Root Cause Analysis: Reduce the Risk of Future Accidents Using OSHA's Incident Investigation Process

A Webinar Presented on January 31, 2019 By:

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OBJECTIVES

- Purpose of root cause analysis
- Types of root cause analysis
- How to conduct them
- Common biases and pitfalls
- Following up on root cause analyses
- Leveraging results
- Getting and keeping employee buy-in

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WHAT IS THE PURPOSE OF ROOT CAUSE ANALYSIS?

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WHAT IS ROOT CAUSE ANALYSIS?

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DEFINITION

OSHA defines a root cause as “a fundamental, underlying, system-related reason why an incident occurred that identifies one of more correctable system failures.” (emphasis mine)

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ROOT CAUSE ANALYSIS

What we can “see”: the symptom of the problem

The underlying cause, aka the “root”

Don’t mistake symptoms/effects with underlying causes! (Also: Remember to re-evaluate the JSA)

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HOW TO CONDUCT A ROOT CAUSE ANALYSIS

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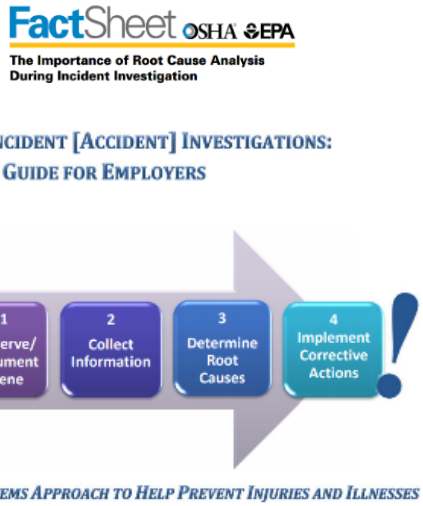
OSHA GUIDANCE AVAILABLE ON WEBSITE



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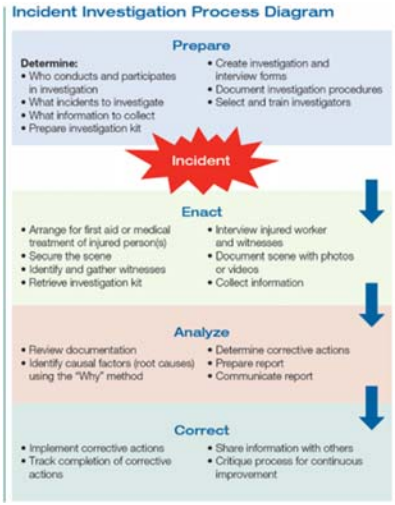
THE INCIDENT INVESTIGATION PROCESS

Root cause analysis
Is one part of an
overall incident
investigation process



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STEPS IN INVESTIGATION PROCESS

- Call the right people to begin investigation
- Secure the area where incident occurred
- Gather witnesses
- Interview involved worker(s)
- Interview all witnesses
- Take photos/videos
- Complete investigation report
- Use results to improve systems/procedures
- Ensure follow-up on corrective actions

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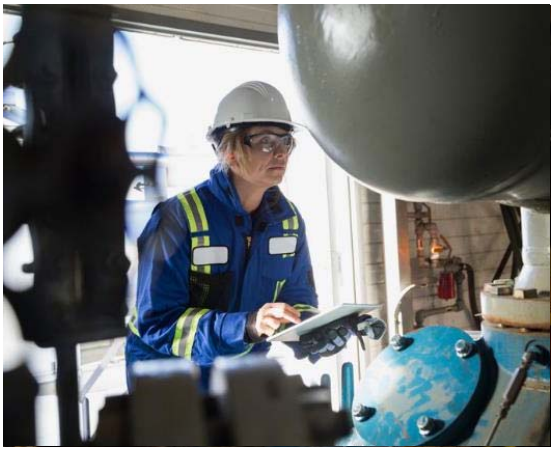
DOCUMENT THE INVESTIGATION

Be sure to document:

- Who is involved
- Who is investigated
- Information collected – e.g., incident description, time, conditions
- Interview statements
- Corrective actions



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DETERMINE CAUSAL FACTORS

The immediate causes may likely be the easiest ones to spot. However, be sure to go deeper. Identify the underlying reasons why the immediate causes themselves happened. These are your "root causes."

