistent with the agency not having promulgated adequate policies specifying how actions of crowd control should be taken. The findings also show that so few tasks were completed and the arresting of the violent rioters was likely compromised. Although the main field officer in this case was directly responsible for only 6% of the errors, the chain of command is indirectly implicated for failing to supervise the lead officer's actions according to accepted standards. Having proper equipment, you can design out potential error, and then procedures and skill are not really necessary. Properly designed equipment will tolerate foreseeable use and misuse, both mistakes and malice. Although police officers where proper equipped, their equipment was not duplicated. For example, they could have had extra tear gas in their police cars. Redundancy could have been a powerful error-reducing tool. It might provided them a backup, safeguarding the system and one use of redundancy was to repeat a procedure like checking the second given order against the first one.

Another error reducing tool is maintenance. The standard assumption is that the equipment is properly maintained and operates properly, but unfortunately, in this case it wasn't true. Most of the tear gas launchers were not working properly.

2.   CONCLUSIONS

What can the police managers learn from a single case study? This study reveals the failure points during the preliminary action that may have facilitated and accelerated the harm, the acts of violence. The study also reveals proof of concept, that the organisational incident framework is well suited for investigating critical police incidents. Approaching such incidents through a systems theory of causation can help police managers, supervisors and support staff act with foresight to identify system failures before they occur, leading to a safer public environment. An organisational incident is a cumulative event that does not necessarily tell the story of the individual police organisation, or of the police chief and command staff. Rather it shows how the organisation is indirectly linked to other things like judgment, organisational climate, established policies and operating practices and the people connected to the organisation like the front-line police officers, supervisors and top police managers. Each stage of the event is an example of a nested subordinate organisational issue that signals an incremental descent into an active failure. The appropriate inquiry shifts from how the individual fail the organisation, to how do the organisation failed the individual. When an incident occurs, police managers share the risk and accountability with the individual who committed the unsafe act. Working from the top of the organisation, the research revealed that a local policy was not promulgated and management failed to detect its absence. This left the officers in the field to improvise without any operating guidelines and little or no way to moderate the competing interests of safety. Although some officers did receive training in show-up procedures earlier in their career, in the Police Academy, there is no record of relatively recent training or maintenance of those skills. Although there is only indirect evidence of internal and external pressure for results, it is sufficient for management to look closer at operations to determine whether informal practices, tacit messages and shortcuts are supplanting formal procedures in the interest of crowd control.

Police managers and supervising officers likely knew about the informal practice beforehand, they tolerated it and failed to correct it. As a measure of organisational defence, supervision also failed. The on-the-spot supervisor in this case, the main field officers made both procedural decision errors and poor-choice errors, despite their previous training and experience supervising public manifestations. They did not know the correct procedures, but proceeded anyway, which may be why they failed to issue specific instructions to subordinates, they simply did not know what to tell them. These omissions resulted in a lost opportunity to identify the violent rioters. As the officers proceeded

under ambiguous circumstances, they relied on perceptual knowledge instead of information from the witnesses and surveillance cameras and systems. Ultimately, when the officers presented the violent person to the victims, the last organisational safeguard was breached. This procedural error provoked the misidentification, and then the officers acted on the victim's equivocal identification about the violent persons' involvement. In the end, concern should be about police leaders that are willing to respond to the issues presented in this case with appropriate initiative that helps all police departments prevent similar future incidents. Errors are therefore not beyond control (acts of God) but are events that can be reduced. For example, birds striking an aircraft could be considered an "act of God" and therefore impossible to prevent. One prevention strategy is using collies to drive birds from airports and choosing routes with fewer birds (Konz and Johnson, 2008).

Each person in a police department has a responsibility to act as a safety agent. Top police managers must accept responsibility for risk, failure, success and safety by remaining conscience to the results their decisions have on the system if they are to prevent future incidents.

The biggest challenge across the organizations and industries is not the engineering and science, the big area of control is people. And people are interesting because people have choices.

But when it comes to us, we have independence, we have our own view of situation and we are very variable. And that variation links us to problems and errors.

Managers must control the training, the knowledge and procedures to guarantee a certain result. And that is the thinking managers must adopt in the organisation as well. In the organisation's wellness, one of the first things they must do is to understand why things fail, discover what causes that in the organisation and change the documentation to include the perception of that failure. So there is going to be a lot of documentation revised, because the trouble is going to be people not knowing and documents that are useless. So if having done a root-cause-analysis (RCA) on the procedures and on the entire organisation and everybody learn RCA and still the procedures keep on failing, it is because they are being broken by the organisation's practices and the lack of knowledge of the people. What tends to happen with the RCA is that they find the problem and very often they go back to the procedure failure, writing a new procedure for that problem. What they are missing is that every procedure is in the same risk. Sometimes managers intentionally go in and look for problems and imagine problems and look where the risk is, and if the risk is too big, than they go back and improve the procedure and retraining the people in the right practices. In doing that all the money that might have been lost are staying in the organisation.

When it comes to preventing errors, there are few things about human behaviour that are vital but never been looked. First, people do what they do in complex environments. Second, people don't want to get hurt. A initial look on why people do what they do leads us to think about the individual's motivation and ability. The employee doesn't want to make an extra effort to follow safe operating procedures that would be motivation or he doesn't know the procedures that are ability.

Most people work with other people. And these people can motivate, demotivate, enable or under safe behaviour. A police supervisor presses his fellow officers to get a job done ahead of schedule, motivating them to side steps, time consuming procedures. The organisation which includes among other things, the organisation's policy and procedures, can also impact both motivation and ability. There had been seen a lot of police departments that have unintentionally motivate unsafe behaviour by promising bonuses for completing jobs ahead schedule. And organisations that originally required employees to follow certain operating procedures that employees stuck to the procedure instead of doing what was safe.

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