(Intro to) Root Cause Analysis

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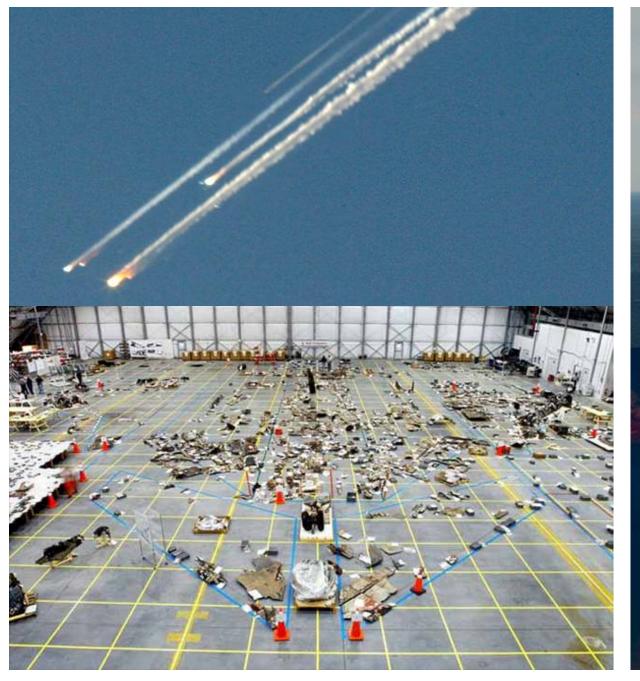
About Me

- Safety story
- Current work
- Distinctives
- Family
- Hobbies
- My why

Overview

- Have better understanding of RCA and how to use it
- 20+ minutes, not week-long workshop

- Incident investigation basics
- Root cause analysis
- RCA methods
- Common traps



