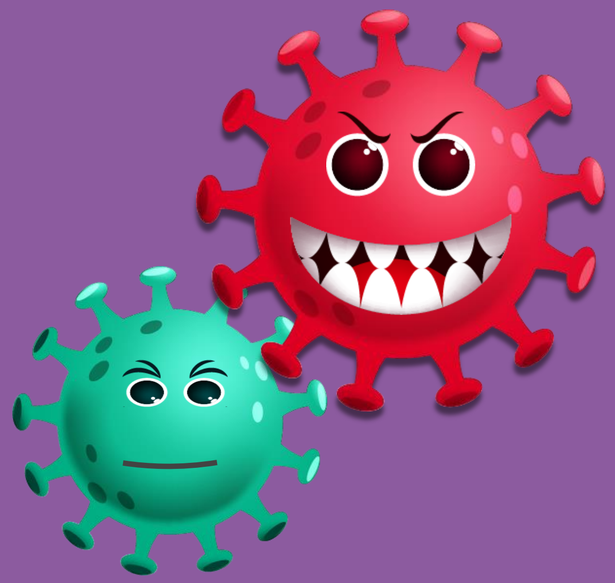
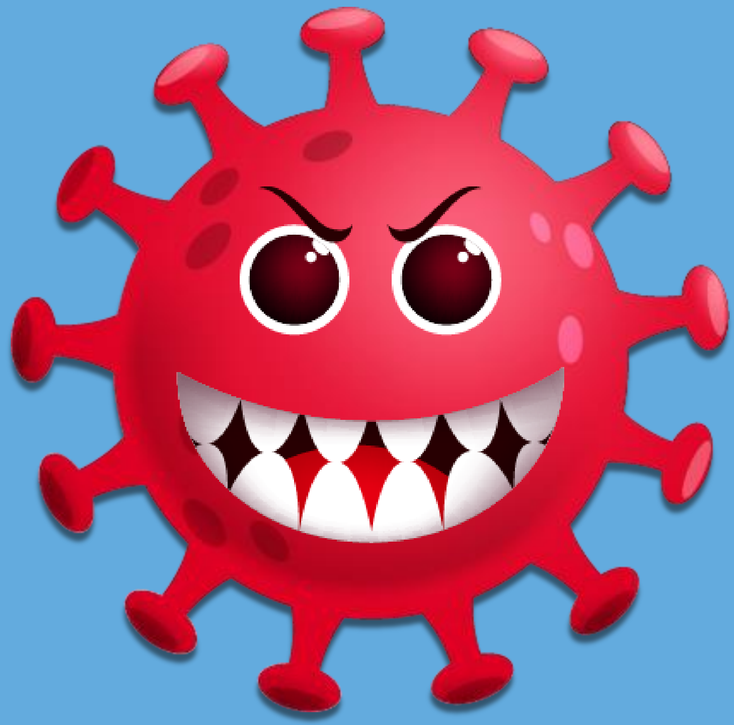
Unlocking Root Cause Learning

A Single Truth of HSE Performance



Presented by ‘Wreck it Roy’ & ‘Potential Pete’

Wreck it Roy



Wreck it Roy

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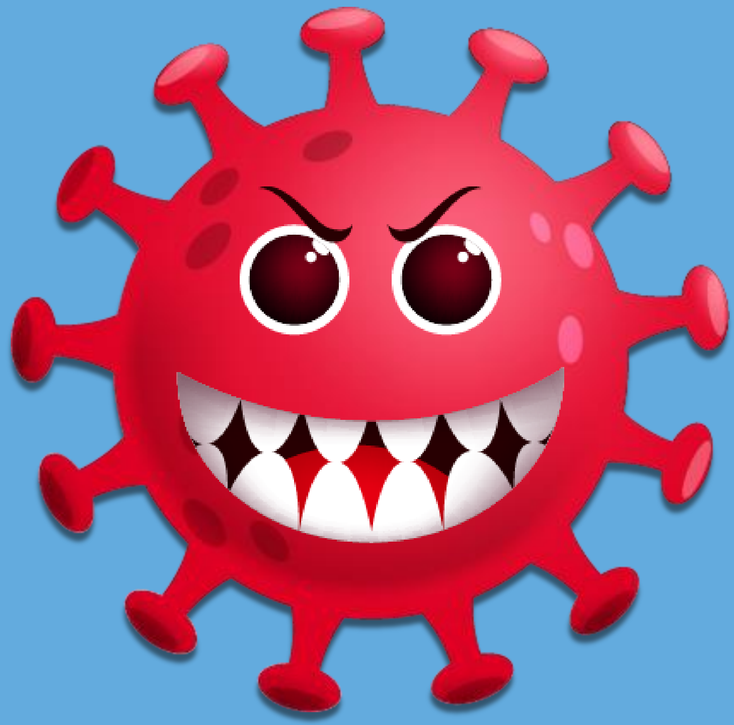

