

Learn from the present to improve the future — root cause analysis in incident investigation

April 1, 2009 Session SCH143 Presented by Ralph Oliveti, CSP

# Accident Investigation SCH 143

Learn From the Present to Improve the Future – Root Cause Analysis in Incident Investigation



Ralph Oliveti, CSP



# **Objectives**

- Identify reasons for conducting incident investigation
- Define root cause analysis
- List pros and cons of root cause analysis
- Describe 4 types of root cause analysis methods



"Those who do not learn from history are condemned to repeat it"

# **Apollo 13**

- 000 0000 00000 0000 0000 0000
- Rapid release of oxygen from a tank on board the Apollo 13 led to severe damage and an almost catastrophic incident.
- The oxygen tank was shipped apparently in "good" condition.
- Going backwards from the incident to the point when everything was in satisfactory shape identified 12 "failures".

# The Investigation Process

# **Identify Causes**



- •What do you know?
- •What don't you know?
- How can you find out what you don't know?

#### **Causal Chain**



- An ordered sequence of events in which any one event in the chain causes the next.
- Breaking the chain at any point can prevent the unwanted event.
- Finding out what caused the chain reaction to start can prevent the incident from ever occurring.

#### **Causes**

- Proximate Cause
  - an event which is *closest*, or immediately responsible, for causing some observed result
- Single Cause
  - Based on the belief that there is a single cause for any outcome that, if prevented, would prevent the outcome itself
- Multiple Causes
  - Based on the belief that there can be more than one root cause that can contribute to the existence of the proximate cause

#### **Root Cause**



- The beginning of the causal chain
- That element or group of elements that allowed the proximate cause to exist.
  - Interest
  - Inattention
  - Knowledge
  - Understanding

### **Root Cause Analysis**

- System for finding the underlying causes of an event.
- When using root cause for accident analysis ..... The event is the accident.

#### 000 0000 0000 0000 0000 0000

# Why Root Cause Analysis



- Find the "Causes" of the cause.
- Typical accident investigations stop when the investigator identifies the proximate cause
- Proximate cause is the event that led directly to the incident.

#### **Potential Investigation Failures**

- 000 0000 00000 00000 00000 0000
- The investigation concludes when a proximate cause is determined.
  - The employee slipped because there was oil on the floor.
- The investigator has a preconceived idea of the cause.
  - The oil was on the floor because the person responsible for clean-up wasn't doing his/her job.
  - The person who slipped wasn't watching where he/she was going.
- Result
  - Employee disciplined for not cleaning the floors (Poor job performance)
  - Person counseled for not watching where they were going.

#### **Potential Investigation Failures**



- Follow-up
  - Employee responsible for cleaning the floors increases the number of times that they clean the floor from 2 times per day to 6 times per day.
  - Opportunity for slipping in that location is reduced significantly.
  - Other responsibilities not fulfilled creating other opportunities for incidents to occur.

#### **Potential Investigation Failures**



- The investigator doesn't understand the process well enough to ask the right questions in the investigation.
- The investigator doesn't understand the significance of the answers that they are getting.
- The investigator doesn't like or believe potential causes that are discovered.

#### **How Does Root Cause Help**



- Does not stop with the proximate cause.
  - So why was there oil on the floor?
  - Because of a leaking flange.
  - Why was the flange leaking?
  - Wrong gasket.
  - Why was the wrong gasket being used?
  - Supplier doesn't have the correct gasket.
  - Why not use a different supplier?
  - That supplier is the only one available on the approved vendor list.
  - Why are they the only ones on the approved vendor list?
  - Their prices were significantly lower than anyone else.

# **System Approach**

 Requires a set of questions be asked and answered regardless of the circumstance and regardless of how "Obvious" the answer.

## **How Does Root Cause Help**

- Team Approach
  - Reduces the likelihood that a potential cause will be ignored or eliminated because the investigator doesn't like or believe the potential cause (s).
  - Different perspectives of the same set of conditions.

# **Investigation Process**

- Team members:
  - Supervisor
  - Individual involved
  - Co-worker/witnesses
  - Trained facilitator
  - ERT representative
  - Technical Expert

# **Fact Gathering**

- 0000
- Gather all possibly relevant facts that may contribute to understanding the accident.
  - What do we know?
  - What do we think we know?
  - What don't we know?
  - How can we confirm what we think we know and find out what we don't know?

#### **Evaluation**

- 000 0000 0000 0000 0000
- Is the information consistent with the facts?
- Is the information plausible?
- Let the analysis begin!

#### **Types of Root Cause Analysis**



- 5 Whys
- Change Analysis
- Ishikawa Diagram also known as the fishbone diagram or cause and effect diagram
- Fault Tree

# 5 Whys



• Start from the result and work backward

#### I fell on my face

Why? Tripped over my shoelaces Why? My shoe laces weren't tied

Why? Too much effort to bend down and

tie them

Why? Completely out of shape Why? Too lazy to exercise

#### 5 Whys



- Simple
- Can be done in minimal time
- Single person investigation
- Needs to be reviewed by a second investigator

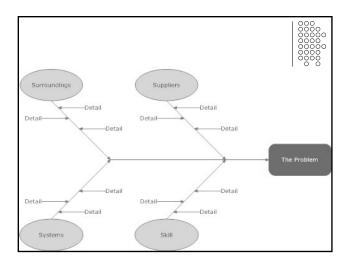
# **Change Analysis**

- 000 0000 0000 0000 0000 0000
- Compare two similar circumstances.
- One has no problems and one does.
- What are the differences that could have led to the existence of the problems?

#### Ishikawa (Fishbone) Diagram



- Diagram analysis into categories
  - Equipment, Materials, People, Procedures
- <a href="http://www.classtools.net/main\_area/fishbone">http://www.classtools.net/main\_area/fishbone</a>
  .htm
- Best used to identify the proximate cause or causes.



### Ishikawa Diagram



- More detailed than 5 Whys
- Uses "brainstorming" as means of identifying potential causes.
- Select 3 most likely causes from each category and investigate
- Find the proximate cause or causes
- Use 5 Whys to determine root cause

# **Fault Tree Analysis**

- 000 0000 0000 0000 0000 0000
- In depth investigation tool
- The incident is taken as the top event of a logic tree.
- Each situation that could cause that incident is added to the tree as a series of logic expressions.
- Identifies causes and eliminates "non"causes

#### **Methods**

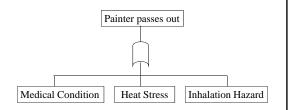


- Start with the result
- Work backwards using "and" gates and "or" gates.
- "And" gates are used if more than 1 factor is required to achieve the result
- "Or" gates are used if any one of several factors alone can lead to the result.

# **Example**



• A painter passes out while sandblasting the top of a chemical tank containing Acetone



#### **Additional Information**



- Painter was wearing an airline respirator
- Initial thought is it can't be an inhalation hazard
- Three potential points of failure
  - Respirator Face Piece
  - Air Hose
  - Air Compressor