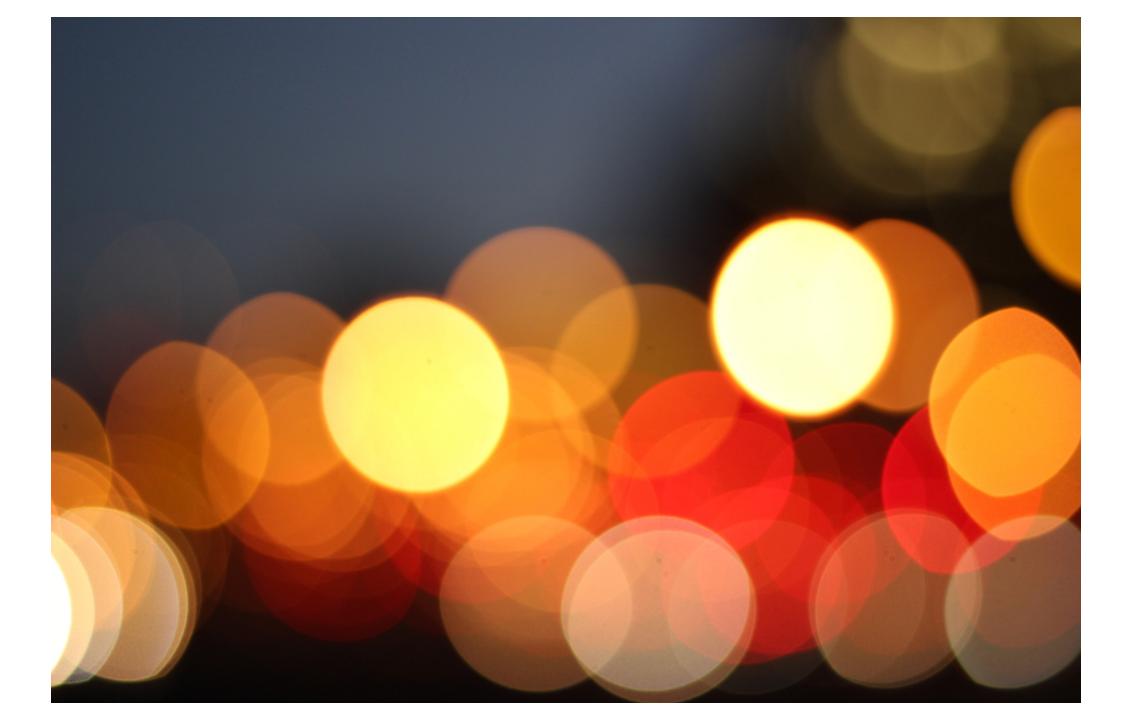


State	Title
NC	Sanitation worker struck by backing refuse truck - North Carolina.
ID	Logging processor lost traction and rolled down hillside fatally injuring operator - Idaho.
ОН	City electric maintenance worker electrocuted while installing lines for security cameras - Ohio.
TN	Laborer, pipefitter, and utility foreman crushed by falling block wall - Tennessee.
WV	Two tower climbers fatally injured when a cellular tower collapsed while performing tower upgrades - West Virginia.
SC	Officer dies in motor vehicle crash at an intersection while responding to a shots fired call - South Carolina.
NC	Feller struck by dead locust tree while felling adjacent tree - North Carolina.
WV	Oil and gas delivery driver crushed between a dozer and a semi-truck while connecting towline - West Virginia.
NC	Feller struck by tree limb while felling adjacent tree - North Carolina.
KY	Trooper crashes on roadway while responding to reckless driver complaint - Kentucky.
TN	Officer struck by a motorhome while establishing temporary traffic control on interstate - Tennessee.

Incident Investigation Steps

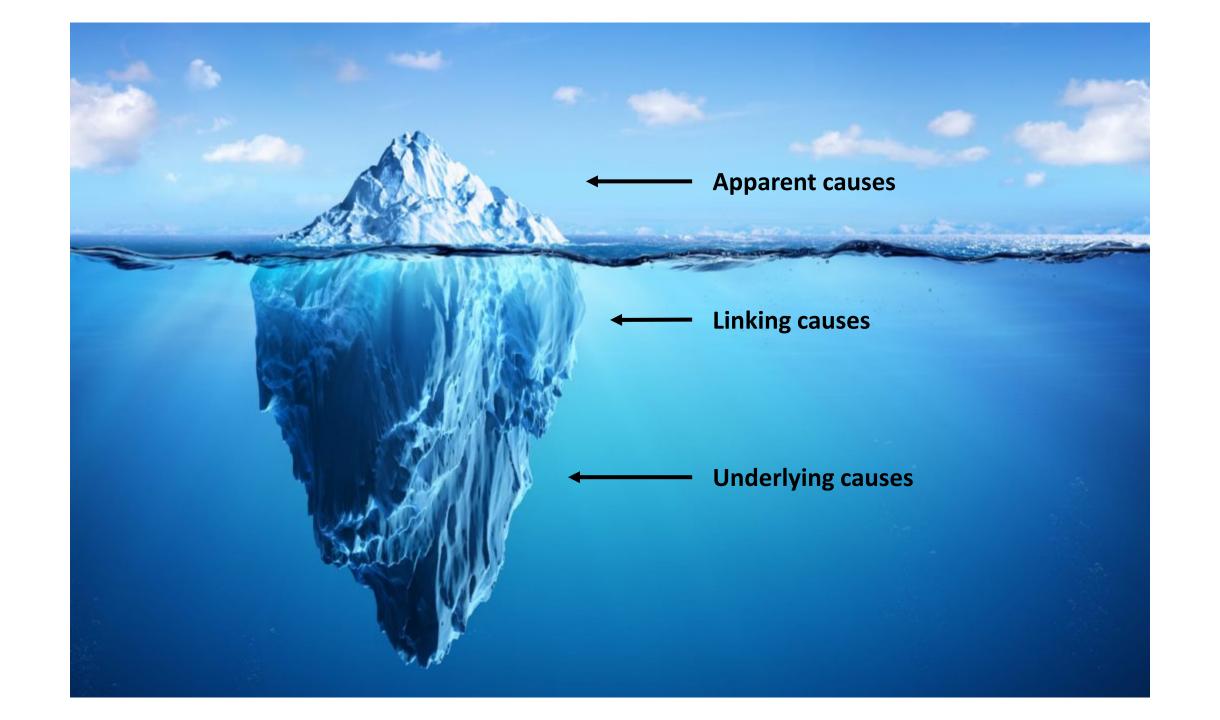
- ★Incident occurs
- Report incident?
- Investigate now?
- 1) Start investigation
- 2) Collect info
- 3) Interpret info
- 4) Find root causes
- 5) Make recommendations
- 6) Close out investigation





