

THE  
**PEW**  
CHARITABLE TRUSTS

# Root Cause Analysis & Environmental Assessments

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**November 9, 2017**

# Outline of today's presentation

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- **What is RCA & why is it needed?**

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- **Pew's RCA initiative**

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- **Some lessons learned about RCA**

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# Why root cause analysis (RCA) is needed?

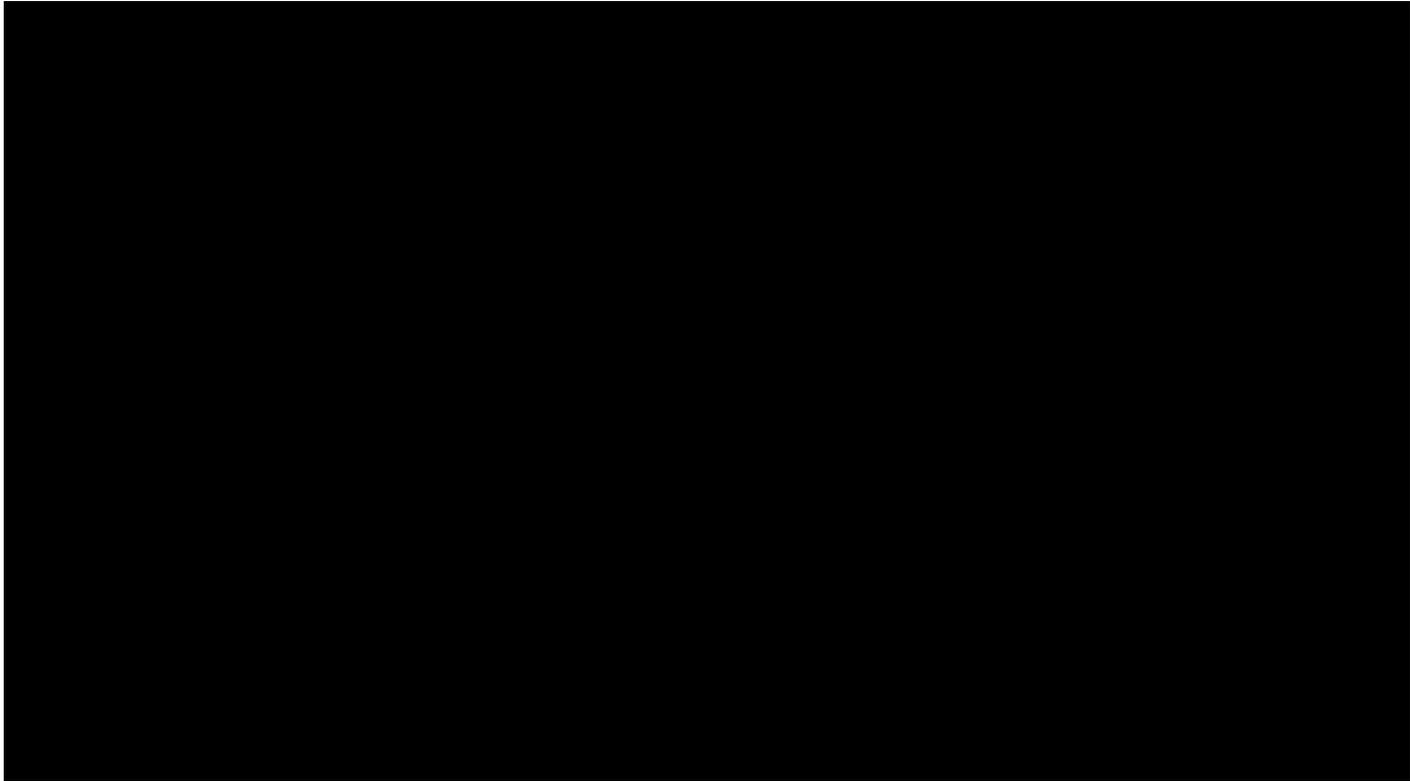
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“It is our view that **complex systems** almost always fail in **complex ways**, and we believe it would be wrong to reduce the complexities and weaknesses associated with these systems to some simple explanation. Too often, accident investigations blame a failure only on the **last step in a complex process**, when a more comprehensive understanding of that process could reveal that **earlier steps might be equally or even more culpable.**”

Columbia Space Shuttle Accident Investigation Board, 2003

# RCA: explain why disaster strikes & how to prevent it

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[1986: Space Shuttle Challenger disaster Live on CNN](#)