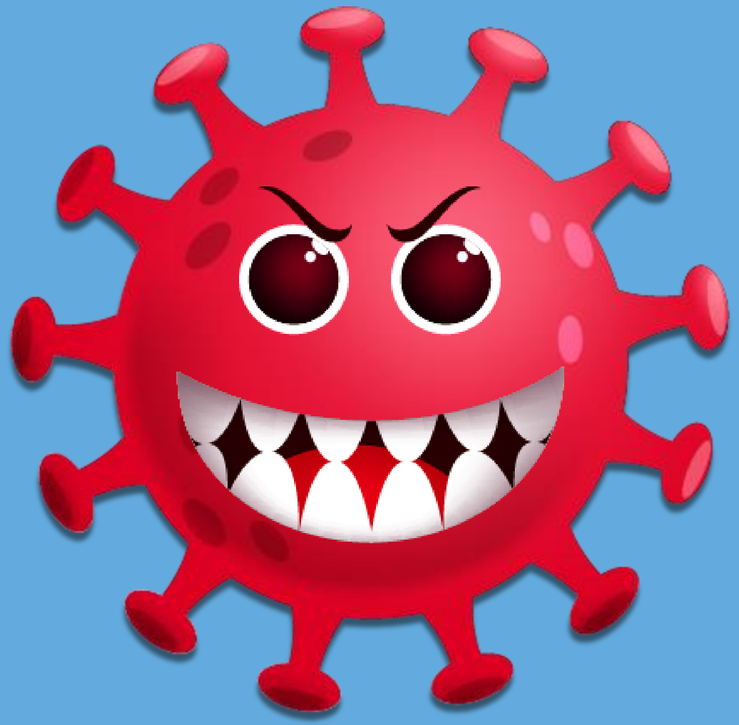


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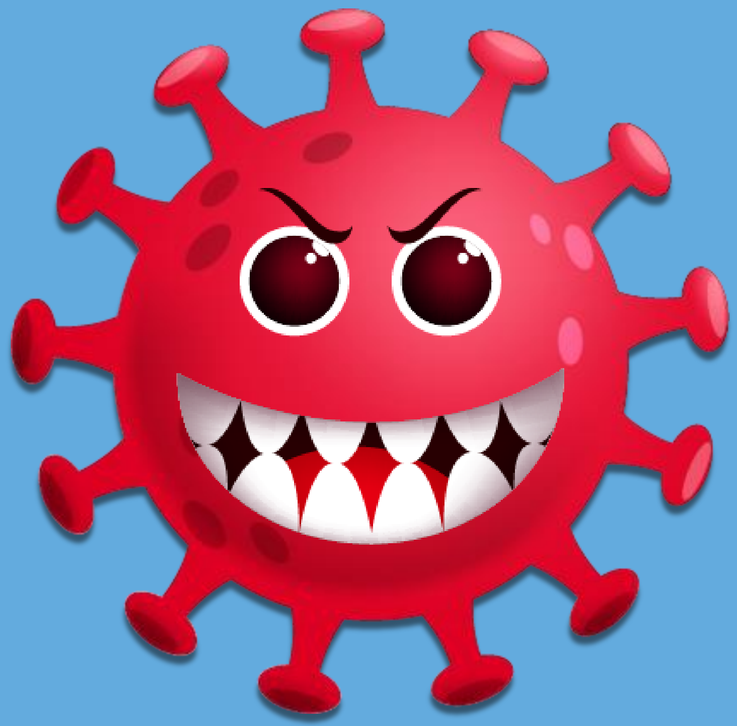
Wreck it Roy



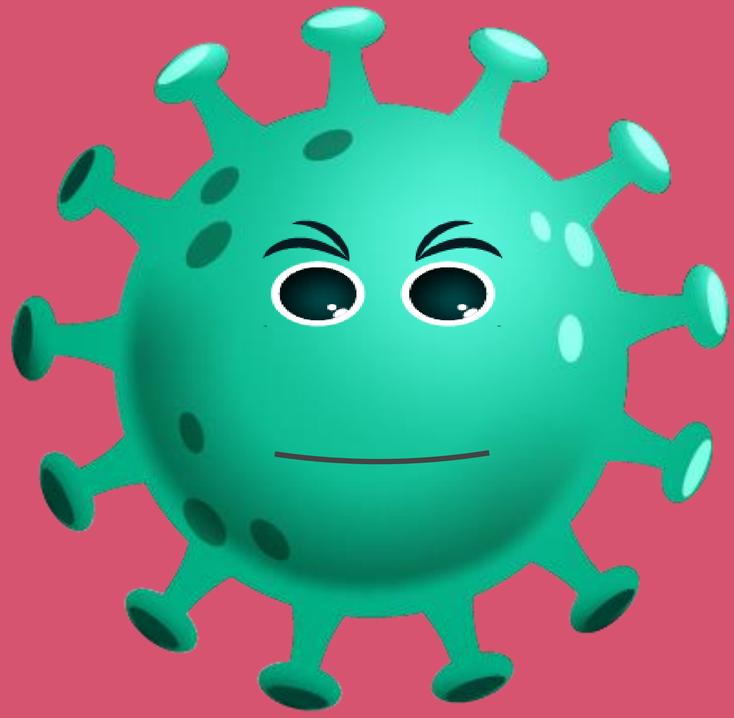
20%

of me

80%

of your pain

Potential Pete



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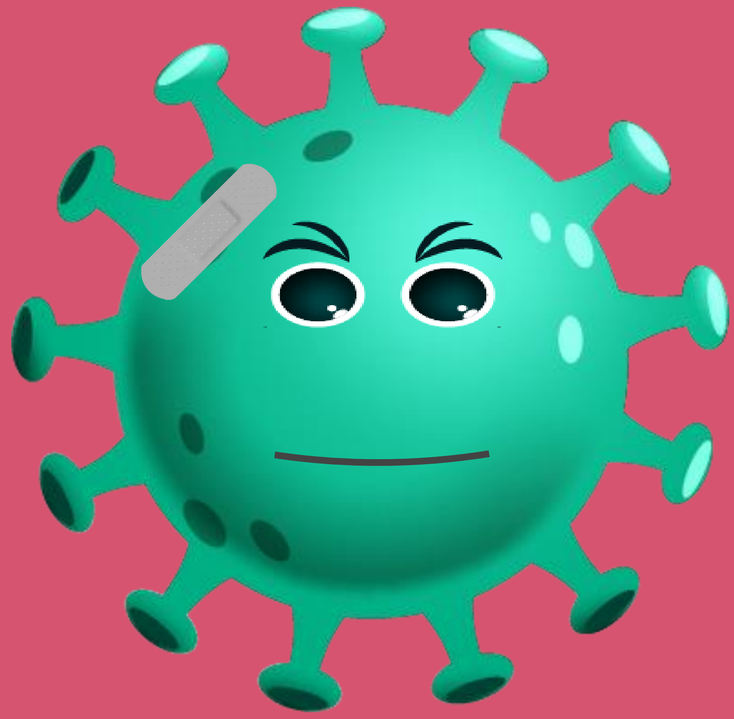

