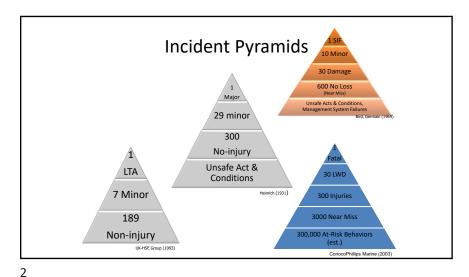


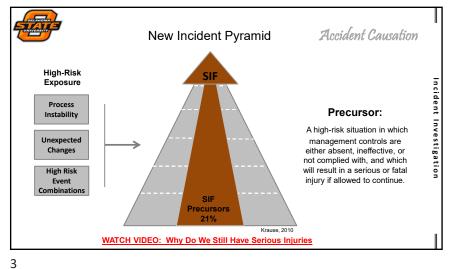


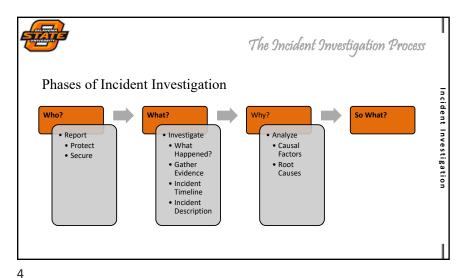
#### FPST 3013 - SAFETY MANAGEMENT THE INCIDENT INVESTIGATION PROCESS

Lecture 6

Accident Causation Models and Root Cause Analysis

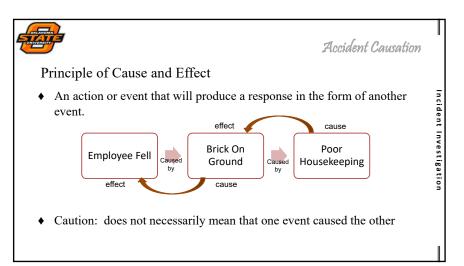






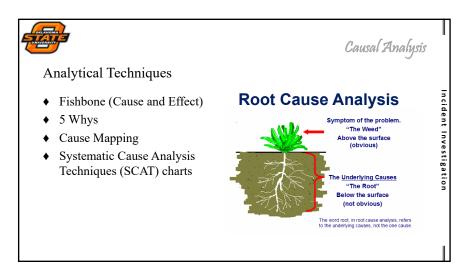






Accident Causation Multiple Causation Principle Hot water heater ♦ Very seldom will just one root cause create a condition that results in an incident. Relief Valve line Relief Valve plugged ♦ In most cases, a chain of events occurs RV line Frozen ~ Substandard conditions ~ Substandard acts RV line Crimped ~ Management system failures Installed in line

5



In order to understand why something happened, we must first understand how something happens







Consider this situation...

◆ New maintenance trainee in the last three months





 Training was held to review, among other things, plant rule to wear a face shield while grinding



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◆ New employee missed training due to illness





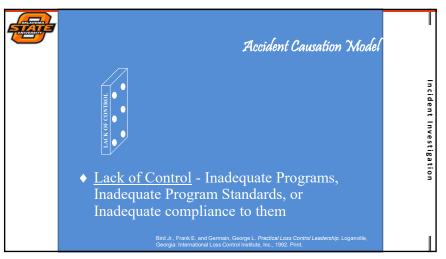
◆ A week after returning to work, Newbie was grinding on steel. The disc broke and he lost an eye.

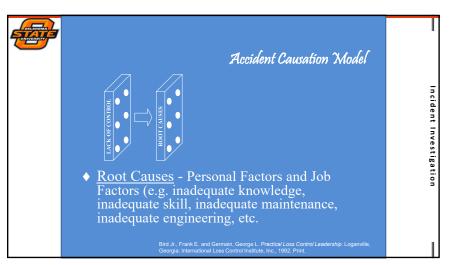


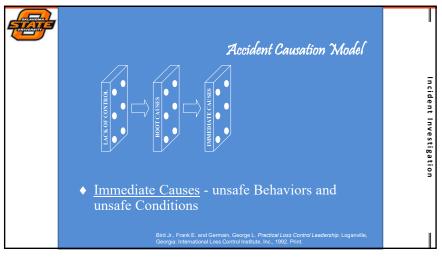
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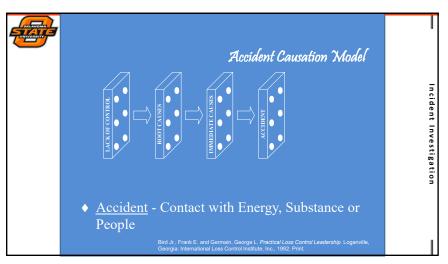