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EXAMPLE: DETERMINING ROOT CAUSES

The incident: An employee at a chemical manufacturing company is cleaning up the workstation at the end of a hot summer day, and dumps several residual quantities of chemicals into a waste drum. A reaction is catalyzed and the drum begins to bulge, nearly exploding were it not for the response of fire fighting personnel. What are the causes?

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IDENTIFYING IMMEDIATE CAUSES

Immediate causes:

- Employees did not follow proper storage procedures for the waste
- The employee did not know how to properly dispose of the waste
- Employees didn't realize the residual chemicals were "incompatible" with the waste in the drum

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BUT….WHY DID IT REALLY HAPPEN?

Deeper causes:

- Inadequate procedures for reviewing hazard info of chemicals.
- No system in place to train employees on waste handling
- Risk assessments/chemical reviews did not identify the potential to catalyze a chemical reaction when the chemicals were mixed together

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KEEP DIGGING!

And some even *deeper* causes:

- Recent budget cuts led to headcount reduction
- Some people who used to review chemicals and conduct training left the company
- Others in the company did not fully understand the roles played by the employees who left
- No procedures existed to ensure continuity of procedures

Key point: At the deepest level, this was a **system** failure.

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ESPECIALLY IMPORTANT TO RMP/PSM

Good root cause analysis informs risk assessment procedures, and ensures better mechanical integrity programs and management of change (MOC) workflows.

Example: Investigation of leak of hydrocarbons from a valve system

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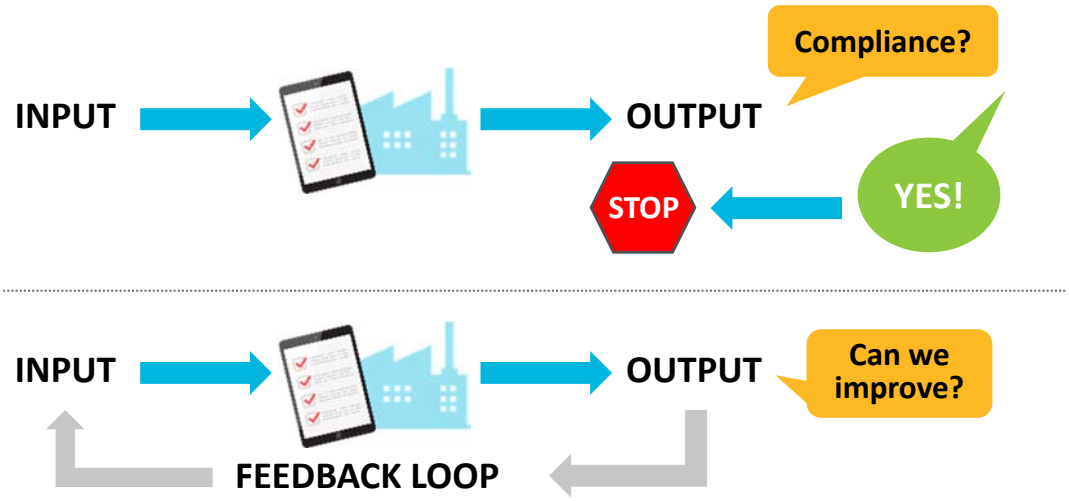
TRUE CONTINUOUS IMPROVEMENT VS. A COMPLIANCE FOCUS



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THE TYPES OF ROOT CAUSE ANALYSIS

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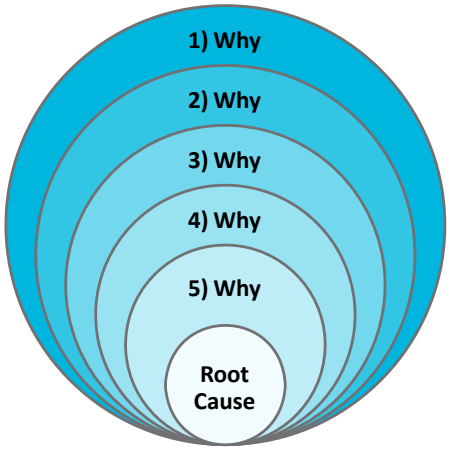
THE “FIVE WHYS” METHOD



Problem or challenge
Simple in concept, but hard to do well in practice. For every incident, you ask “why” it happened five times, each time going to a “deeper” answer.