# From *Challenger* to *Columbia*: root causes reoccur

- **Challenger investigation**
  - Root causes identified
    - Physical causes
    - NASA history
    - NASA culture
  - Corrective actions suggested
- **Seventeen years in-between**
  - System returned to *status quo*
- **Columbia investigation**
  - Root causes reoccurred



# The goals of RCA: prevent disaster reoccurrence

## Root causes are

- Causal influences
  - Caused event or
  - Increased impact
- Controllable
  - Manageable
  - Within control
- Usually > 1 RC

## RCA focus

- Learn from past
- *Why* system failed
  - Events
  - Interactions
  - Root causes
- Prevent repeat

## RCA approach

- Systematic
- Comprehensive
  - Physical factors
  - Human factors
  - Organization
  - Other

# Systems theory: attributes of complex systems

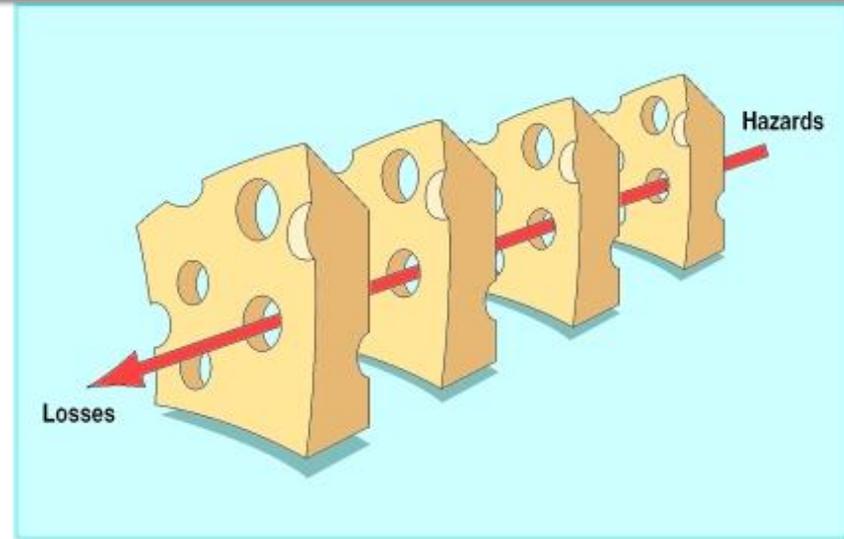
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- consist of multiple interdependent parts
- have 'set points' shaped by these interactions
- changes require deep knowledge of interactions
- system is prone to return to 'set points'

# Understanding accidents: Swiss cheese model

- **Basic premises**

- Humans are fallible
- Errors happen
  - Understand why
  - Adapt conditions



- Understanding is key to prevention [James Reason, 2000](#)

- **Complex systems have many safety barriers**

- Every safety barrier has weaknesses
- Accidents happen when 'holes' align
- Need to understand 'near misses'

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# Why is root cause analysis a priority for Pew?

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Foundation of a prevention-based food system

