

# Root Cause Analysis

## Carolinas Air Pollution Control Association

Presentation by:

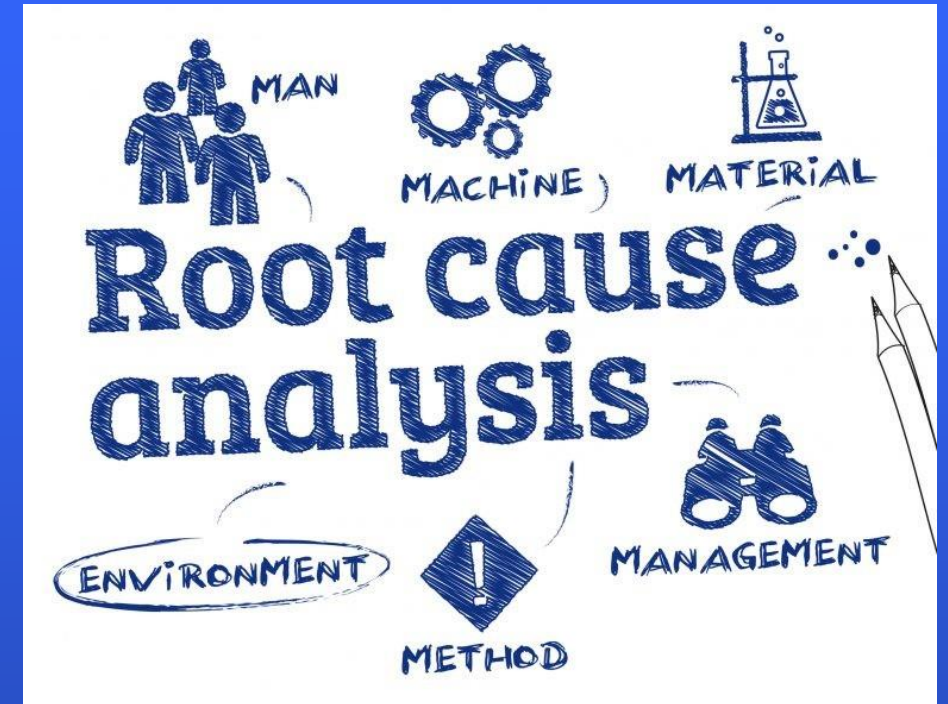
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TRC - National Service Leader – Safety Services



# Agenda

- Process Steps
- RCA - Methods and Techniques
- Causative and Contributing Factors
- Prevention



# Root Cause Analysis

## Process:

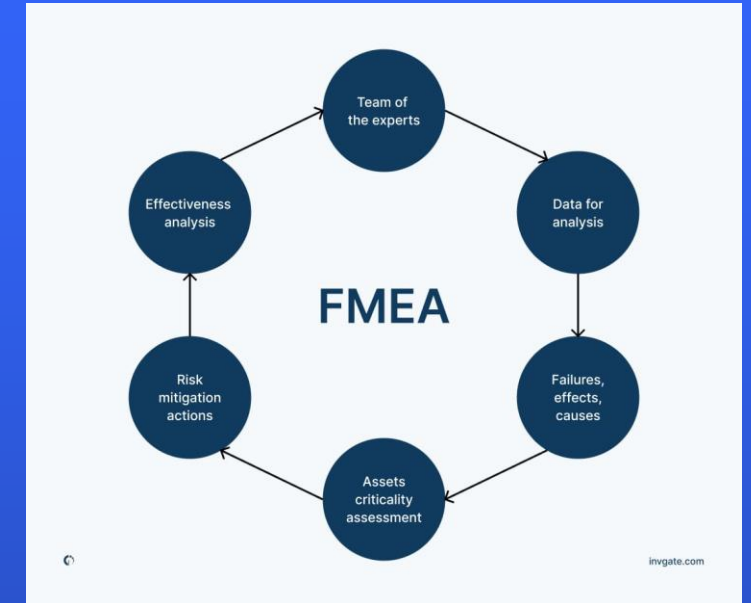
- **Problem Identification:** Clearly define the environmental spill incident.
- **Data Collection:** Gather evidence and data in real-time from the incident scene using incident investigation techniques.
- **Causal Factor Determination:** Identify all the direct and contributing factors leading to the spill.
- **Significant Factor Identification:** Pinpoint the most critical and contributing factors.
- **Prevention:** Implement corrective actions and develop measurement systems to track their effectiveness through verification.