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HERE’S HOW TO DO IT

Let’s revisit the previous example.

Why did the incident happen?
Because the operator followed incorrect chemical handling procedures.

Why did the operator follow incorrect procedures?
The operator wasn’t trained properly.

Why wasn’t the operator properly trained?
Inadequate risk identification, lack of established training procedures

Why were there failures in risk identification and training procedures?
Individuals who formerly possessed this knowledge were no longer available

Why did this gap develop?
Company profits caused staff reduction. It was not sufficiently understood what roles some of the employees played, and no system to ensure continuity if they left.

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FAILURE MODE AND EFFECTS ANALYSIS (FMEA)

Aims to find various modes for failure within a system.

- Determine all failure modes
- How frequent is each cause of failure?
- What correct actions are needed?
- Are the actions effective and efficient?

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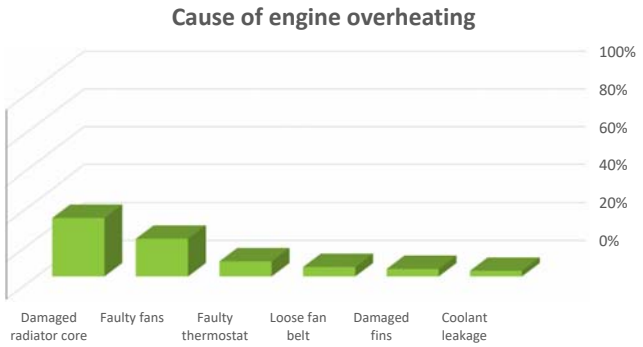
PARETO ANALYSIS

"20% of the work creates 80% of the results" – the Pareto principle

Pareto analysis might be useful when there are multiple causes to a problem.

1. Create a Pareto chart
2. Track cumulative % in a line graph to top of table
3. Causes reflected in table should account for at least 80% of those involved in problem



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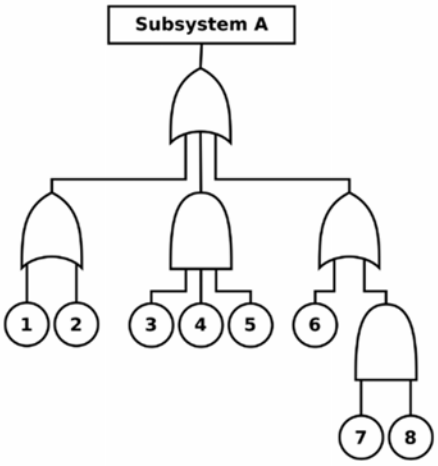
FAULT TREE ANALYSIS

Boolean logic is used to determine the root causes of an event.

1. List the undesirable event at the top of the fault tree
2. Show all potential causes “treeing” down from it
3. Each potential cause is listed in shape of an upside down tree



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GOT ALL THAT? GOOD, BUT REMEMBER….

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…IT DOESN'T MATTER WHICH METHOD YOU USE!!

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JUST DO IT RIGHT

- It's easy to get caught up in method and lose sight of the big picture. We want to capture the real, deeper causes, no matter which method we use. Don't focus on the method. Keep the end result in view.

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DON'T TAKE SHORT CUTS

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LET'S LOOK AT A FEW EXAMPLES OF ROOT CAUSE ANALYSIS

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EXAMPLE #1

The problem: You discover that an employee recently began managing hazardous waste but never received hazardous waste training.