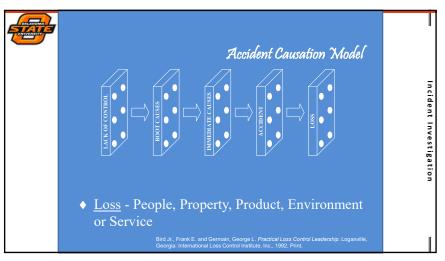


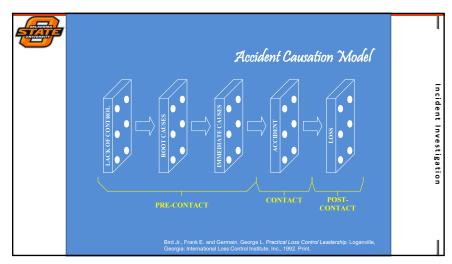










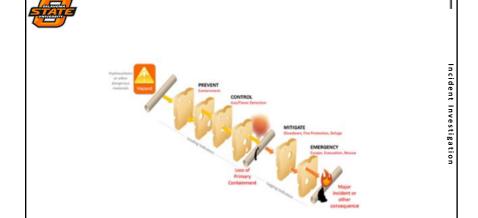


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### Other Types of Accident Causation Theories

- ◆ Reason's Swiss Cheese Model (1990)
- ♦ Pure Luck models
- ♦ Accident Proneness
- ◆ Time Sequence Models
  - ~ Benner (1975)
    - · four issues which not addressed in the domino theory
      - need to define a beginning and end to an accident
      - need sequential time line of events
      - need structured method for discovering the relevant factors involved
      - need to use a chart to define events and conditions





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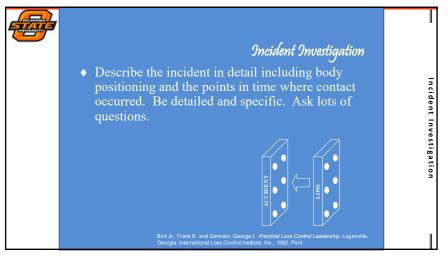


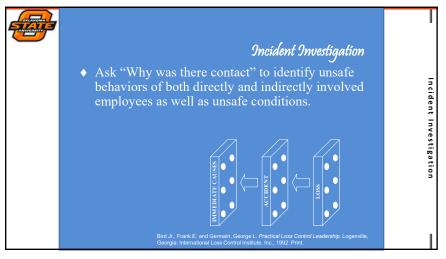
#### Other Types of Accident Causation Theories

- ◆ Systems Theoretic Accident Model and Process (STAMP)
  - ~ "interrelated components that are kept in a state of dynamic equilibrium by feedback loops of information and control"
    - Leveson, N. (2004). A new accident model for engineering safer systems. Safety Science,
    - 42, 237-270.
  - ~ safety management systems are required to continuously control tasks
  - ~ why did controls fail to detect or prevent changes that lead to an accident
- ◆ Functional Resonance Accident Model (FRAM)
  - ~ three dimensional
  - ~ systems are human error tolerant
  - ~ "forces (being humans, technology, latent conditions, barriers) do not simply combine linearly thereby leading to an incident or accident"
    - · Hollnagel, E. (2004). Barriers and Accident Prevention: Aldershot: Ashgate,.

Incident Investigation is simply standing the dominos up backwards one at a time and asking "why" they fell.

21











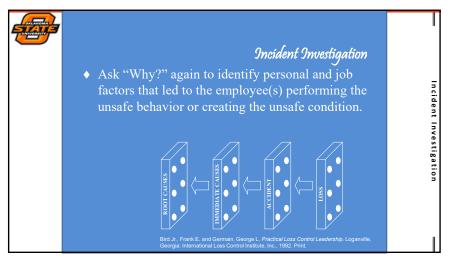
#### Immediate Causes - Indirect Causes - Causal factors- Symptoms

- Unsafe/Substandard Acts/Practices
  - ~ Operating equipment without authority
  - ~ Failure to warn
  - ~ Failure to secure
  - ~ Operating at improper speed
  - ~ Making safety devices inoperable
  - ~ Removing safety devices
  - ~ Using defective equipment
  - ~ Using equipment improperly
  - ~ Failing to use PPE
  - ~ Improper Loading
  - ~ Improper Placement
  - ~ Improper Lifting
  - ~ Improper position for task
  - ~ Servicing equipment in operation
  - ~ Horseplay
- ~ Under the influence of a substance