Not always done; ineffectively shared; lost opportunities

Improvements require collaborative approach

Alignment among FDA, CDC, FSIS, state & local; industry

# Root cause analysis project approach

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## Research

- Other models (e.g., NTSB, CSB, NuReg)
- RCA best practices

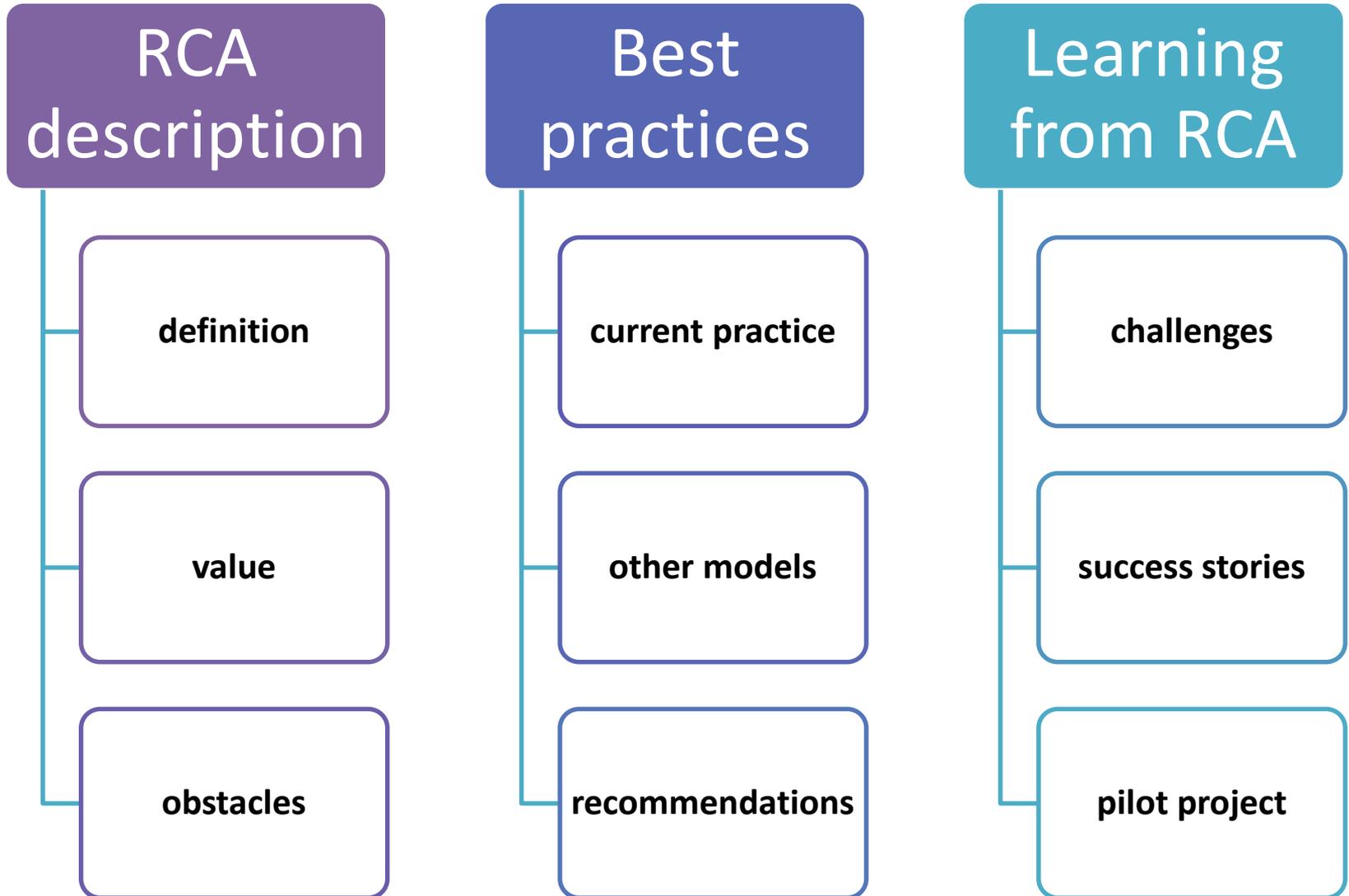
## Convenings

- RCA value; obstacles; definitions
- Communicating RCA findings
- RCA best practices