# Root Cause Analysis

## Common Methods and Techniques

- 5 Why's
- Fishbone Diagram
- Tap Root
- Fault Tree Analysis (FTA)
- Failure Mode and Effects Analysis (FMEA)



# Root Cause Analysis

## Causative and Contributing Factors



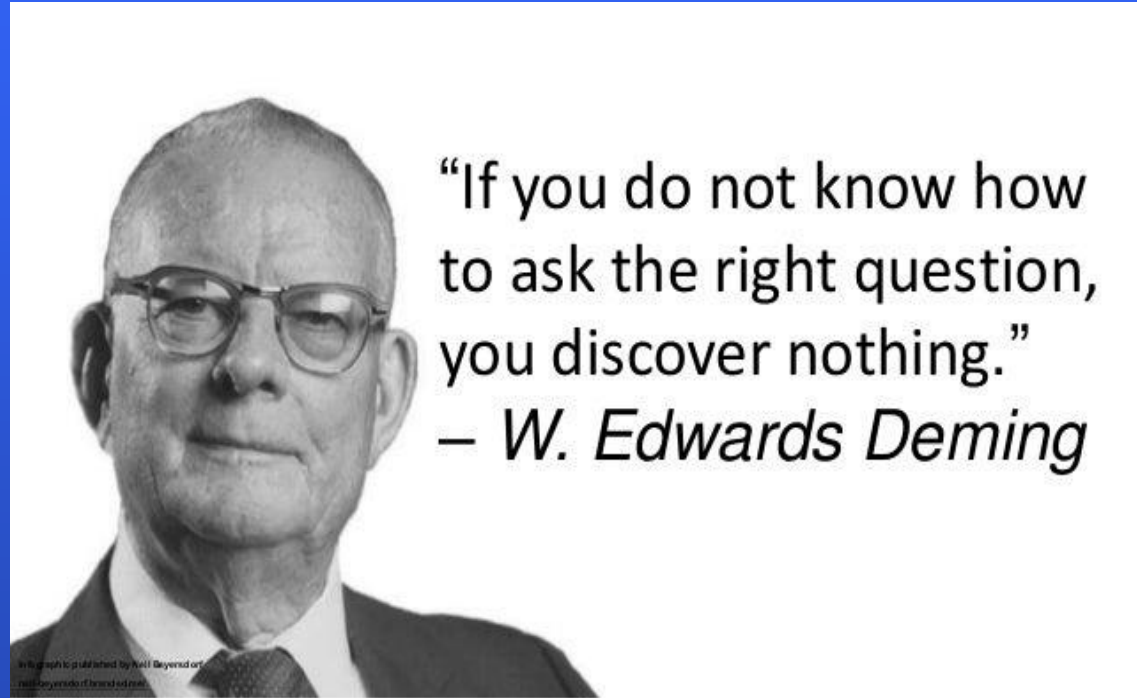
- Perception of RISK – What is acceptable?



# Root Cause Analysis

## Causative and Contributing Factors

- Human Error:
- Equipment Reliability:
- Management Systems:
- Culture/Behavior:
- Environment/Conditions:



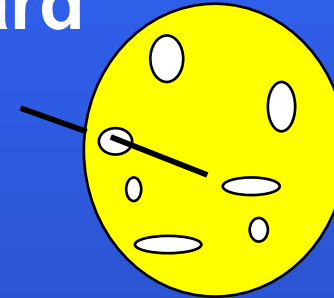
# Root Cause Analysis

## Causative and Contributing Factors - Alignment

### Human Error:

- People make mistakes?
- Blame game
- Symptom not the source

### Risk/Hazard



# Root Cause Analysis

## Causative and Contributing Factors

### Human Factor

- The investigation concluded that ditching in the Hudson was the most viable option, as simulations showed attempting to reach an airport resulted in a crash.

