

# Pitfalls of Incident Investigations & How To Avoid Them

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# Why this topic?



- Missed opportunities to identify real causes and develop effective corrective actions.
- Incident investigations devolve into a "blame game".
- Management practices causing incidents are not identified and addressed.
- Corrective actions are cliché and ineffective.
- The outcomes of incident investigations are wrongly viewed as solely reactive initiatives rather than capitalizing on the proactive possibilities.

# Seeking to Blame



- The incident investigation process is often used to assign blame for the negative outcomes.
- Which element of the organization is most often blamed in incident investigations?
- EMPLOYEES
- Why are employees so often assigned the blame for an incident?
- Easy targets with layers of policy and training that give employers a false sense of confidence they are protected.

## **Negative Impacts**



- When employees are blamed, trust in the process breaks down.
- When employees are blamed, trust in those engaging in the process breaks down, and it carries over to other duties.
- Can lead to less reporting for fear or punishment, retaliation or humiliation.
- Can minimize employee participation in investigations leading to incomplete analysis and corrective actions.

## **Avoiding Blame**



- State purpose of Incident Investigation Process and adhere to it!
- Do not enter into investigations with the intent of figuring out "who messed up" or "which employee(s) is at fault".
- When employee actions may have caused the incident, seek to understand why the employee engaged in the specific behavior(s).
- Keep in mind that CONTEXT is just as important as INCENTIVES and POLICIES.

#### Non-Methodical Approach



- The lack of a methodical or systematic approach to investigating incidents increases the likelihood causal factors (causes) could be missed or misdiagnosed.
- Higher probability of missing elements of a successful investigative and corrective action process.
- Often observed when investigators have not been trained in or exposed to a methodical approach.

## **Methodical Approach Solutions**



- Research and adopt an incident investigation method that suits the organization.
- Build and follow and incident investigation policy/process focused on identifying causes, developing corrective actions and measuring effectiveness.
- TRAIN incident investigation team members on selected methodology.
- Communicate the intention of the incident investigation policy/process to all impacted parties so they understand the purpose and value.

#### **Confirmation Bias**



- "Confirmation bias is our tendency to seek out or interpret information that supports our pre-existing beliefs, expectations, or hypotheses."

  (https://ethicsunwrapped.utexas.edu/glossary/confirmation-bias)
- "I already know what happened just by the description."
- "I've seen this a thousand times and it's always..."
- Investigators will seek evidence that confirms their preconceived notions and may miss pertinent facts or evidence leading to real casual factors (causes).

# **Avoiding Confirmation Bias**



- Acknowledge the possibility and train your investigation teams to resist the temptation.
- Follow a methodical process to investigate the incident.
- Be intentional about letting the evidence lead investigators to causal factors (root causes).
- Apply Change Analysis tool to confirm the identified element is a cause and not a condition (to be addressed next).

#### Conditions vs. Causes



- Conditions are not causes!
- Conditions are the result of a cause.
- Conditions are often lower-level elements and tend to place the process breakdown at the feet of employees.
- Addressing conditions will not maximize the desired outcome of implementing effective corrective actions.

# **Conditions Example**



- Employee falls from step stool being used to access a valve placed out of reach from ground level.
- Rigging fails during a critical lift but there is no record of rigging training or inspections of rigging materials.
- Employee injured while not wearing PPE or wearing the wrong PPE but management doesn't enforce policy.

# **Avoiding Identifying Conditions as Causes**



- Methodical approach to incident investigations.
- Use of the 5 Why method is a simple tool to help: If there's a why to the factor, it could be a condition and not a cause.
- Use Change Analysis to validate the alleged cause.

#### No or Ineffective Corrective Action



- Company will hold a safety stand down with employees.
- Retrain employees.
- New policy to be written and implemented.
- How often do we hear these recited as "corrective actions"?
- Corrective actions are the most critical informational component of a successful incident investigation! (Not a fancy flow chart, diagram or report.)

#### **Effective Corrective Actions**



- Agreed upon by all stakeholders.
- Supported by management (resource allocation and accountability).
- Measurable!
- Time bound.
- Likely address other types of unforeseen incidents. (Hot work example.)

# **Failure to Verify Corrective Actions**



- Corrective actions are worthless if they are not implemented and measured for successful impact and/or improved as needed.
- Creates a "smoking gun" that could be used by regulators (think SOX Act) or in civil litigation to demonstrate willful disregard if not plain indifference.
- Invalidates virtually the entire process of investigating the incident and determining causal factors (root causes).

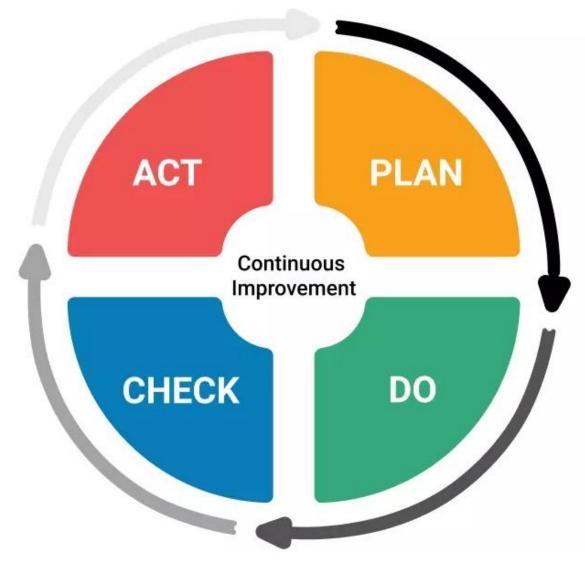
# **Successful Implementation of Corrective Actions**



- Ensure there is full management and operational support prior to implementation.
- Understand the value propositions for not only the high-level stakeholders, but those directly impacted by process changes.
- Thoroughly communicate the corrective action implementation plan to all impacted parties and provide the knowledge and tools needed to successfully execute.
- Set time-tables, KPIs and measure impact.
- Apply Continuous Process Improvement Cycle to corrective actions.

# Continuous Process Improvement Cycle (PDCA Cycle)





#### **Honorable Mention**



- Not doing an investigation at all.
- Failing to include operational personnel in incident review teams.
- Failure to communicate challenging findings to management.
- Failing to preserve "clean" documentation.
- Including statements or content in investigative materials that could prove to be embarrassing or damage the integrity of the process.

## **Question and Answer Period**



Thank you all for your time and participation!

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