Mini/Midi-Latent Cause Analysis

version 13 March 2013

An LCA is a way to help people see themselves as part of their problems. As opposed to blaming other people and things, the LCA requires a person to ask "what is it about the way we are," and "what is it about the way I am that contributed to this problem?" Mini and Midi LCAs are to be performed on any typical problem normally encountered in a persons life (work or home). All LCA's ask a person to be introspective about themselves and their surroundings.

Imagine a world where everyone looked at themselves rather than pointing fingers at others.

One of the most frustrating findings of formal Latent Cause Analyses is that many of the underlying causes of major incidents are known AHEAD OF TIME. Warning signs almost always precede major incidents, but are neglected. Frustrating equipment, people, and systems are usually recognized, but often ignored until they result in disaster.

It is people that ignore and neglect these problems. In the limit, people cause problems – ALL people. We either do things we should not have done, or neglect to do things we should have done. Although most people easily see these qualities in other people, it is rare to find individuals who can see their own role in things that go wrong.

A Latent Cause Analysis is an attempt to help people see themselves as part of their problems.

First we need to see ourselves as part of the problem, then we'll be ready to change.

The ultimate intent of the Latent Cause Analysis is not to generate action items or recommendations. Instead, the ultimate intent of a Latent Cause Analysis is to change people, because:

When people change, everything else will change.

A Latent Cause Analysis is primarily, therefore, a self awareness exercise. If we look for our own role in things that go wrong often-enough, healthy people will "connect the dots" and desire a change.

But a Latent Cause Analysis is also an organizational awareness tool. In this respect, when you finish your Latent Cause Analysis, please send it to whomever is responsible to looking for and addressing COMMON LATENT THREADS.

Incident Description

The following should read like a paragraph..

Who (did it happen to)?

What (was the undesired actual/potential consequence)?

Where (did it happen)?

When (did it happen)?

Your Name(s):
Completion Date:

Incident Description-2

Simple Schematics from “5 Items”

Insert **labeled schematics** so the reader can understand the remainder of this document.

Make sure ALL items referred-to in other portions of this document are included. Keep it **simple**.

Incident Description-3

Not the detailed Sequence of Events, but only a 5-8 bullet summary

Summary Sequence of Events from "5 Items"

- …
- …
- …
- …
- …
- …
- …
- …

Why Statement *(what question will you answer in this Mini/Midi-LCA -- should relate to WHAT on page 1)*

People Evidence Summary-1

Detailed Sequence of Events from People

What did you learn from People about Sequence of Events (a synopsis based on all that you heard), bullet-style? Add pages if necessary.

People Evidence Summary-2

Why do People think this event occurred?

What were some of the “theories” you heard about the possible causes of the incident (sentence and paragraph style)?

People Evidence Summary-3

Frustrations

What did you learn from People about their Frustrations, and then each frustration's weighting on this incident?

Who/Role	Frustration	Weight

Warning Signs

What did People mention about warning signs?

Physical Evidence Summary

What did you learn from the Physical Evidence? Provide a written summary of findings.

attach labeled photos and sketches

What warning signs were revealed in the Physical Evidence?

Paper Evidence Summary

What did you learn from the Paper Evidence? Provide a written summary of findings.

attach a list of paper evidence you reviewed

Did the Paper Evidence reveal any warning signs?

Physical Causes

Physical Causes: Based on all the evidence, **HOW** did the incident occur (What were the **PHYSICS** of the incident)? BE SPECIFIC. Do not mention anything about people. Use sentences/paragraphs. Write in past tense.

Reactive Actions Taken: What has already been done in response to this incident?

Preventative Actions Recommended: What else should be done to make sure the Physical Causes cannot recur?

Human Causes

WHO did **WHAT WRONG** (functions, not names)

List ACTIONS that people DID (or did NOT do) . Do not mention "thoughts or attitudes." Be specific. Bulleted list. Write in past tense. Acknowledge DESIRED BEHAVIOR for each Human Cause.

Actual Behavior (Human Causes)	Desired Behavior

Thoughts that led to the behavior

Fill-in ONE copy of this page for each of the identified HUMAN CAUSES.