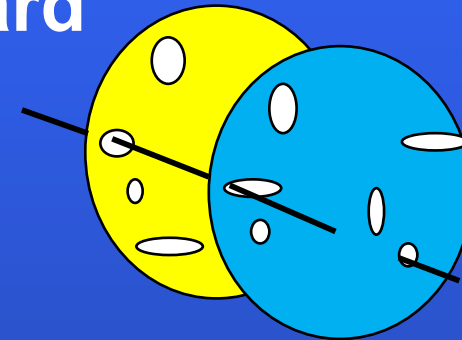


# Root Cause Analysis

## Causative and Contributing Factors - Alignment

- **Human Error:**
- **Equipment Reliability:**
  - Pump Failed
  - Seals leaking
  - Lack of maintenance
  - Used beyond capacity

Risk/Hazard



**"Quality comes not from inspection, but from improvement of the production process."**

- Deming believed that quality should be built into the process
- rather than relying on inspection to catch defects.

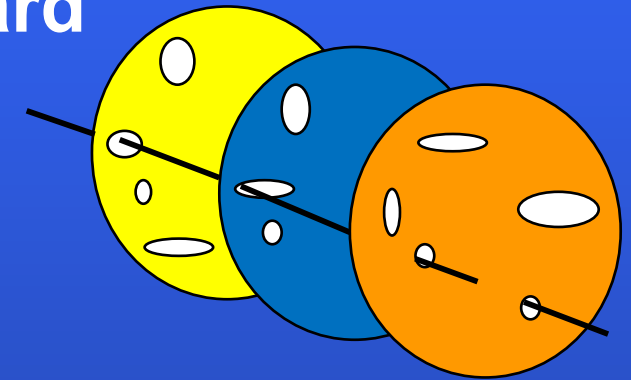


# Root Cause Analysis

## Causative and Contributing Factors - Alignment

- Human Error:
- Equipment Reliability:
- **Management Systems:**
  - Accountability or Inadequate resources
  - Training ???
  - Missing controls or MOC not in place
  - Corrective Actions never verified

Risk/Hazard



**"A bad system will beat a good person every time."**

- Reflects the idea that even the best employees cannot succeed in a poorly designed system.

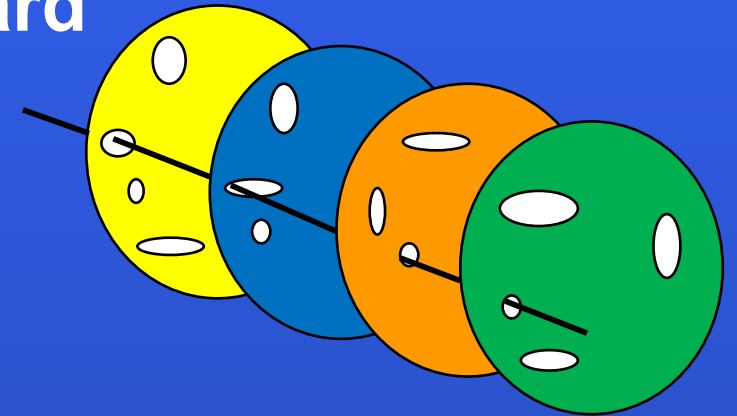


# Root Cause Analysis

## Causative and Contributing Factors - Alignment

- Human Error:
- Equipment Reliability:
- Management Systems:
- **Culture/Behavior:**
  - Procedures not followed
  - Employee shortcuts
  - Management cut program and reduced expenditures

Risk/Hazard



**"The worker is not the problem. The problem is at the top!"**

- Management practices often contribute to organizational issues.

