Workplace Learning System

Weekly Safety Briefings

Week 10 – Monday, March 2 – Friday, March 6, 2026

Outcome Bias in Safety

Introduction

Introduction for Leaders (Use Prior to Monday's Toolbox Talk)

Purpose:
In safety, we often judge decisions based on how things *turned out* rather than *how the decision was made*. This is called **Outcome Bias**. When nothing goes wrong, unsafe choices can look acceptable. When something goes wrong, we may unfairly blame individuals, even when their decisions made sense at the time.

This week, we'll explore:

- How outcome bias shows up at work
- Why it increases risk over time
- How to recognize it in ourselves
- What better questions leaders and teams can ask

The goal is **better decisions**, not perfect outcomes every time.

Key Message to Set the Tone:

- Avoid hindsight language ("You should have known…")
- Separate **decision quality** from **result**
- Ask curiosity-based questions
- Reinforce speaking up, even when nothing bad happened
- Focus on systems, conditions, and tradeoffs

Monday - What Is Outcome Bias?

Key Message

Outcome bias is judging a decision by its result instead of the information and conditions present at the time. **Blaming feels good because it gives us closure without requiring effort.** When an injury occurs, assigning fault to a person creates a clear answer, protects our belief that the system works, and allows us to move on quickly.

Learning is harder. It requires sitting with uncertainty, challenging assumptions, and examining how *perfectly reasonable people* were set up to fail by brittle systems - tight margins, conflicting goals, time pressure, or inadequate defenses.

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Blame preserves comfort; learning improves safety. One stops the discomfort today, the other reduces the risk tomorrow.

Real-World Example

A mechanic skips wearing cut-resistant gloves to speed up a repair. The job goes fine, and no one gets injured. Later, others copy the behavior because "it worked." The unsafe decision is reinforced because the outcome was good.

Discussion Question

- If the same decision caused an injury tomorrow, would we judge it differently?

Takeaway

A good outcome does not automatically mean a good decision.

Supervisor Talking Points

- Emphasize that today is about awareness, not calling anyone out.
- Reinforce: "Luck is not the same as safety."

Tuesday - How Outcome Bias Hides Risk

When unsafe decisions have good outcomes repeatedly, risk becomes invisible. When people take shortcuts and "get away with it," the decision starts to feel acceptable, even smart. It feels efficient. As good outcomes pile up, risky behavior becomes the *new normal*. What once felt uncomfortable becomes routine. The organization loses sensitivity to the hazard. Risk becomes invisible because it hasn't yet produced harm. Outcome bias creates a false sense of system strength. When failures don't occur, leaders assume processes, procedures, and defenses are working. The system is brittle, appearing strong until conditions change. Outcome bias delays learning until consequences force attention. Near misses, workarounds, and weak signals are ignored because "it worked." Outcome bias doesn't just misjudge decisions, it **rewards exposure**, **blinds leaders to weak signals**, and **allows brittle systems to persist** until they fail under pressure.

Real-World Example

Employees routinely mention tools that don't quite fit the task, but since no one has been injured, the concern is deprioritized. Only after an injury does the organization investigate and discovers the issue has existed for years.

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Discussion Question

- "What parts of our job rely more on experience or luck than controls?"
- "Where do we quietly accept exposure because nothing bad has happened yet?"
- "What shortcuts don't feel like shortcuts anymore?"
- "What makes certain risks invisible to us day-to-day?"

Takeaway

Repeated success does not reduce risk, it often hides it.

Wednesday - When Outcomes Drive Blame

In many workplaces, **injuries flip a mental switch**. Before the incident, risk is often overlooked. After the incident, the organization suddenly becomes certain about what went wrong, who's responsible, and what should have been done. This shift is not driven by new evidence; it's driven by the **outcome**. Once someone is hurt, everything looks obvious.

What felt uncertain, complex, and messy before the event now seems clear and avoidable. This is hindsight amplified by outcome bias. Outcome-driven blame shows up clearly when **identical behaviors are judged differently**.

Workplace Reality

- Worker A performs a task the same way as Worker B.
- Worker A finishes safely - no investigation.
- Worker B is injured - discipline, retraining, write-ups.