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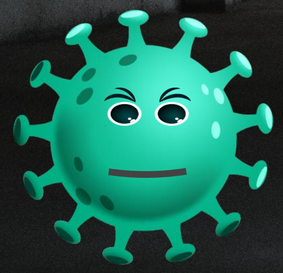

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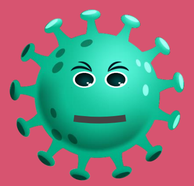

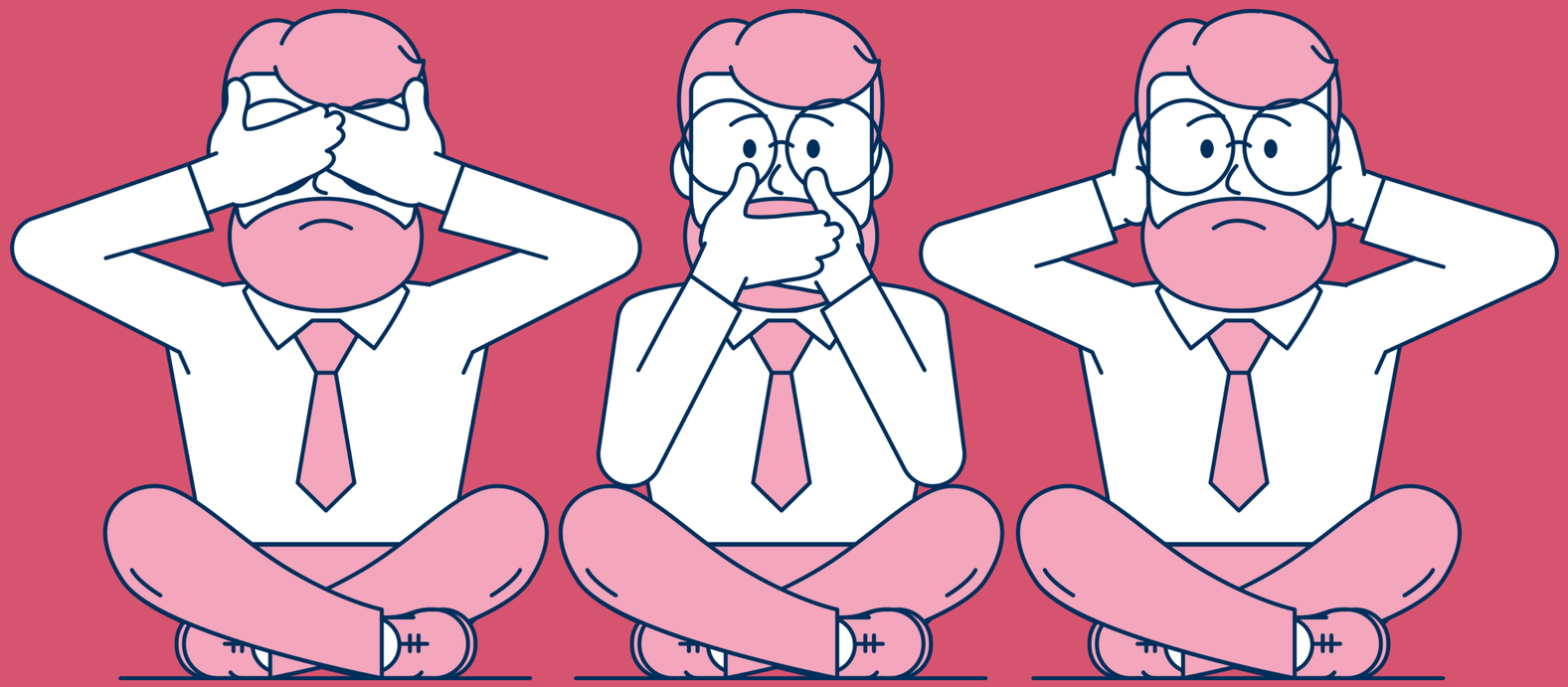