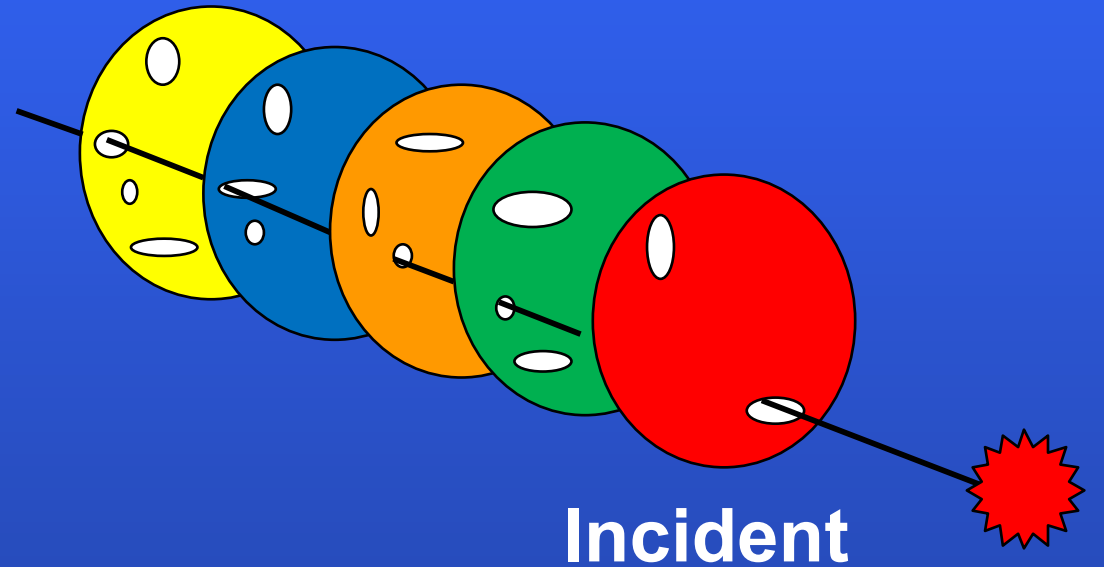


# Root Cause Analysis

## Causative and Contributing Factors – Alignment

- Human Error:
- Equipment Reliability:
- Management Systems:
- Culture/Behavior:
- **Environment/Conditions:**
  - **Weather**
  - **Working area**

Risk/Hazard



# Root Cause Analysis

## Causative and Contributing Factors – Alignment

- Human Error
- Equipment Reliability
- Management Systems
- **Culture/Behavior**
- Environment/Conditions



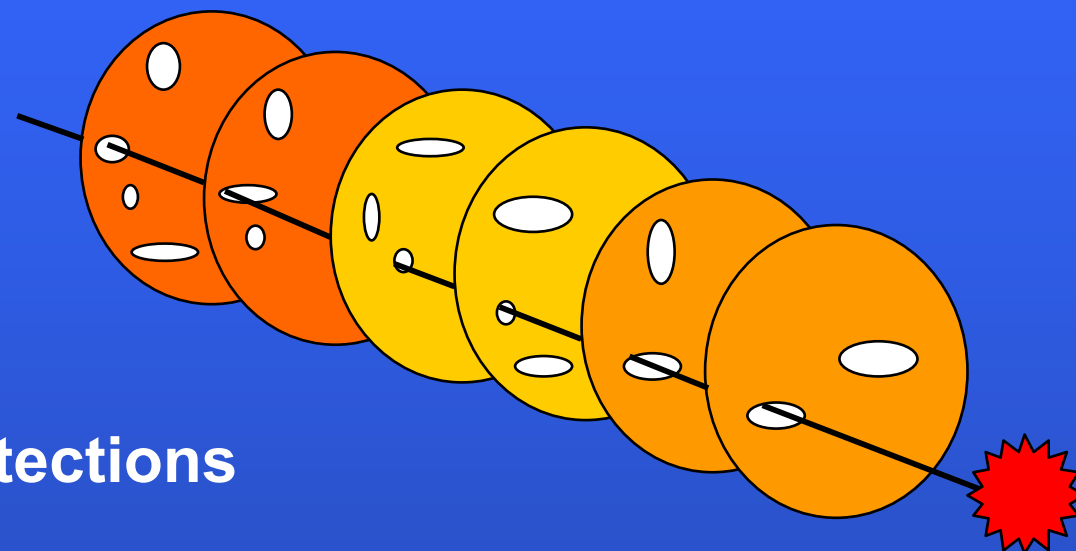
# Root Cause Analysis

## Why Do We Have Incidents?

### Alignment of:

1. Hazards or lack of recognition
2. Working conditions
3. Lack of controls, safeguards and protections missing
4. Lack of management systems
5. Training not effective or not provided
6. Unsafe Acts/Behavior