- ♦ Unsafe/Substandard Conditions
  - ~ Inadequate guards or barriers
  - ~ Inadequate or improper protective equipment
  - ~ Defective Tools, equipment or materials
  - ~ Congestion or restricted action
  - ~ Inadequate warning systems
  - ~ Fire and Explosion hazards
  - ~ Poor housekeeping, disorderly workplace
  - ~ Hazardous Environmental Conditions
  - ~ Noise Exposures
  - ~ Radiation Exposures
  - ~ Hi/Lo temperature exposures
  - ~ Inadequate or excessive illumination
  - ~ Inadequate ventilation



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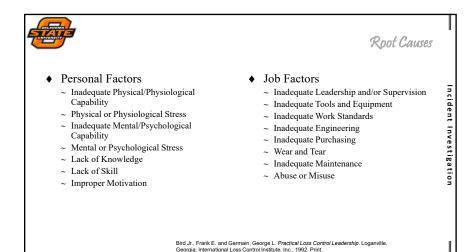




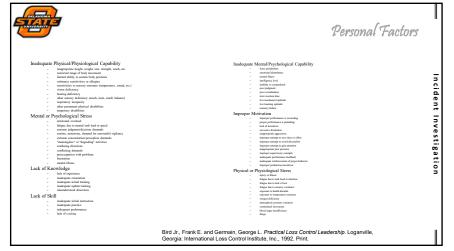


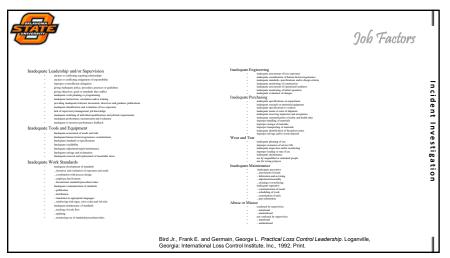






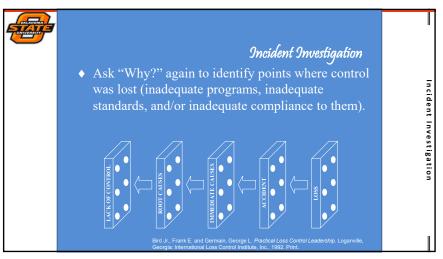
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Lack of Control – Management System Failures Inadequate Programs, Inadequate Standards, and/or Inadequate Compliance to Them

- ♦ Leadership and Administration
- ♦ Management Training
- ♦ Planned Inspections
- Task analysis and procedures
- ♦ Incident Investigation
- ♦ Job Hazard Analysis
- ♦ Emergency Preparedness

- ♦ Personal Protective Equipment
- ♦ Health Controls
- ♦ Program Evaluations
- ♦ Hazard ID and Controls
- ♦ Employee engagement
- ♦ Employee Training

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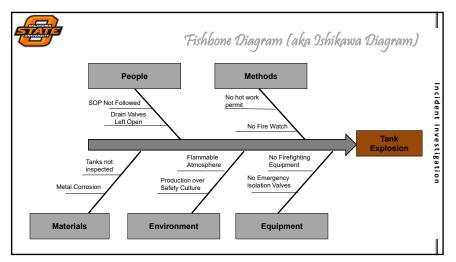
Fishbone Diagram (aka Ishikawa Diagram)

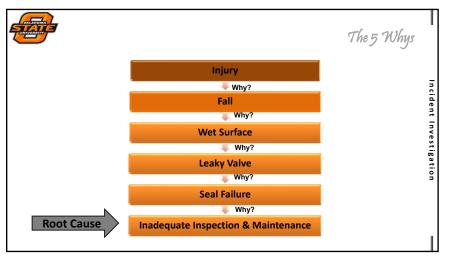
- ♦ Allows for brainstorming
- ◆ Categorizes many potential causes into orderly groups

Fishbone Diagram (aka Ishikawa Diagram) People Methods Materials Environment Measurements









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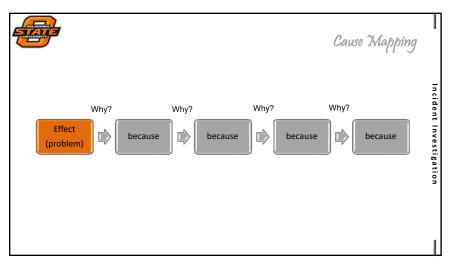
A Cause Map provides a simple visual explanation of all the causes that were required to produce the incident. The root is the system of causes that reveals all of the different options for solutions.