The behavior didn't change. The system didn't change. **Only the outcome changed.** Yet the response becomes personal instead of systemic.

Blame Protects the Belief That "Our System Works"

Blame serves an emotional and organizational function. If the injury is caused by "human error," then:

- Procedures are still good
- Training was sufficient
- Equipment is acceptable
- Leadership doesn't need to change

Learning, on the other hand, creates discomfort. It forces organizations to ask:

- Why were people put in this position?
- What tradeoffs did we unintentionally encourage?
- Where did the system rely on people being perfect?

Blame keeps the system intact. Learning threatens it.

What people often think after an injury occurs:

- "They should have known better."
- "The procedure was clear."
- "If they followed the rules, this wouldn't have happened."

What unfortunately gets ignored:

- Competing goals (production, quality, time)
- Tool limitations or design issues
- Experience-based shortcuts that had been reinforced
- Signals that the system depended on luck

The injury outcome creates a false sense that the answer was always there.

Discussion Question

- "What usually happens after someone gets hurt that doesn't happen after a near miss?"
- "When injuries happen, what gets focused on first - conditions or people?"
- "What labels do we commonly use after incidents? ('Didn't follow procedure,' 'Inattention,' 'Human error'.)"

<u>Thursday - Improving Decision Quality</u>

In safety, we rarely control outcomes but we **can** improve the quality of decisions made under real-world conditions: pressure, uncertainty, limited time, and imperfect information. Strong safety performance comes from **better decisions before harm**, not better punishment after harm.

Improving decision quality means shifting focus from:

- *Who failed?*
  to
- *How did this decision make sense at the time—and how can we make better decisions easier next time?*

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Real-World Example

In the maintenance shop, everyone knew the SOP for clearing minor jams, but no one followed it because it slowed the job and never seemed necessary, until one day a technician's hand was caught when the equipment unexpectedly shifted. The supervisor's first reaction was frustration and blame, pointing to the written procedure and asking why it wasn't followed. But instead of stopping there, he asked better questions: how the job really got done, why the SOP was routinely bypassed, and what made the shortcut feel like the normal way of working. He learned the procedure didn't match the equipment layout, production pressure was constant, and the system quietly relied on workers adapting to keep things moving. The injury wasn't caused by one person ignoring a rule, it was caused by a brittle system that worked only when everything went right.

Discussion Question

- "Where do our procedures look good on paper but don't quite fit the job in real life?"
- "Which steps are hardest to follow when things get busy or unexpected?"
- "If we truly followed every step, what would quickly become difficult?"
- "Where does our system force people to choose between 'getting it done' and 'doing it by the book'?"

Takeaway

Strong decisions consider risk, uncertainty, and available information.

<u>Friday - Turning Awareness Into Action</u>

Recognizing outcome bias helps teams speak up and fix risk **before** someone gets hurt. "Recognizing outcome bias means we stop letting luck decide our safety. When we talk about risk early and honestly, we prevent injuries instead of reacting to them. The goal isn't perfect work, it's safer work." To make this a reality in our workplace, we must be open and honest about where risk is hiding. If something feels risky, awkward, or relies on luck, I want to hear about it. These conversations aren't about blame; they're about improving the system while everyone is still okay. Let's not wait for injuries to learn, lets start learning before injuries happen!

Real-World Example

A line worker noticed that the pallet jack path was getting tighter every week as more material stacked up near the line, and it started to feel like someone was going to get clipped or pinched. When she mentioned it, her supervisor didn't brush it off or tell her to "be careful," he walked out to the floor with her, watched how everyone was squeezing through, and asked what made it hard to keep the area clear. Together with the crew, they realized staging space had slowly disappeared and folks were

adapting just to get the job done. They rearranged the area, marked a clear travel path, and staged pallets differently, fixing the problem before anyone got hurt and showing the team that speaking up actually leads to change.

Discussion Question

- "What's one thing we could fix now instead of learning the hard way?"

Takeaway

Safety isn't about judging people based on results, it's about strengthening decisions in uncertain, real-world conditions. When we learn instead of blame, everyone goes home safe.

Supervisor Talking Points

- Commit to asking better questions.
- End the week by thanking employees for sharing concerns.
- Reinforce: "The best outcome is learning before someone gets hurt."