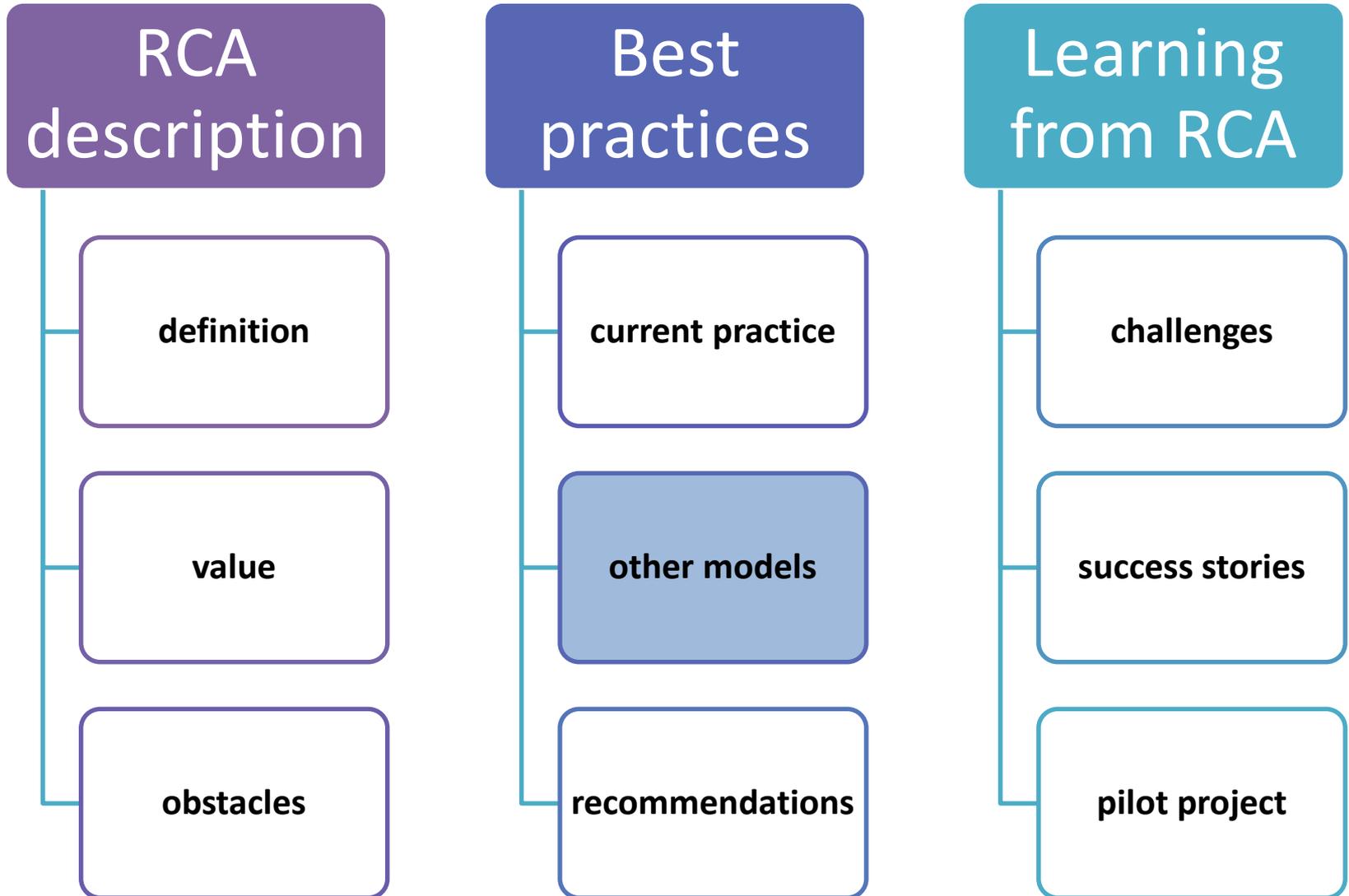
## Outreach

- Conference presentations (IAFP, InFORM)
- Publication in trade magazine (upcoming)

# Pew's work on RCA: Goals and objectives



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# Pew's work on RCA: Learning from other models