Potential Pete

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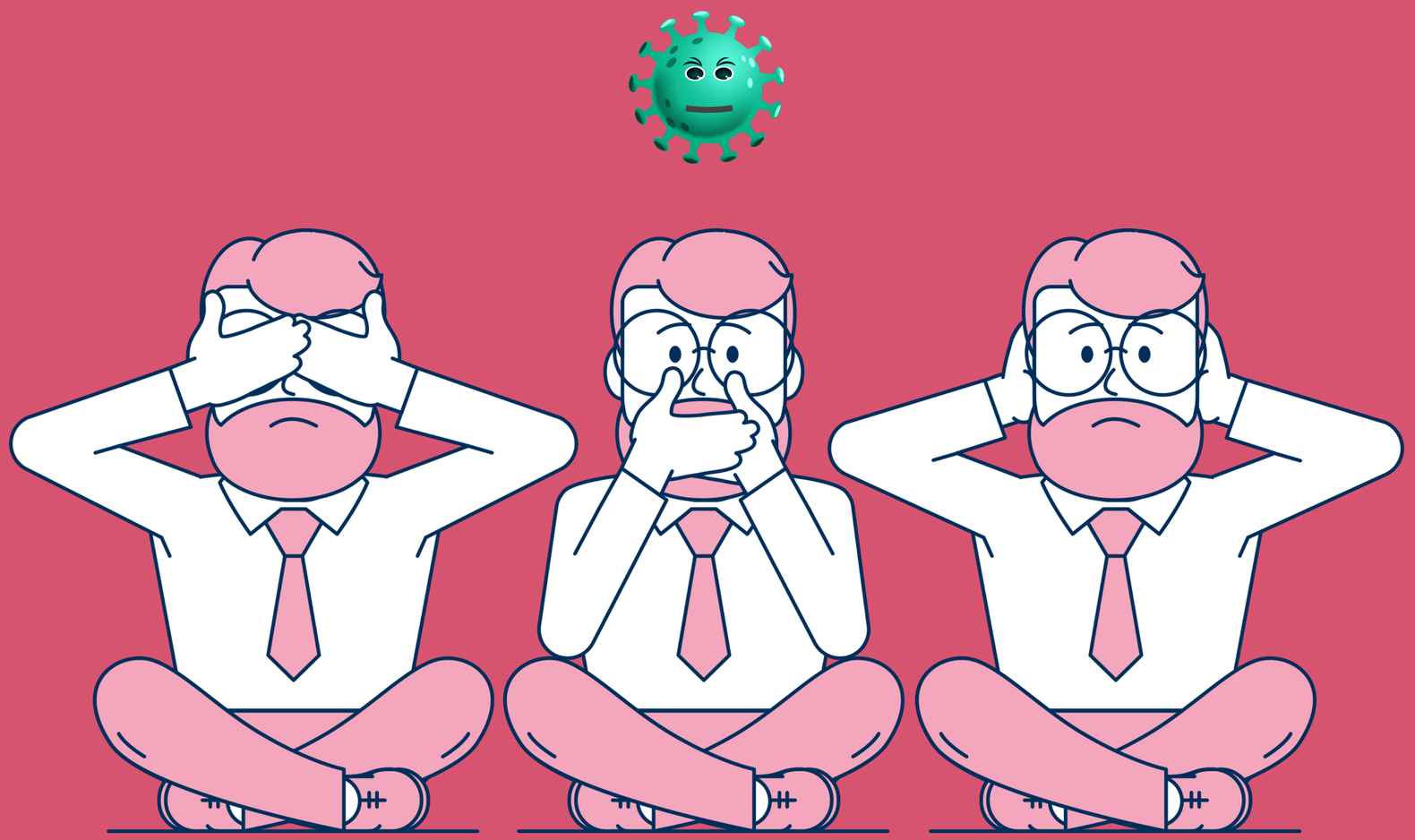
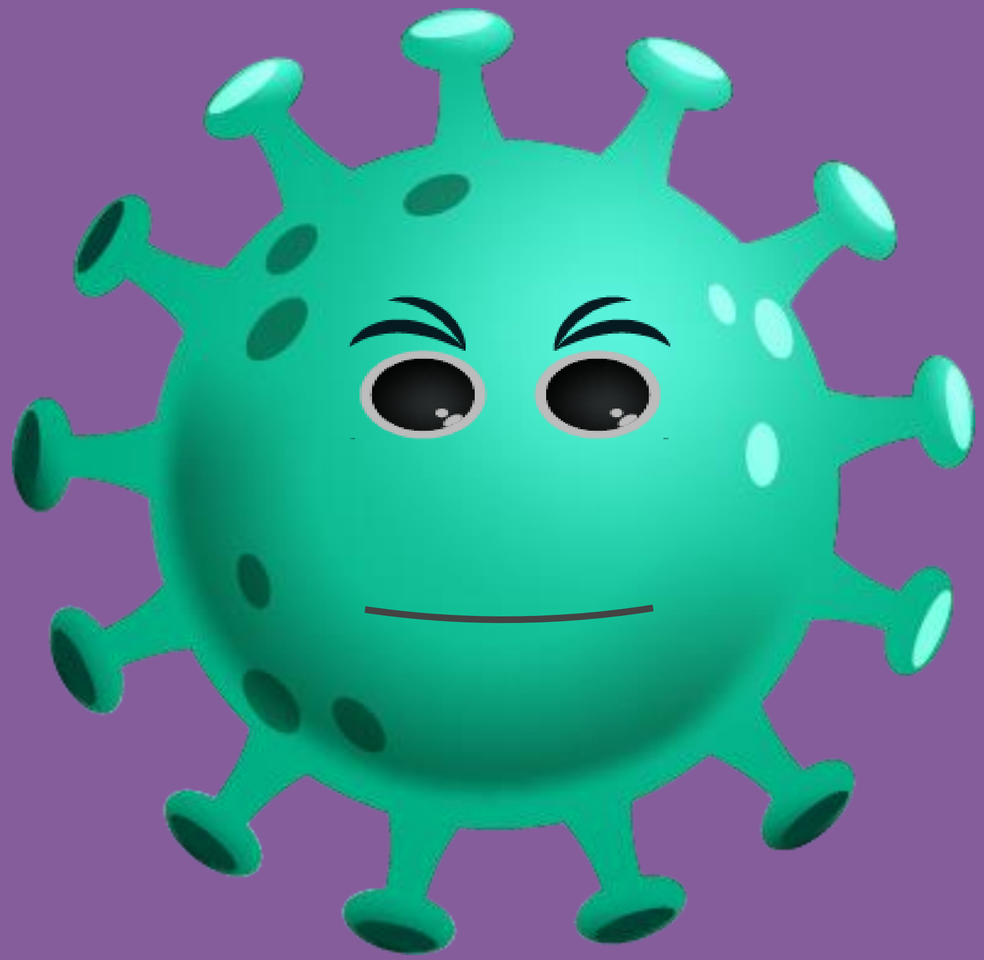
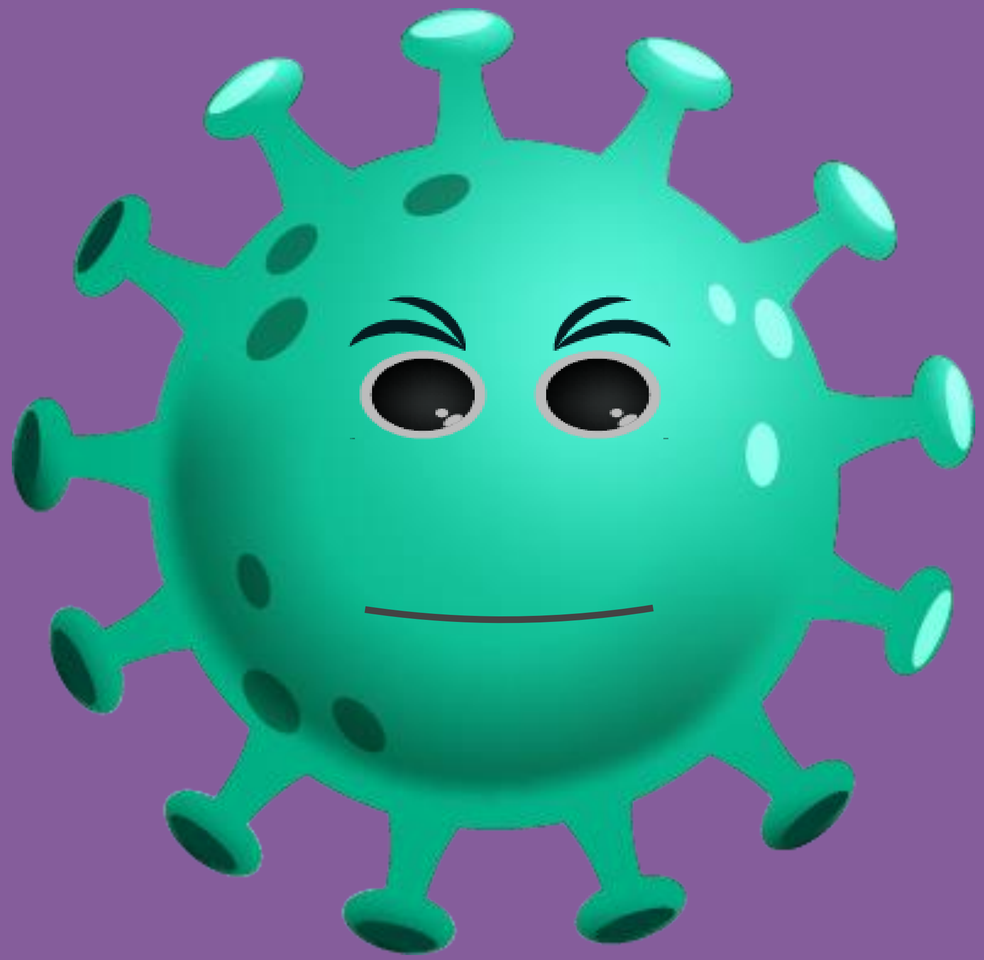
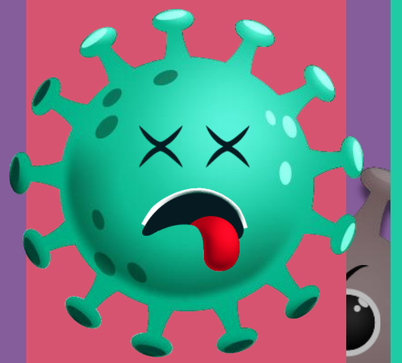