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THE "OBVIOUS" SOLUTION

1. Train the employee who needs training
2. Declare the problem solved!

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THE DEEPER, "SYSTEMS-FOCUSED" SOLUTION

1. Train the employee who needs training
2. Identify the underlying reasons why the employee had not been trained
3. Correct any issues with procedures/policies
4. Conduct communication/training for all affected parties
5. Make sure responsibility for training is known, and ideally shared among several people
6. In general, make it very unlikely it will happen again!

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EXAMPLE #2

A toy manufacturer creates metal parts that are coated with a resin blended from several ingredients, and routinely cured in an oven. While curing is in in process one day, a fire starts in the oven. No one is injured, but the oven is rendered too damaged for use. During the investigation, we learn that the curing time was exceeded, and a box containing other residual materials was also left in the oven.

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THE “OBVIOUS” SOLUTION

Don’t let anything else be in the oven when the parts are curing. Reduce the curing time. Those are the two things that were “different” this time, so fixing those things also fixes the problem, right?

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MAYBE NOT…..

We’re psychologically disposed toward thinking that the “different” things that happened must be the cause. But that doesn’t go deep enough. How do we know that the things we do regularly aren’t the problem? It might be that there are risks associated with the process we never identified, and would still be there if we fix the “obvious” stuff.

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FOR INSTANCE….

How well do we understand all of the ingredients we blend to make the resin? Are we aware of their flash points and incompatibilities? Which combinations of ingredients might be problematic? And how are we sure that the curing temperature and curing time are really safe?

Most importantly….

How do we ensure that any operator will always know the hazards and safe work practices for this job task? (What if the usual operator leaves, and we have to train someone? How would we do that?)

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EXAMPLE #3

As part of a plant beautification process, Management of a retail company orders some topcoat and epoxy to paint the main warehouse. During application of the coatings, employees complain about the fumes, and several need to go home due to complaints of dizziness and nausea.

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WHY DID THIS HAPPEN?

Subsequent investigations reveal that the paint was never properly assessed by corporate EHS prior to being brought on-site. Therefore, no one reviewed hazard information on the SDSs, which would have revealed that some of the components are volatile and have permissible exposure limits (PELs) and short-term exposure limits (STELs). Ventilation recommendations, if followed, could have prevented the incident.

So, the big take-away is “no more painting without proper review,” right?

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NOT SO FAST….

OK, if we had that as a take-away, we’d head off problems with future painting incidents….probably.

But what if years from now we need or want to *remove* the paint, and need to use paint stripper? What if we don’t paint at all, but get a new floor cleaner to make the concrete floors nice and shiny? Neither of these cases would involve painting, but both could introduce new hazards.

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THE DEEPER ISSUE

Why weren't the paint and epoxy properly reviewed? Chances are, you probably have a procedure for reviewing hazards of new chemicals and processes when it comes to **operations**. But since this wasn't operations-related, you didn't have a procedure for reviewing hazards. Without that in place, you may have an analogous incident in the future.

So, one of the biggest real root causes is the lack of procedures or plans for assessing risks related to operations besides production ops.

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EXAMPLE #4

An automobile parts manufacturing facility decides to implement a new uniform policy for all shop-floor employees. One week after distributing the uniforms, a manual machinist gets part of his sleeve stuck in the machine, pulling his arm partially into the gears and luckily just scraping the skin. A first aid-incident that could've been a serious recordable, even an amputation.

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THE OBVIOUS STUFF….

Several things jump out at us right away. Clearly, there was a failure to properly risk assess the uniforms. If we'd risk assessed them, we would have seen (possibly) the risk for manual machinists, where loose/hanging clothing is a serious hazard. Likely, we thought of the uniforms as just being "clothes," and of entirely lacking EHS considerations.

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LOOKING A LITTLE HARDER…

We can start to ask related questions. E.g., what about other types of risks that we might have missed? E.g., are welders wearing these, and is the material fire-resistant? And why did we miss that there might be EHS issues here, and how do we fix that?