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## RCA in other high-risk industries

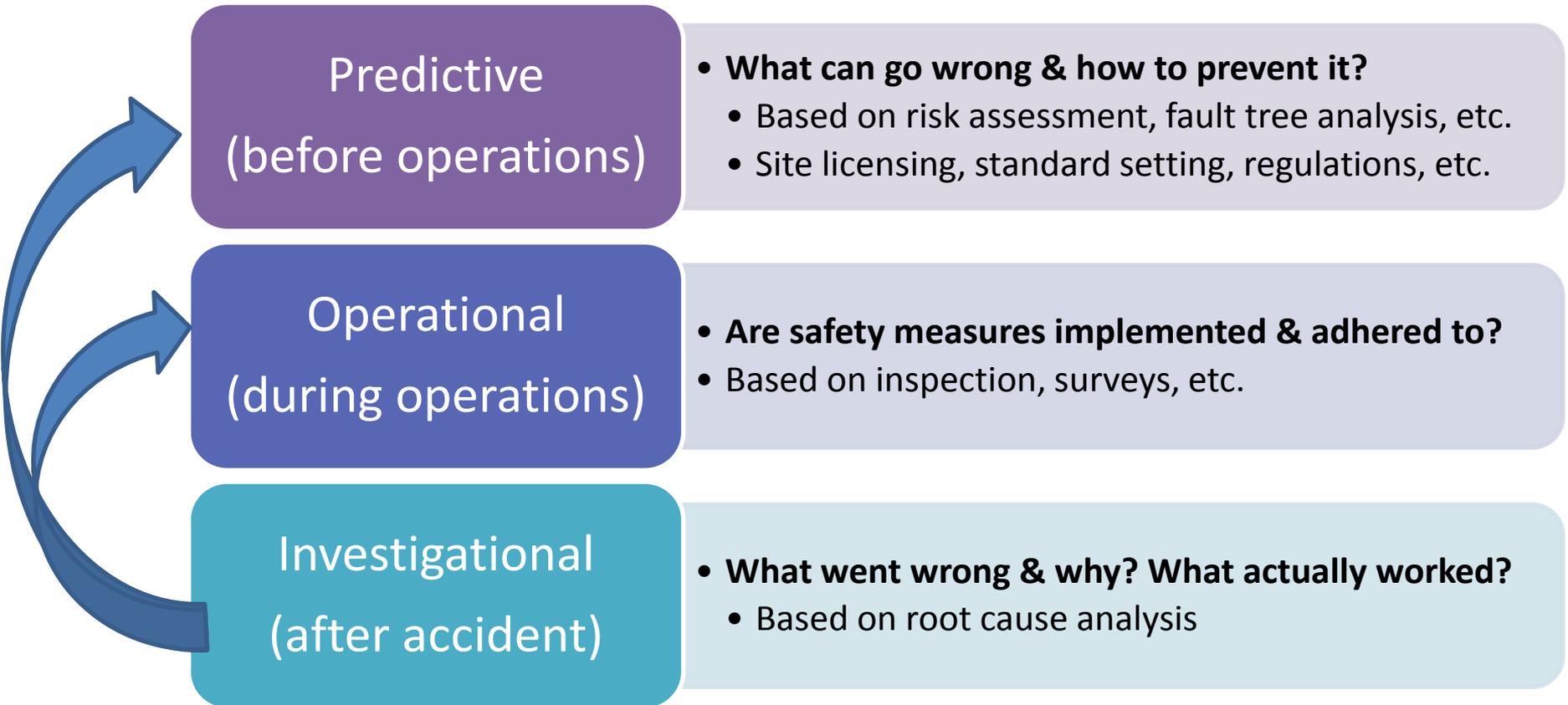
- Transportation, chemical, nuclear industries
- Occupational safety; consumer product safety
- Recreational scuba diving