90%

RCA effort is investigating actual events



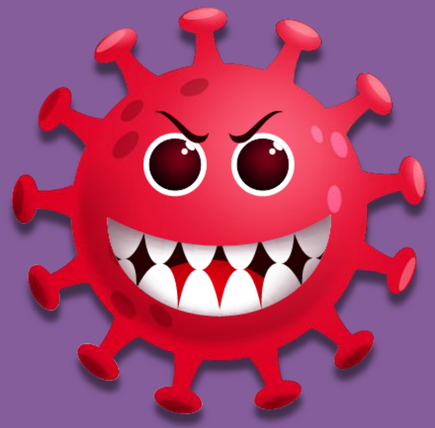


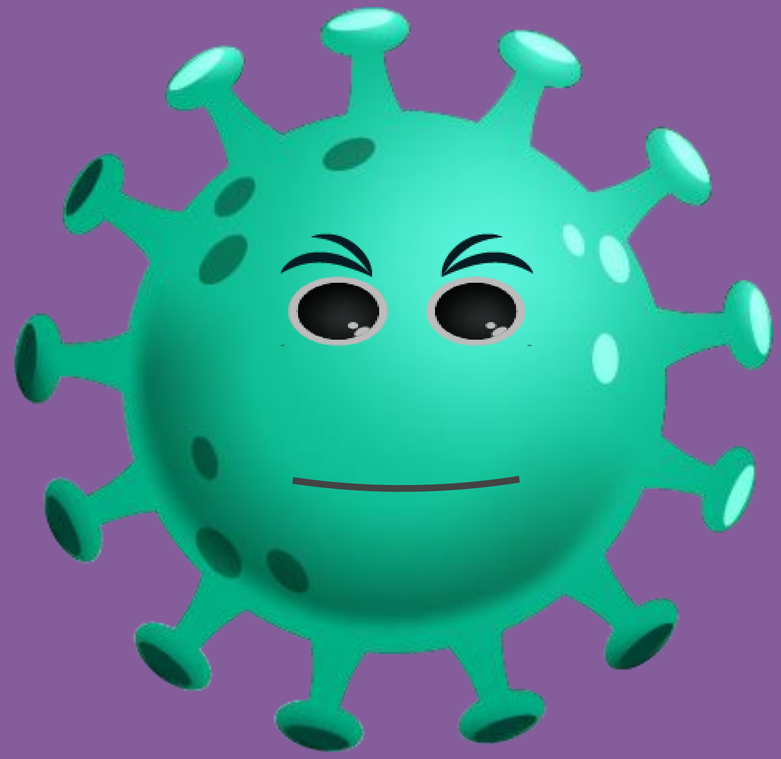
90%
RCA effort is investigating actual events

