Stop Training Every Incident



An incident happens. The investigation is completed. The corrective-action list appears. Somewhere near the bottom is a familiar line: “Retrain employees.”

It is one of the most common responses in safety because it is fast, visible and easy to document. A toolbox talk can be delivered tomorrow. An online course can be assigned to everyone. A sign-in sheet closes the action. Leadership can see that something was done.

But training only works when the problem is something training can change.

If the worker already knew the rule, the equipment was difficult to use safely, production pressure rewarded the shortcut, the procedure did not match the job, the required tool was unavailable or the supervisor routinely tolerated the behaviour, another presentation may add paperwork without adding control.

> **Training is a control for a knowledge or skill gap. It is not a universal corrective action for every human action that appears in an incident report.**

Worker error is the beginning of the investigation

OSHA’s incident-investigation guidance is explicit on this point. A good investigation does not stop when it concludes that a worker made an error. It asks whether the worker had appropriate tools and time, whether training was adequate, and whether supervision was appropriate. The objective is to identify root causes and safety-program shortcomings that allowed the event to happen.

That is important because “the employee did not follow the procedure” describes an outcome. It does not explain why the procedure lost control of the work.

The worker may have misunderstood it. That is a training problem. Or the worker may have understood it perfectly and chosen a different method because the approved method was slower, physically difficult, unavailable or contradicted by

the way experienced employees actually worked. Those are different problems and need different controls.

Incident-investigation principle: OSHA Safety Management guidance recommends investigating beyond worker error to the tools, time, training, supervision and underlying program conditions that shaped the event.

Why retraining becomes the default

Retraining is attractive because it satisfies several organizational needs at once. It produces a dated record. It can be assigned quickly. It usually costs less than redesigning equipment or changing staffing. It feels corrective without requiring a difficult conversation about production, maintenance, supervision or capital.

It can also create false reassurance. The organization closes the action because the training was completed even though the condition that produced the event remains unchanged.

That is especially dangerous after a serious near miss. A weak corrective action can make the second event more likely because everyone believes the first event was addressed.

Use the five-question training test

Before assigning retraining, force the investigation through five questions. The answers usually make it clear whether learning is actually the control that is missing.

Question	If the answer is no	What it suggests
1. Did the worker know the correct action?	**The worker could not explain or recognize the required method.**	**Knowledge gap: training may be appropriate.**
2. Could the worker physically and operationally do it?	**The safe method was impractical, unavailable, awkward or incompatible with the work.**	**Task or design problem: fix the system first.**
3. Did the work environment support the safe choice?	**Time pressure, staffing, layout or incentives pushed the worker toward another method.**	**Work-organization problem.**

4. Did supervision reinforce the expectation?	**Shortcuts were tolerated, modeled or ignored.**	**Leadership and accountability problem.**
5. Had competence ever been verified in the real task?	**Completion was documented, but safe performance had never been observed.**	**Training-transfer or verification problem.**

The test prevents a common mistake: confusing a behaviour problem with a learning problem. Behaviour is influenced by knowledge, but it is also influenced by equipment, incentives, social norms, workload and what supervisors accept.

When training really is the right corrective action

Training is absolutely appropriate when the investigation finds a genuine knowledge or skill deficiency. The point is not to avoid retraining. It is to use it deliberately.

- The worker did not know the hazard or required control.
- The procedure or equipment changed and employees were not adequately prepared for the change.
- A task requires a skill that was explained but never practiced or verified.
- The original training was too generic for the actual workplace conditions.
- A long interval or infrequent task has degraded proficiency and the skill needs to be refreshed.
- The investigation identifies a broader misunderstanding shared across the crew or organization.

In those cases, the corrective action should describe what the retraining needs to change. “Review the procedure” is weak. “Operators will demonstrate isolation of all energy sources on Line 3 under observation before being reauthorized” is much stronger because it defines the performance requirement.

Training completion is not training effectiveness

One reason retraining fails is that organizations measure the delivery rather than the result. A worker watches the same video again, answers the same questions and returns to the same task under the same conditions. The LMS shows 100 percent completion. The risk has not moved.

If retraining is a corrective action, verify transfer. Observe the task. Ask the

worker to identify the hazard in context. Introduce a realistic variation. Confirm that the required tool or control is actually available. Have the supervisor reinforce the expectation in the field.

The evidence you need is not “the worker attended.” It is “the worker can now perform the required behaviour under the conditions where the failure occurred.”

A forklift example shows the difference

Imagine a forklift contacts a storage rack. The quick corrective action is refresher driver training.

Now investigate more deeply. The operator is authorized and experienced. The aisle has become narrower because peak-season product is staged outside the normal footprint. A blind corner is obstructed. The shift is running behind. Supervisors know the staging is a problem but have accepted it for two weeks because warehouse capacity is tight.

What exactly will forklift retraining fix?