There are three basic steps to the Cause Mapping method:

1. Define the issue by its impact to overall goals

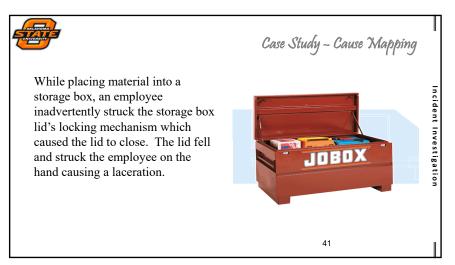
2. Analyze the causes in a visual map

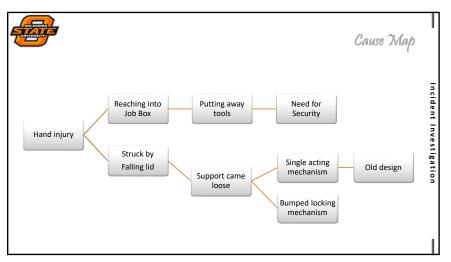
3. Prevent or mitigate any negative impact to the goals by selecting the most effective solutions.





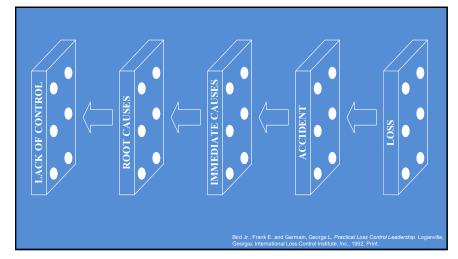






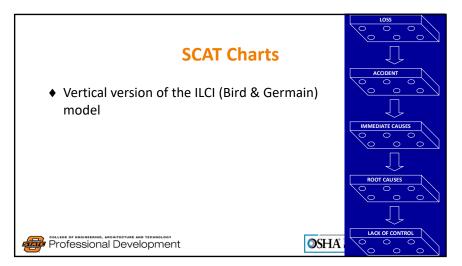
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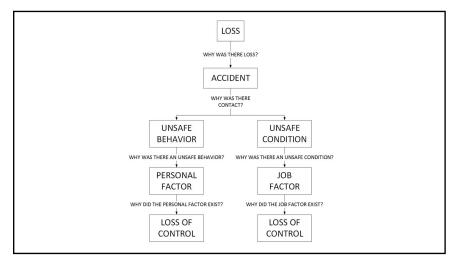




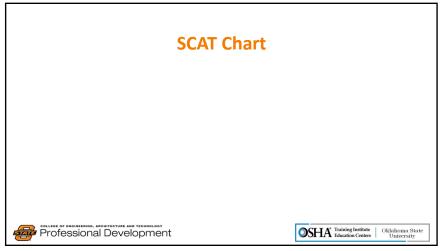








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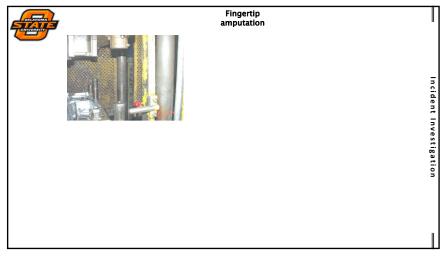


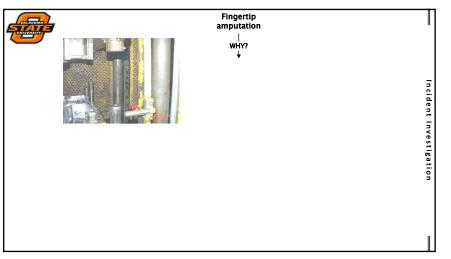
What was the cause in the trim press accident?

♦ Employee was trimming a part in a press. He had already trimmed hundreds of parts that day. He pulled back the pull bars with his wrists on the handles. When the press closed, the tip of his right index finger was caught between the guide pin and bushing resulting in an amputation to the tip of the finger.