90%
preventive effort in good organisations

Audits
Inspection
Review
Learning Teams

Some facts about us Root Causes…

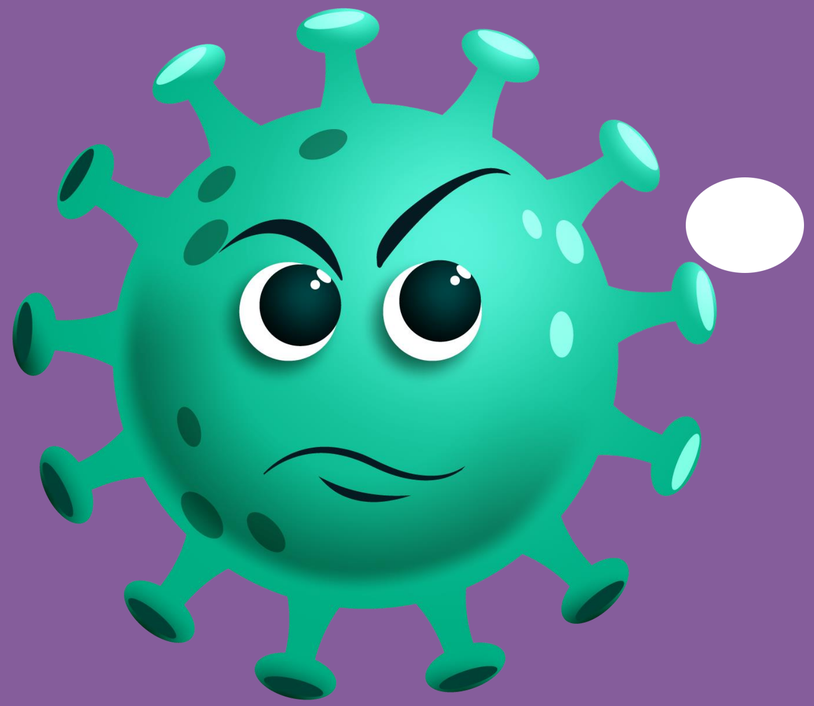




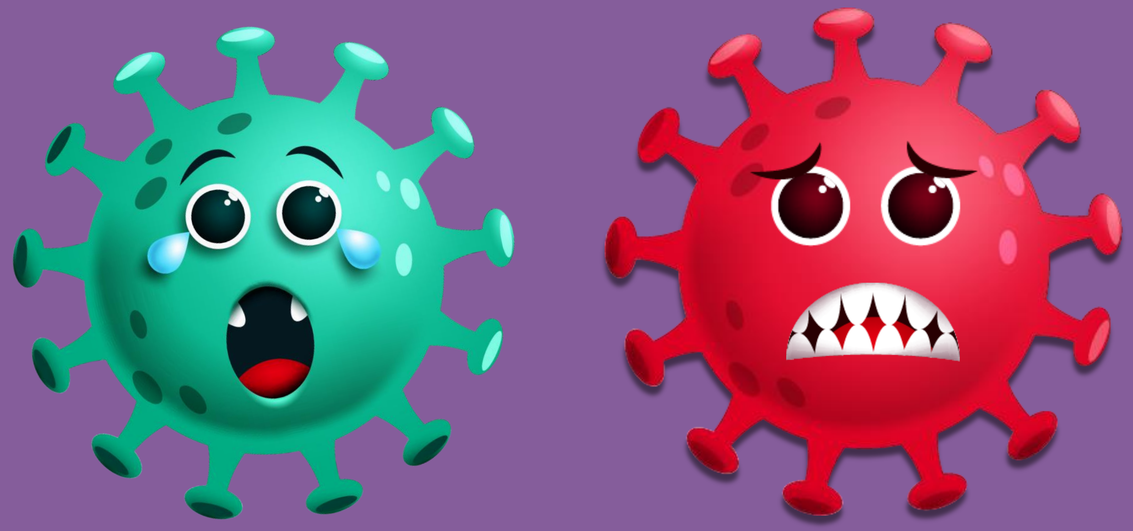
Us Root Causes can have the time of our lives **IF** you don’t do a good job of understanding what happened when you investigate!

Whilst we are interesting in a single case you might investigate, we are much more interesting when you can follow our behaviour at a **macro level!**

As a young root cause, I was always told by a very clever investigator that you can’t properly fix the ‘what’ only the ‘why’!

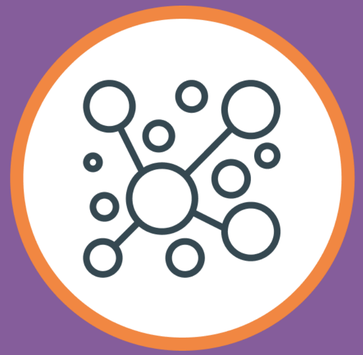


1. Establish an **AGNOSTIC TAXONOMY**
2. Build **PROPORTION** into your toolkit
3. Build **DISCIPLINE EXPERTISE** into your analysis
4. Build **HUMAN FACTOR ANALYSIS** into your investigations
5. Harness **BIG DATA**
6. Investigate and Analyse **ASSURANCE FINDINGS**
7. Use **INDUSTRY 4.0 / AI**



In total there are 7 Deadly Sins for us Root Causes, today we're going to show you 3 of them…

Root Causes… 3 Core Truths



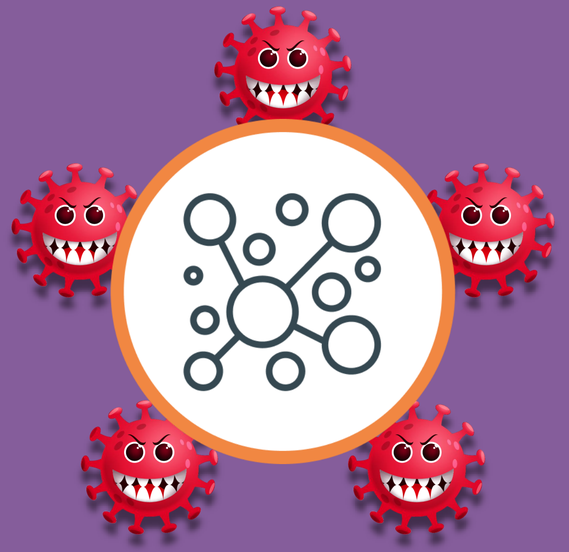
Root Causes never occur in isolation.

Root Causes don’t have a hierarchy of seriousness.

Root Causes don’t change based on failure type.

1

If you know we occur in clusters, how do you understand the clusters?