Causes

- Apparent causes (causal factors)
 - Performance gaps (deviation from desired performance)
 - Human error and/or equipment failure
- Underlying (root) causes
 - Task → process → systems → culture
- Multiple apparent causes per incident
- At least one root cause per apparent cause
- How deep to go?



Causal Analysis

- Informal vs formal
- ACA vs RCA
- Basic problem-solving vs structured analysis
 - E.g., only fix defective part vs correct maint. mgmt. system

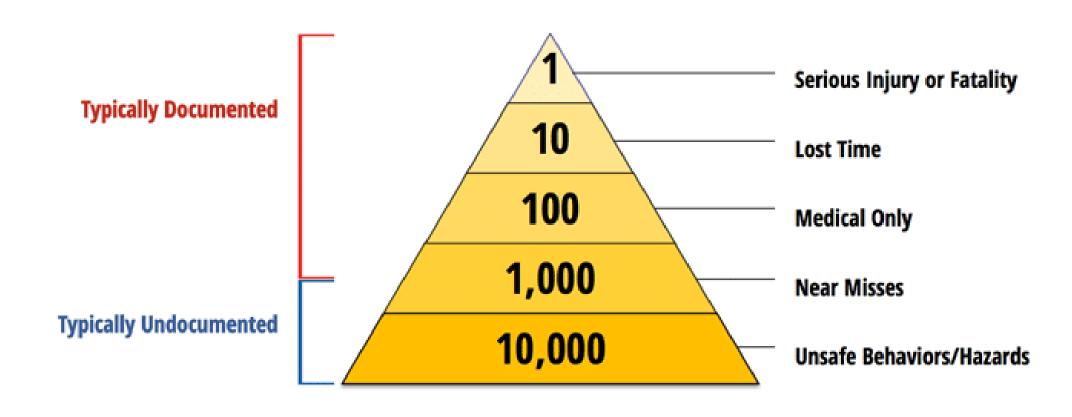
Example (large)

- Broken arm
- Fell forward onto concrete floor
- Tripped over cord in walkway
- Hazard identification & abatement ineffective
- Supervision/enforcement lacking
- Limited to no training & communication
- Policies and standards do not specify

Example (small)

- No injury (near-miss)
- Stumbled and nearly fell
- Tripped over cord in walkway
- Hazard identification & abatement ineffective
- Supervision/enforcement lacking
- Limited to no training & communication
- Policies and standards do not specify

Heinrich's pyramid/triangle



What is RCA?

- Root cause = fundamental, underlying cause
- Reactive, not proactive
- RCA = formal, systematic process for ID'ing root causes
- Digs deeper than causal (contributing) factors
 - More than just putting out fires
- Systems based approach
 - Management
 - Employee
 - Equipment
 - Environment

Why RCA?

- Practical way to add value
- Increase learning
- Permanent solutions
- Prevent/reduce risk/harm
- Save resources (time & money)

Treating Symptom vs Cause





Goal

- All about finding the [root] causes...
 - What? → How? → Why? Why? Why?
- ...so that proper corrective actions are made...
- ...to prevent future occurrences.