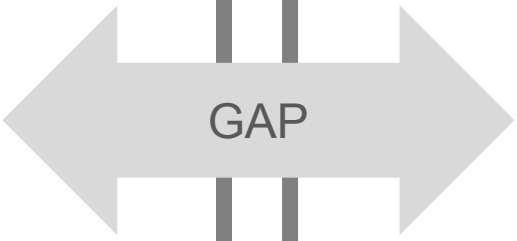
Human Cause #1 (Actual Behavior):

Desired Behavior:

Triggering Situation *(When should the person have behaved differently?)*: *When…..*

Actual Thoughts at this point in time

Desired Thoughts at this point in time



Organizational Latent Causes

What is it about the way WE ARE that accounts for the GAP in the preceding thoughts? General, present-tense statements prefaced with the words "We tend to…." and ending with "and we know this is not right."

- We…
- We…
- We…
- We…
- We…

Circle the most significant item in the above box

What do you think we should do about the circled Organizational Latency? Please be as SMART as possible (specific, measurable, actionable, reasonable, and time-bound):

Personal Latent Causes

"What is it about the way I AM that might have contributed to this incident? General, present-tense statements prefaced with the words "I tend to…." and ending with "and I know this is not right."

- I…
- I…
- I…
- I…
- I…

Circle the most significant item in the above box

What will you agree to do about the circled Personal Latent Cause? Please be as SMART as possible (specific, measurable, actionable, reasonable, and time-bound):

Summary of Causes

The Most Significant Physical, Human, and Latent Causes on preceding pages

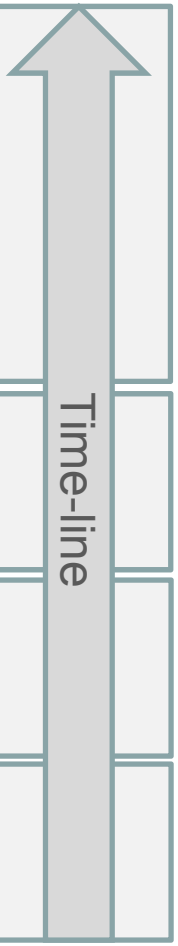
Incident:

Physical Causes:

Human Causes:

Organizational Latent Causes:

Personal Latent Causes:



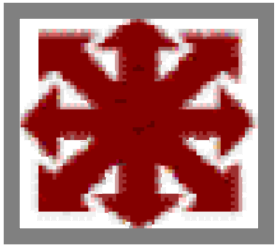
Summary Thoughts

My own, personal bottom-line learning from this incident:

What I think others should learn from this incident:

Summarize emerging symptoms that warned of this event.

While investigating this incident, what did you discover that was good, or positive.



Golden Rule of an LCA

When something goes wrong, we must try to understand to such an extent that we're convinced we'd have done the same thing under similar circumstances. This is true for all who truly desire to understand why things go wrong, everywhere, in all walks of life.

Let's SLOW DOWN and Learn from Things that Go Wrong!

THANKS to ConocoPhillips for many of the ideas captured in this document, and to all those who have sent me their Mini-LCA's for comment! …. C. Robert Nelms

More about Failsafe Network, Inc.

Failsafe exists to help individuals and organizations discover the TRUTH about why things go wrong, without hurting one another in the process. All of Failsafe's approaches are based on the need to SLOW DOWN — to allow EVIDENCE to guide us to the right answers. After all, "**everything we need to know about our existence is staring us right in our face, if we'd only take time to look**."

The concepts underlying this Mini-LCA are natural and basic. The Mini-LCA is merely an attempt to help people see their own role in small problems, in hopes that the people will change so that big problems can be avoided.

Failsafe's Maxi, Midi, and Mini-LCA concepts exist to address large, medium, and small-size problems. A total, comprehensive approach to learning from things that go wrong is available through Failsafe, and is presented in the 4-day class called "**The Latent Cause Experience.**" This 4-day experience was designed to jump-start your site's LCA effort's. It was designed for a cross-section of an organization, since EVERYONE must eventually see themselves as part of their own problems. The 4-day experience will CHANGE the way the attendee thinks about failure and its causes, as well as introducing a vision, vocabulary, tools, and structure for your LCA efforts. It is strongly recommended that a CRITICAL MASS of an organization experience the 4-day class prior pursuing any form of Latent Cause Analysis.

For a FREE DOWNLOAD of the most recent release of the Mini/Midi-LCA, visit www.failsafe-network.com

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