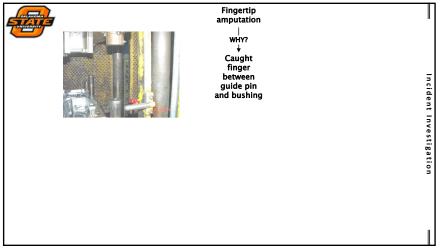


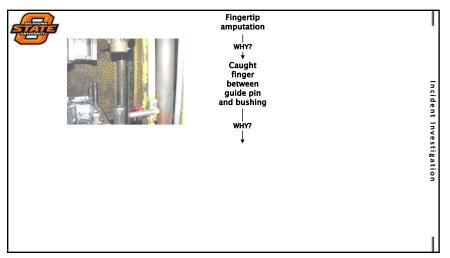






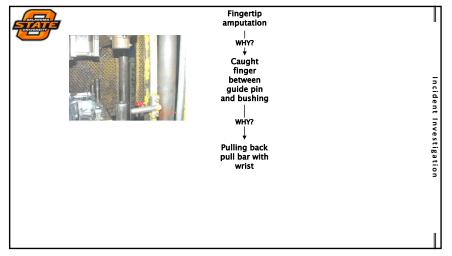
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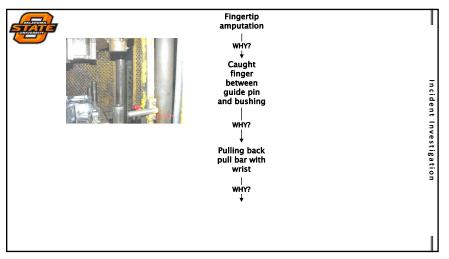


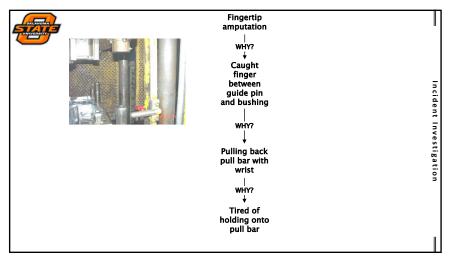


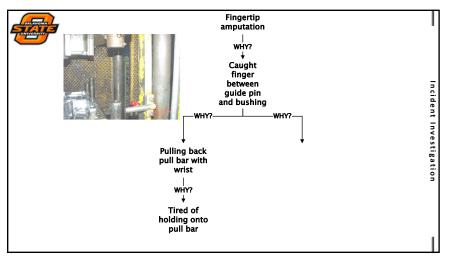






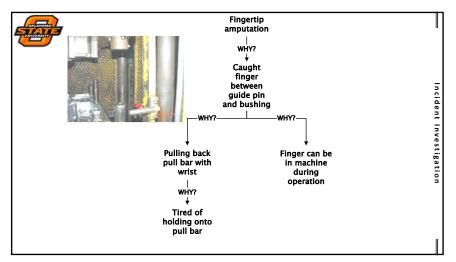


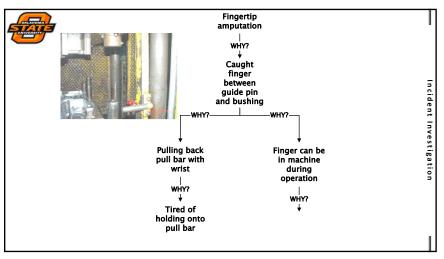




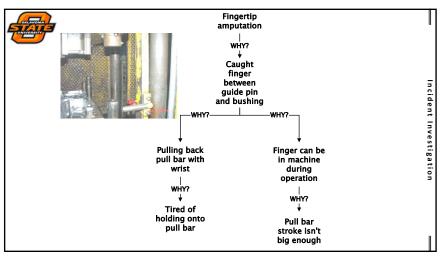








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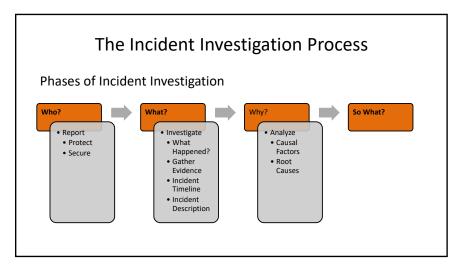


Ask "Why?" until points of control loss are factually identified





#### The Incident Investigation System Levels of Investigation First Aid Injury, Minor property damage less 1-2 person team, usually supervisor. Minor than \$1000. Medical treatment Injury, major damage, 2-4 person team, may need to use analytical techniques and Major process upset, \$1K>\$10K loss. subject matter experts. Lost Workday Injury, Severe property 2-4 person team, use analytical techniques, subject matter Severe damage or process upset, \$10K>\$100K loss. experts, Fatality, Hospitalization, total loss of facility Full team. May need 3<sup>rd</sup> party expertise. May involve regulatory Catastrophic or process, greater than \$100K property intervention. Use multiple analytical techniques and subject damage or loss. matter experts. Legal protection may be necessary. No actual injury, damage, or loss. But strong Variable depending on potential severity of event. See incident



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#### FPST 3013 – SAFETY MANAGEMENT THE INCIDENT INVESTIGATION PROCESS

Lecture 7

Accident Causation Models and Root Cause Analysis