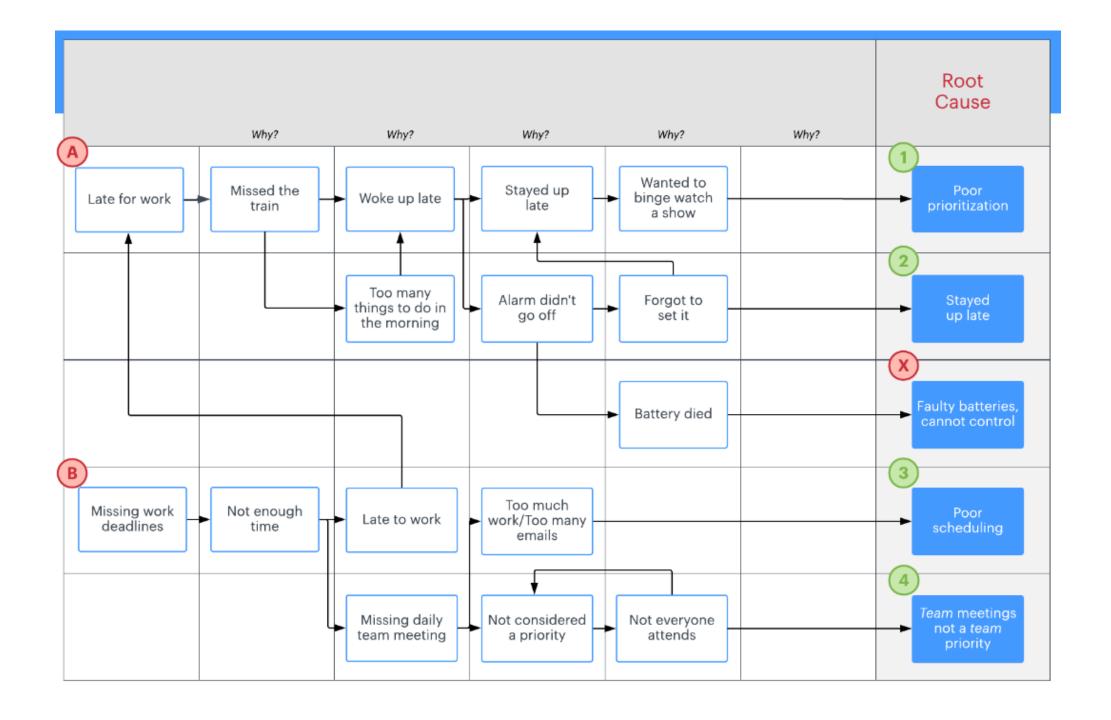
When to apply RCA?

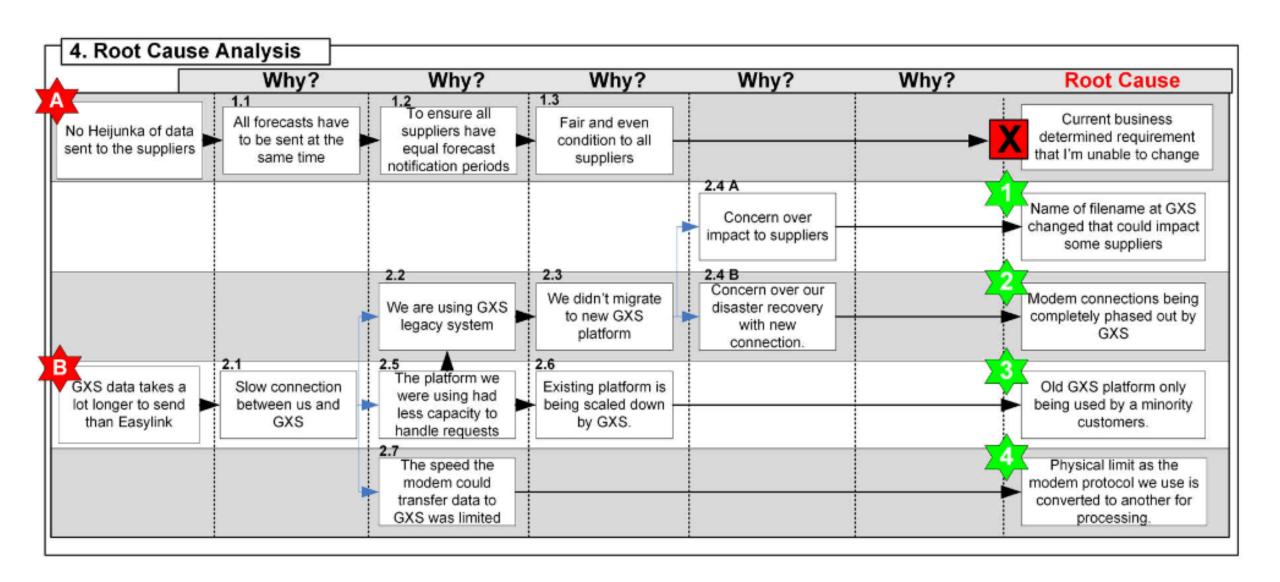
- Major/large incidents
 - Injury, property damage, enviro release
- Large incident near-miss
- Trending from small incidents