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HERE'S WHERE HONESTY IS NEEDED

We can say that "failure to properly risk assess the uniforms" or "failure to have adequate risk assessment policies in place" might be a root cause. To be sure, it's important stuff. But it's not the whole story. Because the painful truth is, in this case, how could we possibly have made these assumptions if we had a good EHS culture, and sought employee input? Any manual machinist would've *told us* the risks, if we'd asked her or him.

So why didn't we?

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DEEPER ROOT CAUSES

Clearly, there is an underlying issue with the culture itself. Management does not seek the input of employees, and therefore cannot learn what they need to know to properly manage risk. This can be fixed, but it will take effort on many fronts:

- Better communications to employees
- Actively seeking input from employees
- Sharing progress on corrective actions
- True prioritization of safety, e.g., "safety stand downs"

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EXAMPLE #5

While moving am old piece of machinery, an employee places his hand near a sharp corner and punctures his hand. He winds up needing stitches and a prescription drug, so the injury is recordable. He had not been wearing a glove.

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THE OBVIOUS ANSWER

Aha! No glove! That's why this incident happened.

Investigation over.

Right?

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NOT SO FAST…

We need to ask WHY the employee wasn't wearing a glove.

We find that this happened 4 days before an important CEO visit. An email from the plant manager urgently urged all supervisors to clean up all work areas, including removing old/inoperable pieces of equipment, and doing all of it ASAP. Supervisors passed these instructions on to the employees. Because supervisors has production priorities related to the visit, they were not around to oversee all of the moves.

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SO, DIGGING DEEPER…

….We find that this was a non-routine task, and existing risk assessments and Job Safety Analyses (JSAs) did not address non-routine task (common mistake)! We also find that combined with the rush, and the related issues like lack of oversight, we had the "perfect storm" for a safety incident to occur!

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Take-Home Lessons

"One central principle…is the need to consider the organizational factors that create the preconditions for errors as well as the immediate causes."

-SIDNEY DEKKER (2006)

General rule: behind the "behaviors," there are program weaknesses that prompted those behaviors.

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AS A GENERAL RULE

You'll do a bad job with root cause analysis if:

- You believe that "unsafe employees" cause most incidents
- You believe "unsafe behaviors" causes most incidents
- You believe lack of "personal responsibility" causes most incidents
- You believe that once training or communication has been provided, it's on the employee if a safety incident still happens

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HOW TO GET THE MOST OUT OF YOUR ROOT CAUSE ANALYSES

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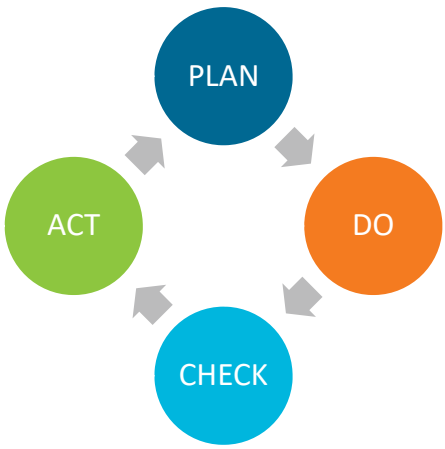
TIP #1 CONTINUOUS IMPROVEMENT

Continuous improvement is central to root cause analysis, as well as to incident management and corrective actions



Each run through the cycle should bring you closer to your goals! This is a defining feature of a good "systems-based approach."

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A LITTLE MORE ABOUT "NEAR MISSES"

- A "near miss" (or "near hit," or "close call") is any unplanned event that did not result in an injury, illness or damage, but would potentially do so if repeated.
- Reporting near misses = stopping incidents BEFORE they happen. **You should do root cause analysis for near misses.**
- Remember: Better near miss reporting means your # of near misses will go UP. This is a GOOD thing. **Try to make others understand this, too!**

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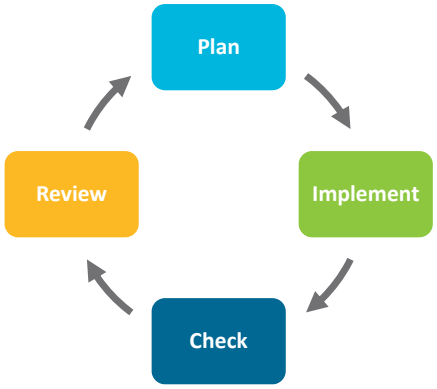
IMPLEMENTING CONTINUOUS IMPROVEMENT



MANAGEMENT ELEMENTS → **MANAGEMENT SYSTEM**

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#2 SHARPEN YOUR TRAINING PROGRAM

Train your employees on root cause analysis & incident investigation

- Awareness of policies and procedures
- Different techniques
- Theories/importance of root cause
- Doing good investigations & avoiding bias

In general, training is how you ensure that you are doing root cause analysis effectively.