Hazard



Incident



# Root Cause Analysis

## Working Conditions

- **Cramped work area**

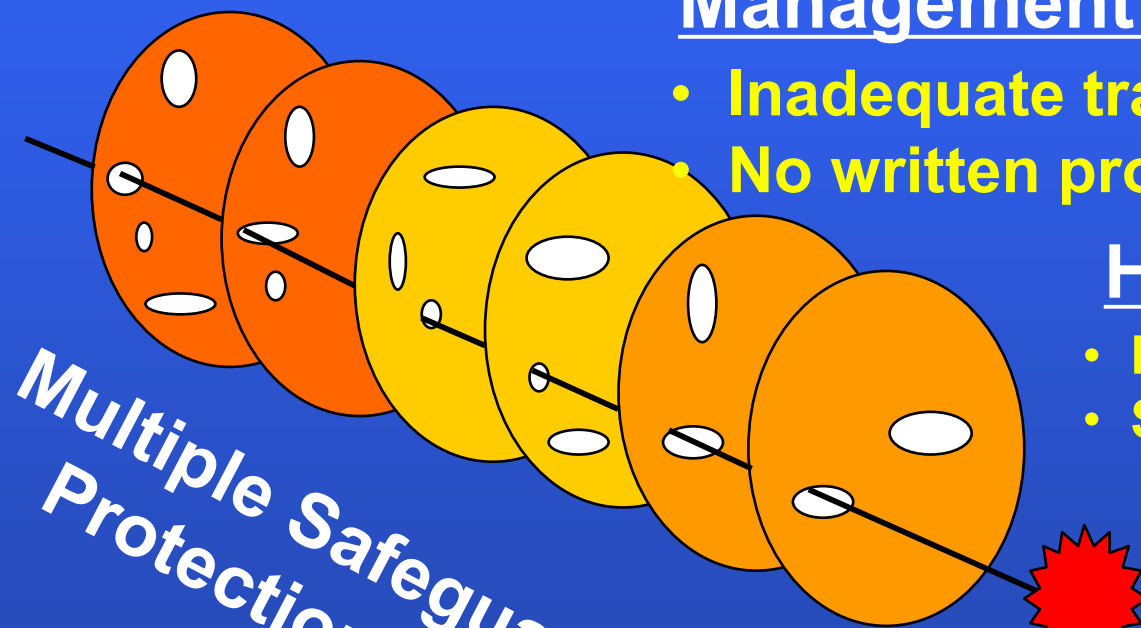
## Management Systems

- **Inadequate training**
- **No written procedures**

## Human Behaviors

- **Hurrying to finish task**
- **Skipping steps**

Transferring  
Corrosive  
Chemicals



Multiple Safeguards and  
Protections missing

Spill and Eye  
Injury!