## 3 Key research questions

- How are RCAs conducted? (When, why & how)
- How are key findings disseminated & used?
- What is working & what is not?

# Key finding: Not every investigation is a RCA

Three distinct but related types of investigations:



Predictive  
(before operations)

- **What can go wrong & how to prevent it?**
- Based on risk assessment, fault tree analysis, etc.
- Site licensing, standard setting, regulations, etc.

Operational  
(during operations)

- **Are safety measures implemented & adhered to?**
- Based on inspection, surveys, etc.

Investigational  
(after accident)

- **What went wrong & why? What actually worked?**
- Based on root cause analysis

# RCA: learning from past to prevent future

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*retrospective*

Root cause analysis

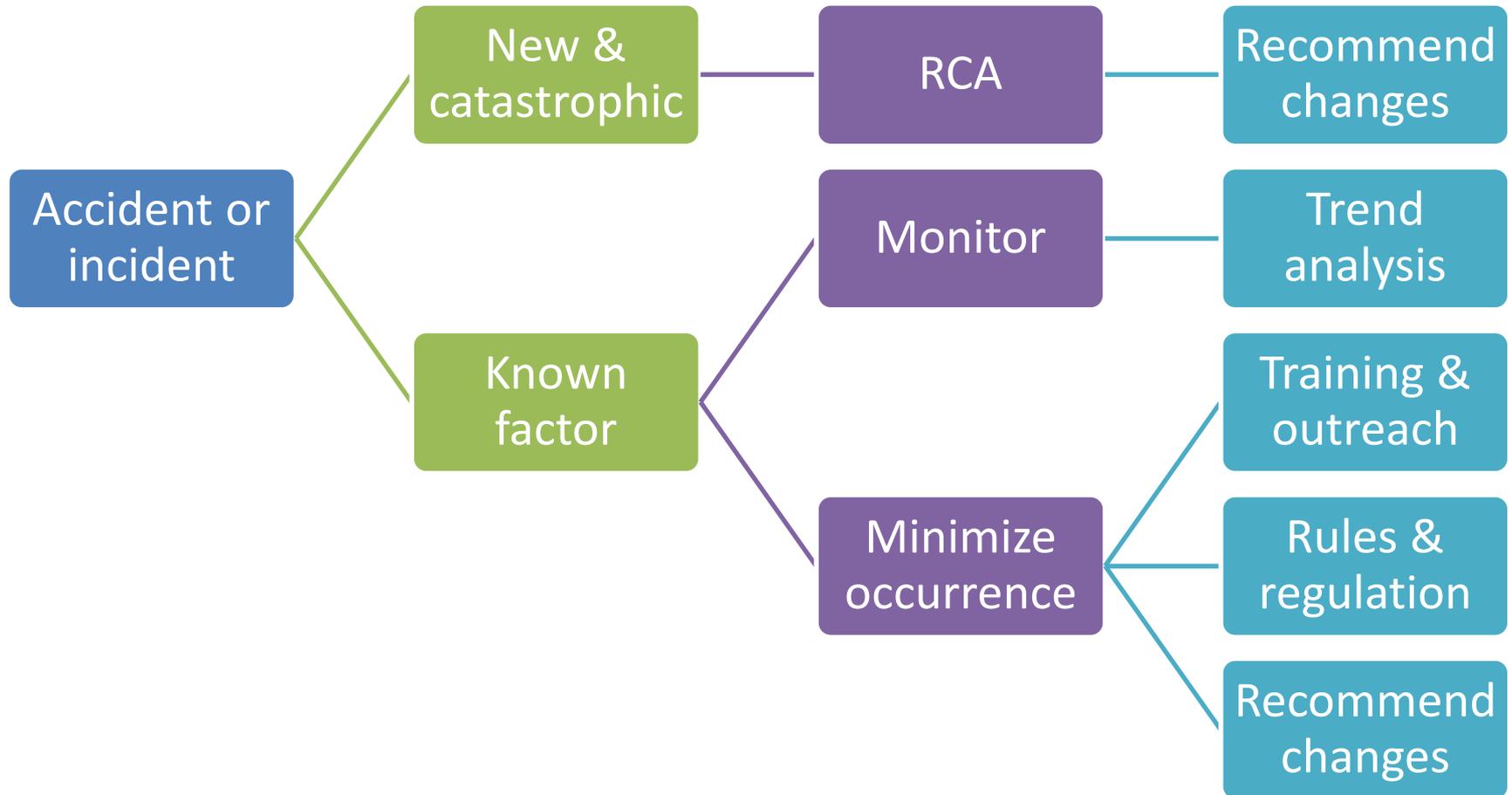
- What went wrong and why?
- How to prevent reoccurrence?
- What could create future problems?