The operator may still benefit from a discussion about speed and visibility, but the primary corrective actions belong elsewhere: restore aisle clearance, redesign staging, improve sightlines, control traffic and remove the production condition that made the unsafe geometry normal.

If the organization retrains the driver and leaves the aisle unchanged, it has converted an engineering and operating problem into a worker-responsibility problem.

A machine-guarding example is different

Now consider an employee who reaches through an opening to clear a jam without isolating hazardous energy. The investigation finds that the employee completed generic lockout/tagout training but had never been trained on the machine-specific energy sources or the jam-clearing procedure. Coworkers provide conflicting instructions, and competency was never verified.

Training is clearly part of the corrective action. But “retrain on LOTO” is still too broad. The organization needs machine-specific instruction, supervised practice, verification of energy isolation, clear jam-clearing expectations and supervisor reinforcement. It should also assess whether the frequency of jams or difficulty of access is creating pressure to bypass the safe method.

Good investigation rarely produces only one corrective action because real incidents rarely have only one cause.

Do not use retraining to repair a bad

procedure

A procedure can be technically correct and operationally unusable. It may require tools that are not stored near the task. It may assume two people are available when the job is routinely staffed with one. It may describe equipment that was modified three years ago. It may be so long that experienced employees rely on memory because finding the relevant step takes too much time.

If workers routinely deviate from the same procedure, stop treating each deviation as an individual training failure. Observe the work and compare the written process with the real one. The pattern may be telling you that the procedure needs redesign.

Training workers harder on an unrealistic procedure can actually reduce credibility. People learn that formal safety expects something the operation does not support.

Supervisor behaviour can overpower training

Employees learn quickly which rules are real. If a supervisor praises output after a shortcut, ignores a recurring deviation or personally uses an unsafe workaround, the field lesson is stronger than the course.

That is why a corrective action aimed only at frontline workers can fail when the causal factor sits at the supervisory level. The supervisor may need coaching on intervention, planning, production expectations and how to handle the operational friction that caused the deviation.

In some cases the right corrective action is not more training at all. It is accountability. If a competent person knowingly violates a clear, workable and consistently enforced rule, the organization needs to address that through its established performance process rather than pretending another course will supply information the person already has.

Trainers should ask for a diagnosis before accepting the prescription

Safety trainers are often handed corrective actions after the investigation is effectively closed: “Build a refresher.” A strong trainer should ask for more context before designing anything.

- What specifically did the worker not know or not know how to do?
- What evidence tells us this is a knowledge or skill gap?
- Was the correct method available and practical at the time?
- What did the supervisor and coworkers normally do in the same situation?
- Has the equipment, procedure, staffing or production environment changed?
- How will we verify that the intervention changed performance rather than only completion?

Those questions are not resistance to training. They are quality control for training. They help ensure the trainer is solving the causal problem instead of producing content to close an action item.

Build corrective actions around the hierarchy of control

Training is an administrative control. Administrative controls are often necessary, but they are inherently dependent on human consistency. When an incident reveals an opportunity to eliminate the hazard, substitute a safer process, engineer out the exposure or physically separate people from it, those options deserve priority.

That does not mean every incident needs an expensive engineering project. It means the corrective-action discussion should not start and end with the easiest administrative response.

Finding	Better corrective-action direction
Worker did not know the hazard	**Targeted instruction plus understanding check**
Worker knew but could not perform the safe method	**Redesign task, equipment, access or resources**
Procedure did not match actual work	**Rewrite and validate procedure with workers**
Shortcut was normal and tolerated	**Supervisor and leadership intervention; address incentives and norms**
Equipment repeatedly creates the same abnormal condition	**Engineering or maintenance correction**
Training was completed but competence never verified	**Field observation, practice and authorization process**
One worker knowingly violated a workable, enforced rule	**Apply the organization’s accountability process; do not disguise it as training**

Measure whether the corrective action survives the field

The final step is verification. After 30 or 60 days, return to the task. Is the condition different? Are people using the new method? Is the tool available? Has the supervisor reinforced it? Have near misses or deviations continued?

Corrective-action closure should mean the control is functioning, not merely that the assigned action was completed.

This is where OHS managers can materially improve both safety and credibility. Workers notice when every event produces the same generic retraining. They also notice when an investigation fixes the condition that made the job difficult to do safely.

> **The best corrective action is not the one that closes fastest. It is the one that changes the conditions that made the incident possible.**

Key takeaways

- Do not treat worker error as a root cause. Investigate the tools, time, task design, training, supervision and incentives around the behaviour.
- Use retraining when there is evidence of a genuine knowledge or skill gap.
- Define the performance that must change rather than assigning generic refresher content.
- Verify competence in the real task, not only course completion.
- Fix procedures, equipment and operating conditions when they make the safe behaviour impractical.
- Revisit corrective actions in the field to confirm that the control is actually working.