# Root Cause Analysis

## Prevention - Implement Obstacles to Incident Alignment

### Working Conditions

- Change or Modify

### Management Systems

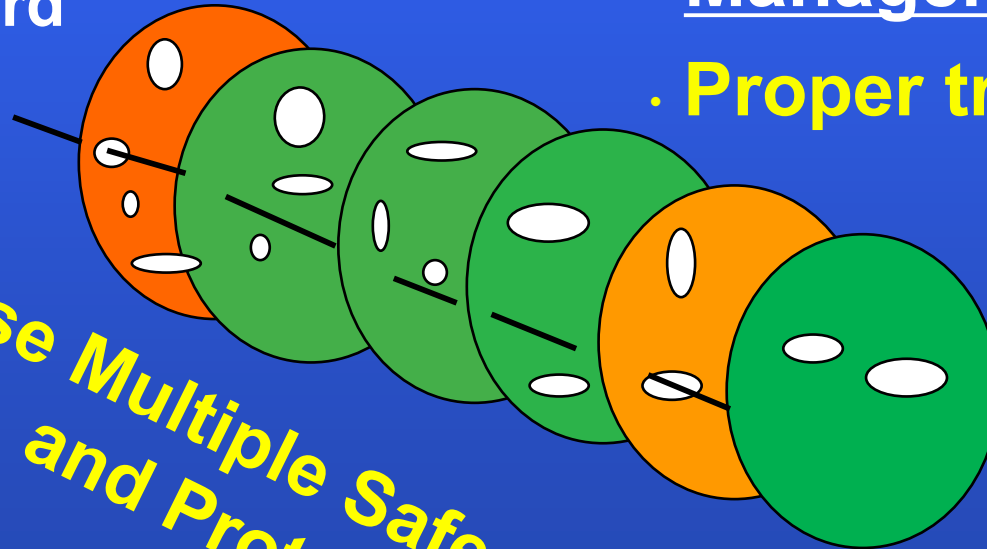
- Proper training and procedures

### Human Behaviors

- Follow safe work practices
- Wear PPE

Recognize Hazard

Use Multiple Safeguards  
and Protections



# Root Cause Analysis

## Tools and Methods of Prevention

- **Equipment Reliability**
  - Preventive Maintenance Program
  - Quality program
  - Pre-Startup reviews and MOC



# Root Cause Analysis

## Tools and Methods of Prevention

- Training
  - Focus on hazard recognition and acknowledgement
  - Proper procedures
  - Reinforce or change behavior
  - Defined objectives of the training



# Root Cause Analysis

## Prevention:

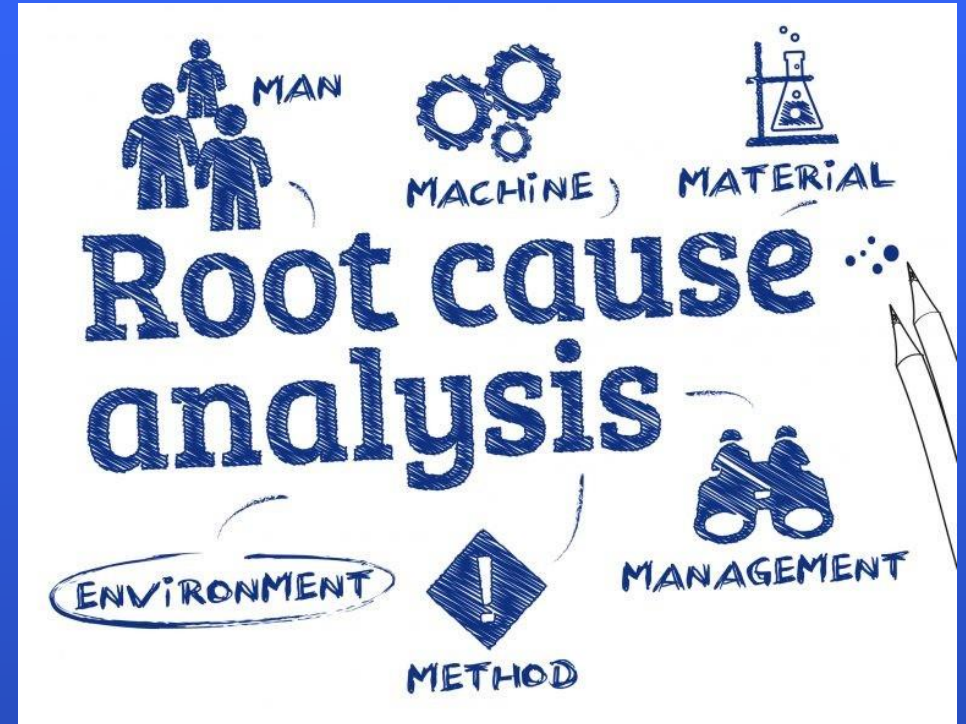
- Corrective Actions Implemented and Verified
- Management of Change
- Messaging/Lessons learned



# Root Cause Analysis

## Summary:

- Process Steps
- RCA - Methods and Techniques
- Causative Factors
- Prevention



# Thanks!



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