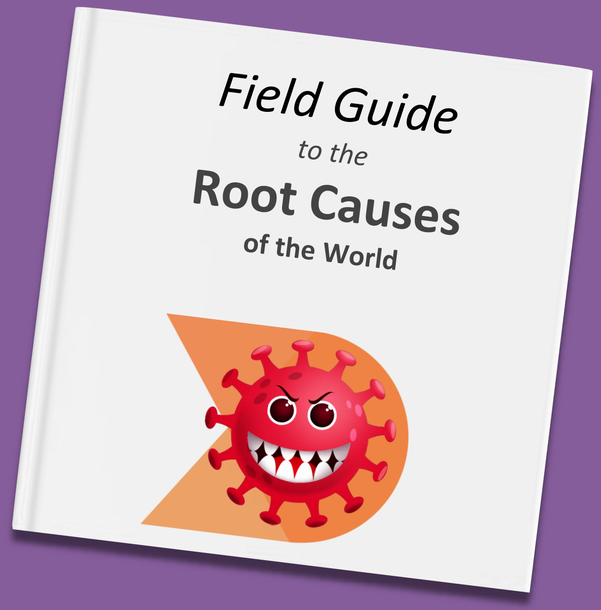


1

If you know we occur in clusters, how do you understand the clusters?

Establish an

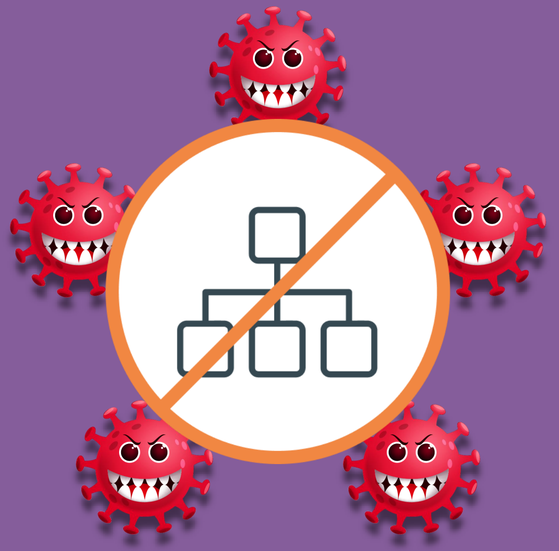
AGNOSTIC TAXONOMY



- One that delivers a spectrum covering all the areas where we occur.
- Code the taxonomy so that root cause patterns (highlighting clusters!) and systemic behaviours can be tracked and better understood
  (not that we like being followed!)
- Make the taxonomy easy to navigate and understand,
  not everyone is a full time investigator.

2

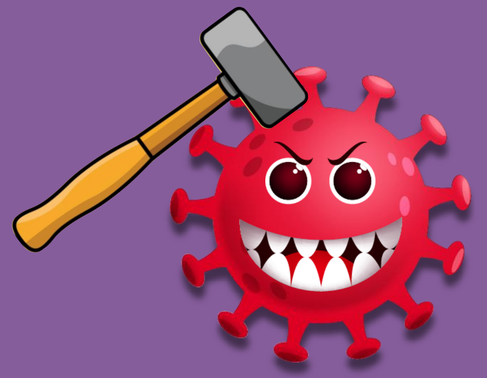
If you don’t respect the seriousness of the event, how do you capture us when we create all those minor outcomes?

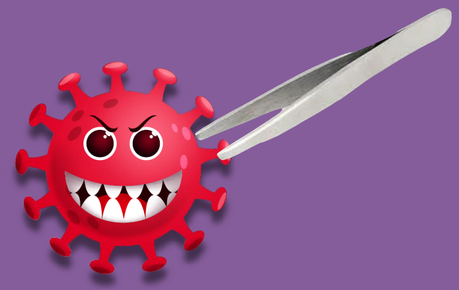


2

If you don’t respect the seriousness of the event, how do you capture us when we create all those minor outcomes?

Build PROPORTION into your toolkit

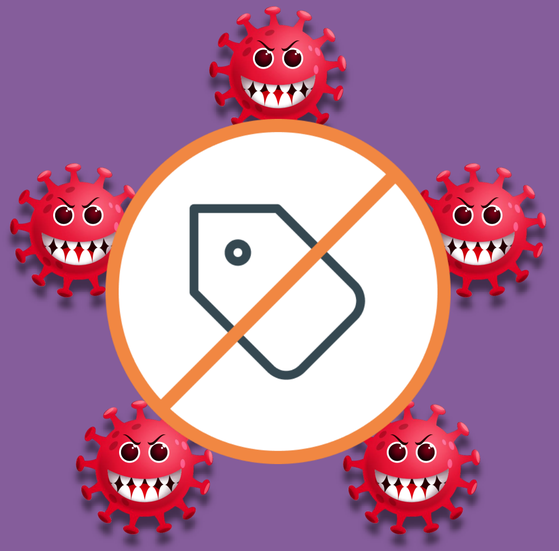




- Don’t use a sledgehammer to crack a nut!
- Have a range of tools in your chosen approach that offer rigour proportionate to the event.
- Make the analysis of minor events slick, allowing many to be added to your data-set.