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TRAINING MANAGEMENT

- Other considerations:
- Employees with special safety roles should receive more specialized training
- For documentation purposes: MUST be able to verify effectiveness of training

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KEY TRAINING CONSIDERATIONS

- How do you ensure the right people are trained in the right things. Example: new maintenance person. What training does she need?
- Should address specifics of your site and your job tasks
- Completion %s should be high, preferably > 80%
- Must be able to document training status of all employees for all trainings, and do so easily

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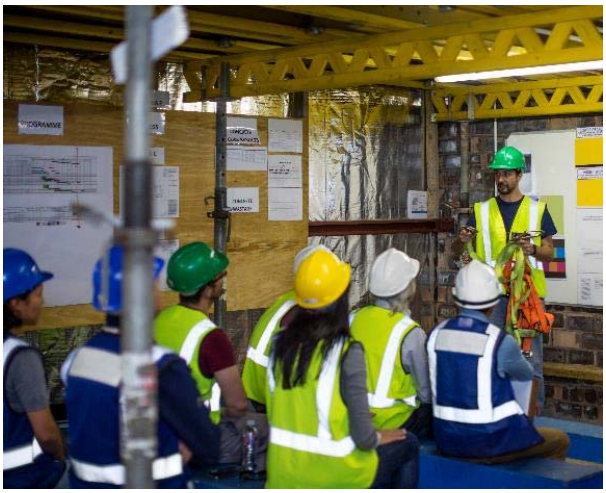
ARE YOU TRAINING EVERYONE WHO NEEDS TRAINING?

Remember to include:

- Office workers (often missed!)
- Executives
- Temp workers
- Contractors
- OSHA's guidance on temp and contracted workers: **You** should train them on the specific safety policies and risks associated with **your** facility. Don't assume they already know what they need to know.



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#3 METRICS – TRACKING YOUR PROGRESS

There are many different metrics you can track, and you'll need to decide which ones matter most to you.

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SOME TIPS ON METRICS

- Track at least some leading metrics and at least some lagging metrics
- Tracking near misses is great – but make sure everyone understand how to interpret trends
- Track metrics related to issues that are a particular challenge for your company (e.g., overdue action items)
- Tracking metrics alone is not enough to improve performance. Must incorporate your tracking into a robust corrective actions program

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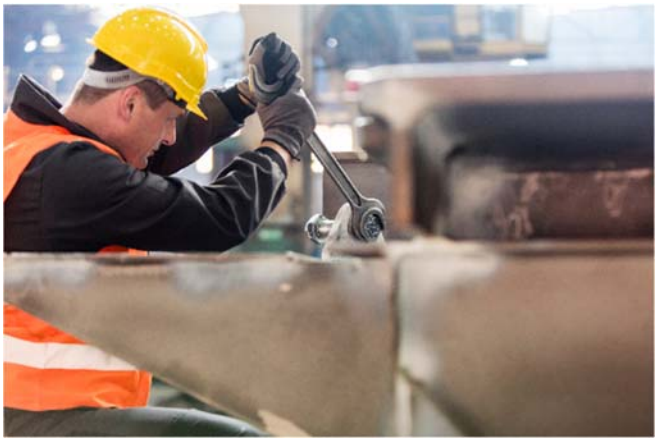
#4 CORRECTIVE ACTIONS

Once you've identified root causes, it's time to develop good corrective actions. Every root cause should be addressed by a corrective action. Don't overlook risk analyses/JSAs!