*prospective*

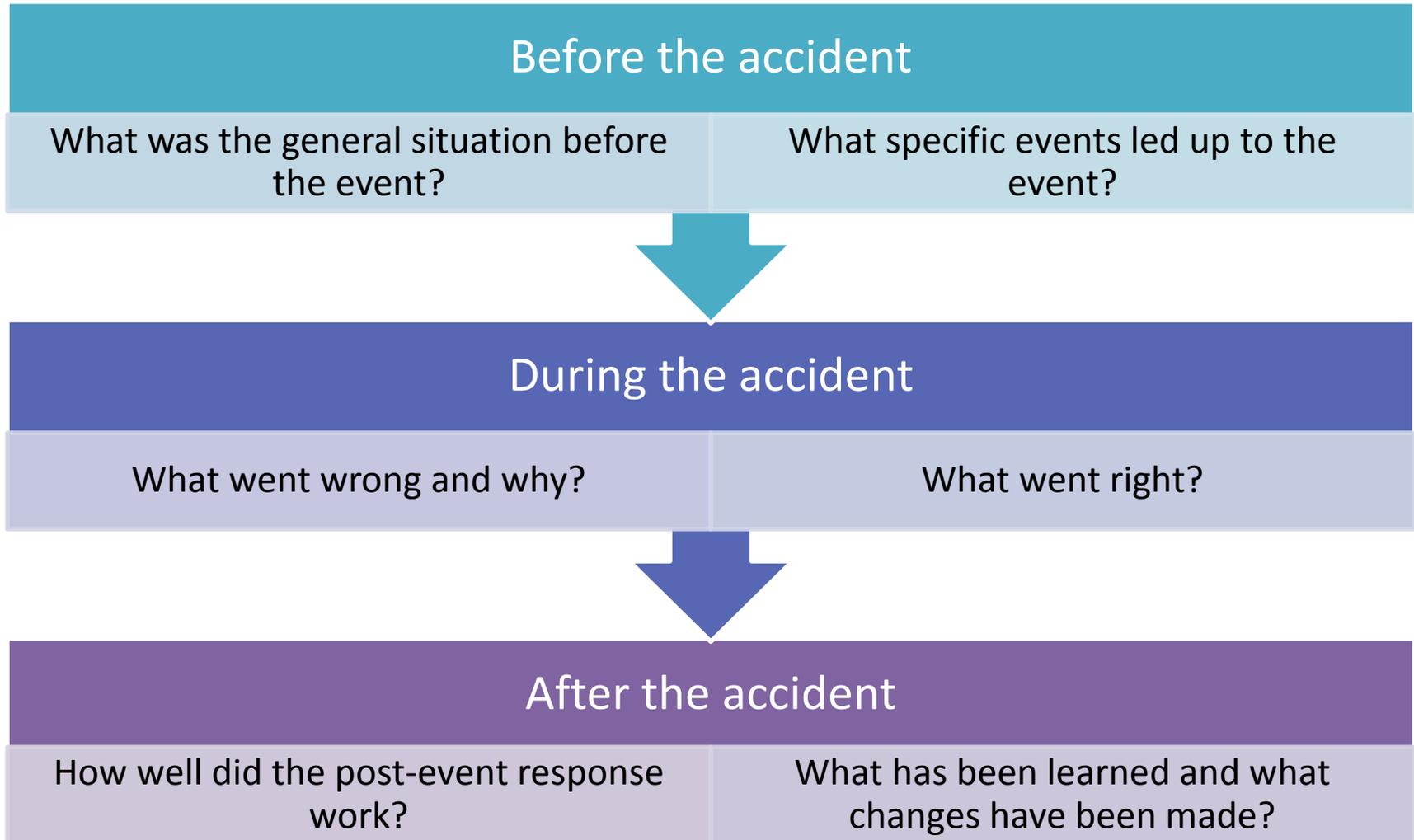
Inspection

- Is operation in compliance?
- How to restore compliance?
- How to prevent future issues?

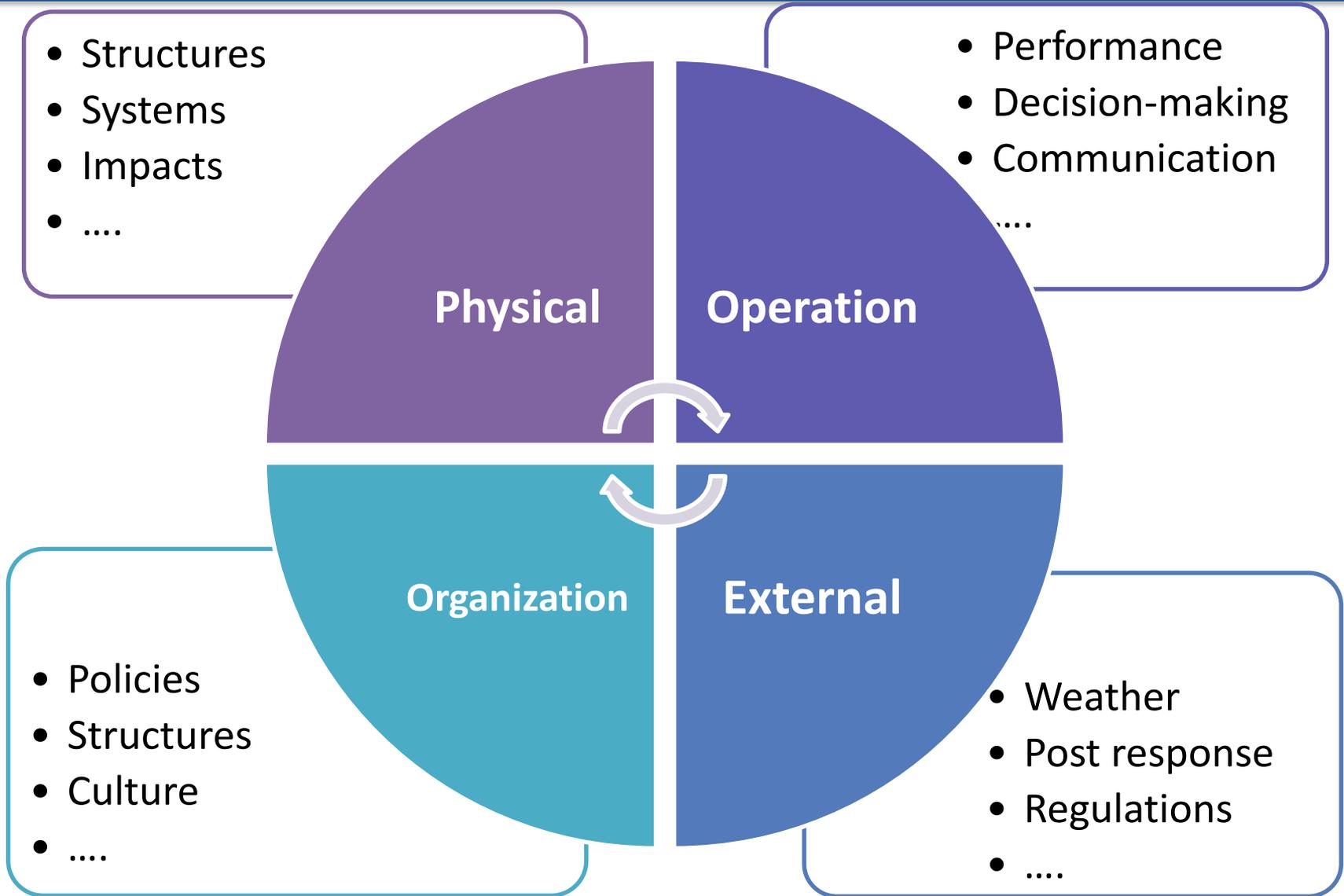
# Key finding: Not every event requires a RCA