3

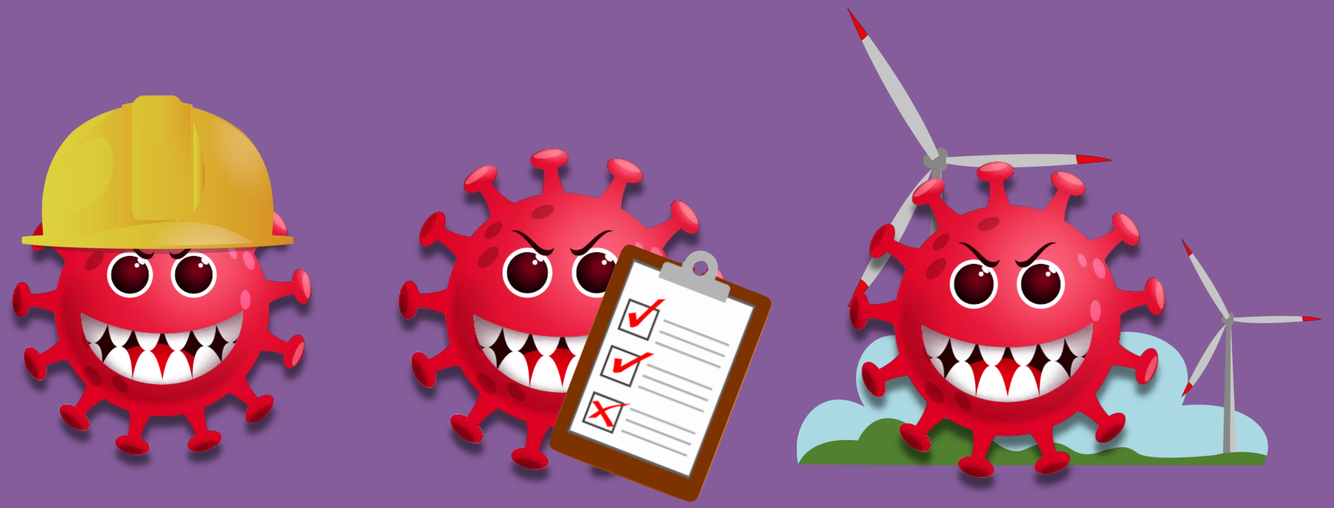
If we are the same regardless of failure type, how do you ensure we are consistently captured when the scope is so broad?



3

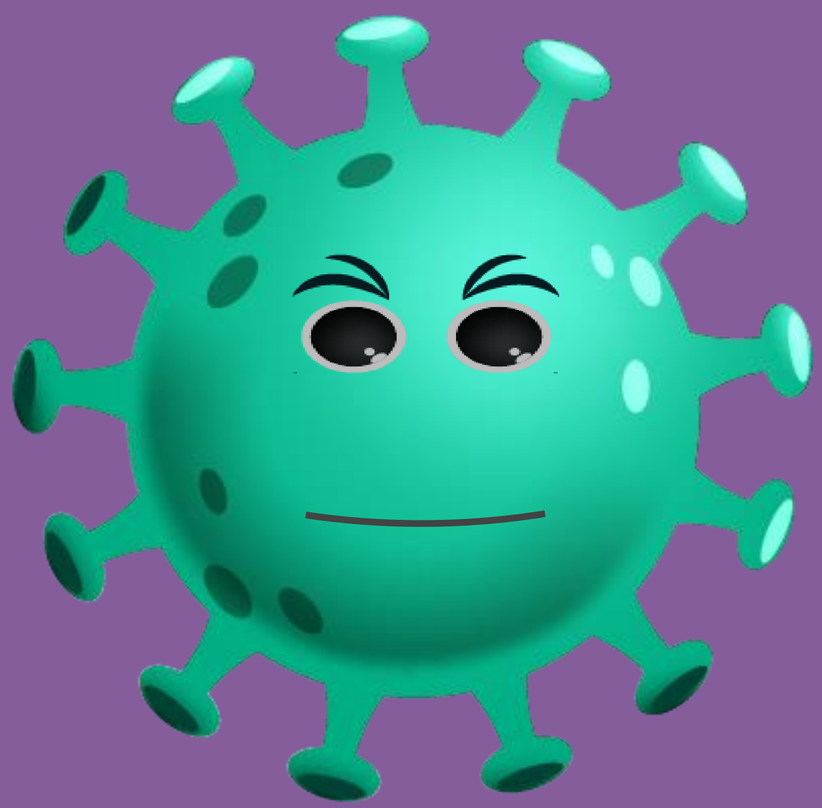
If we are the same regardless of failure type, how do you ensure we are consistently captured when the scope is so broad?

Build DISCIPLINE EXPERTISE into your analysis



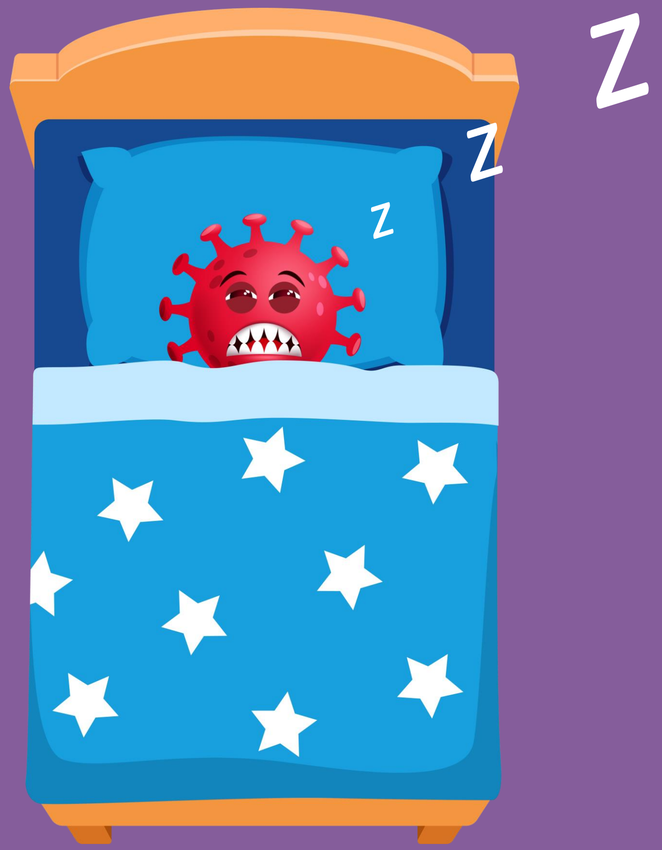
- Use language common to each function or business area. Safety is not the same as Quality!
- Understand the differences to create effective barrier & change evaluation unique to each failure type.
- Engage professionals in each field consistently, even get them to collaborate and work together to catch us!

Why not learn how to use them to catch us…



Because if you can keep me behind bars…

My bigger louder cousin will stay sleeping…



And you might just achieve some Root Cause Learning of your own…

COMET®

Audit. Investigate. Assure.