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DEVELOPING CORRECTIVE ACTIONS

General guidelines:

- Employee involvement – to ensure the solutions will work
- Address all root causes identified through the incident investigation.
- Be sure to include corrective actions for the JSA, if the investigation points to problems with the JSA.
- The most effective corrective actions are those implemented at the design level.

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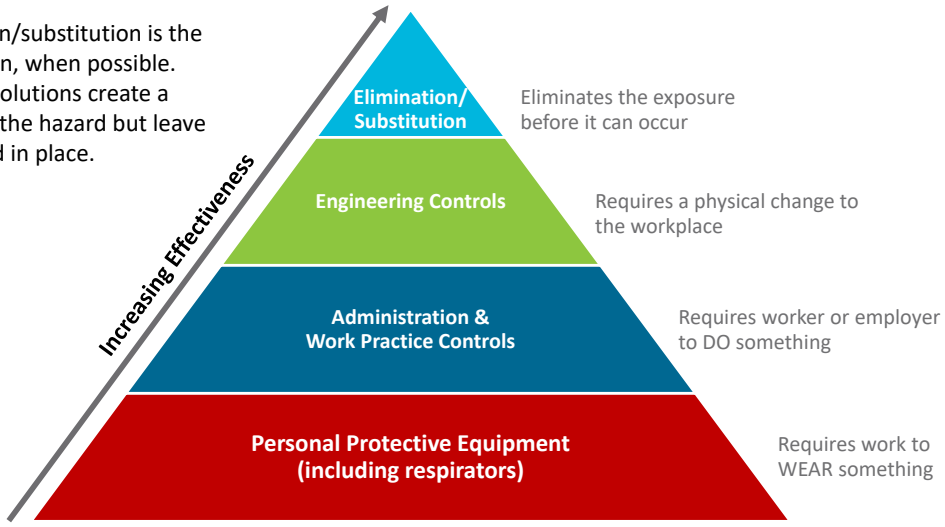
REMEMBER THE HIERARCHY OF CONTROLS!

Elimination/substitution is the best option, when possible. All other solutions create a barrier to the hazard but leave the hazard in place.



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MANAGING CORRECTIVE ACTIONS

Corrective actions must be managed from conception to completion.

Remember:

- Prioritize CAs and assign them to the right people
- Make sure those assigned CAs understand expectations and due dates
- Track CAs to ensure completion
- Verify and review CAs when completed
- **Communicate results to others** – what worked well, what needs improvement**? (This is how you build buy-in!)**
- Adjust CAs as needed

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#5 SHARE RESPONSIBILITY FOR ROOT CAUSE ANALYSIS!

Responsibility should be shared by members of a team, to ensure you're receiving enough input and different perspectives. This helps keep your investigation system intact if some of the primary people involved move on!

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THIS INCLUDES MANAGEMENT "BUY-IN!"

How can you truly have effective root cause analysis if upper management doesn't have buy-in? If they don't sign off on what you're doing, you may not have the blessing or authority you need to dig "deep enough" to identify systemic issues!

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#6 EMPLOYEE ENGAGEMENT

Employee “buy in” and participation is one of the most important elements of a successful system. Without their involvement, you will fail to identify accurate root causes, which will cause you to fail to identify good corrective actions. You’ll just fail, period!

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ENGAGE YOUR TEAM MEMBERS

- Make sure you have active commitment/understanding from top management
- Involve employees at all levels: supervisors, shop floor, office
- Share progress on investigations and especially on corrective actions!!

Remember: You can not maintain an incident management process, or any part of it, all by yourself!

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TECHNOLOGY CAN HELP WITH…

- Incident management, including mobile reporting capability and root cause analysis
- Audits/inspections
- Development and tracking of corrective actions
- Risk analysis/Job Safety Analyses (JSAs)
- Training deployment, management and documentation
- Scheduling/management/follow-up on safety meetings
- Better visibility of metrics
- Driving employee engagement and buy-in

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QUESTIONS?

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https://app.keysurvey.com/f/1405867/12af/

This concludes today's program.

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