# Key finding: Effective RCAs reconstruct events

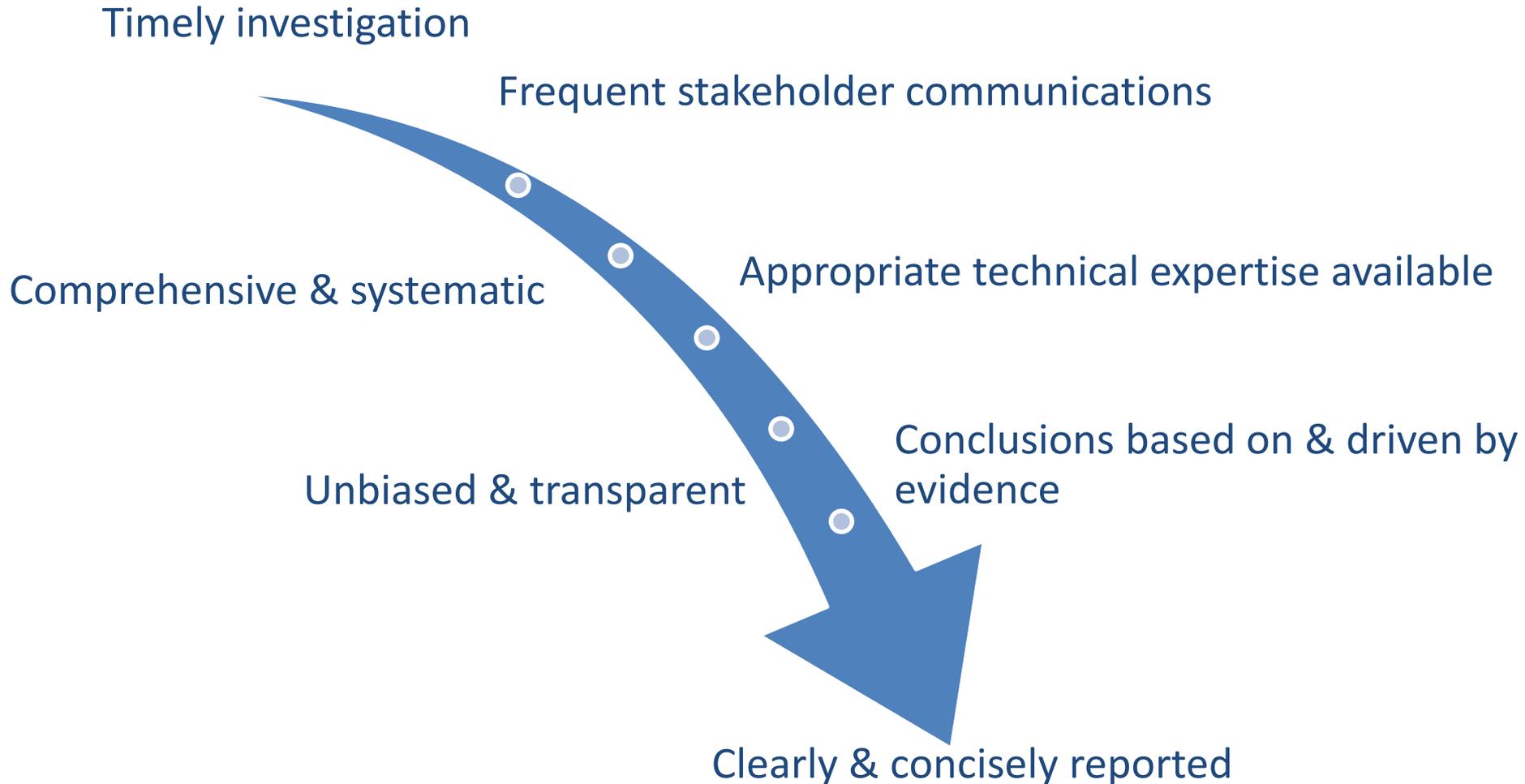


# Key finding: Effective RCAs consider 4 types of factors



# Key finding: Properties of effective RCAs

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# Conclusion: RCA valuable for foodborne outbreaks

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- **Systems-based approach for prevention**
- **Key in prevention-based food system**
  - Understand why outbreak happened
  - Find weaknesses in food system
  - Identify how to prevent reoccurrence
- **Other high-risk industries rely on RCA**
  - Opportunities to learn from them

# Thank you for your time & attention

To continue the discussion beyond today please contact:

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*"Is the asparagus farm-raised or wild-caught?"*

Source: *New Yorker*, 12/06/2004