- Examples:
 - Major collision resulting in totaled vehicle and lost-time injury
 - Total rigging failure on 10-ton load (no injury/damage)
 - Single light bulb vs 500 light bulbs

Methods

- 5 whys
- MEEE
- Pareto principle
- Causal factor tree analysis
- Fish bone diagram
- Fault tree analysis
- Timeline





Trending

- Used for all reported incidents
- Info stored in database
- Provides depth of information
- Guides future efforts

Incident Investigation Steps

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Recommendations

- Where the rubber meets the road
- Thoughtful/artful approach
- Something **could** always be done
- What **should** be done?
- Must be reasonable and measurable
- Short-term vs long-term

Common Traps

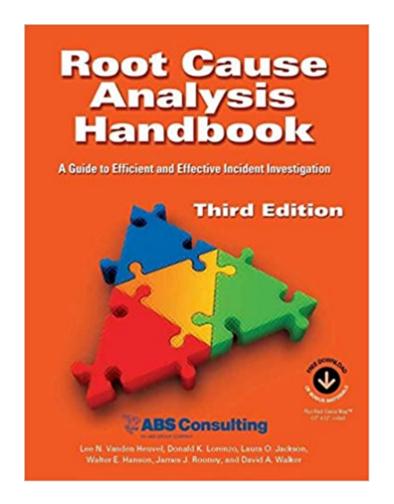
- It was just a fluke accident
- One off equipment failure
- Focus on person's mistake (blame game)
- Apathy towards outside events
- Misguided effort
 - The greater the consequence, the greater the effort

Get Help!

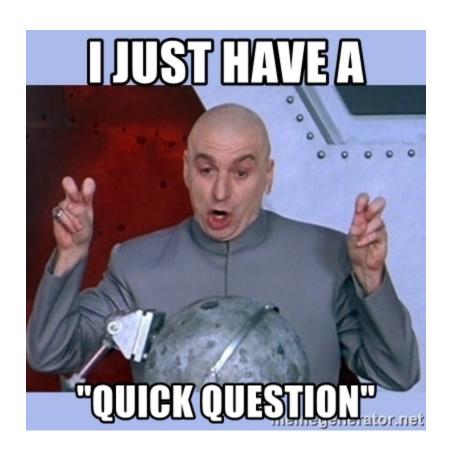
- Continuing education
- Within your org
- Approach Amy & Julio
- Associations (ASSP, etc)
- OSHA consultation
- Paid consultation

Resources

- https://www.saif.com/safety-andhealth/topics/be-a-leader/accident-andincident-analysis.html
- https://www.osha.gov/incident-investigation
- https://des.wa.gov/services/riskmanagement/about-riskmanagement/enterprise-riskmanagement/root-cause-analysis
- https://www.abs-group.com/Training/



Questions?



Thank You!

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