FAILSAFE NETWORK
Helping you learn from things that go wrong

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# The Fundamentals of Latent Cause Analysis

Sharing the details of Latent Cause Analysis (LCA) in our four-day Latent Cause Experience (LCE) is a joy. Many of you reading this likely have fond memories of the first time you attended the Latent Cause Experience. One aspect I genuinely appreciate about LCA is that anyone can use it. It's simple yet very effective. Simple and effective are winning attributes for any endeavor.

Many times, when you encounter things that have been simplified, they've been simplified through shortcuts, and honestly, the value has been drained out of the process. Yet, those rare times when you can find the combination of simple and effective are when you discover a process to embrace and use throughout your career. That has been the secret of Failsafe's success for almost 40 years.

One illustration of simple yet effective, is the LCA process is applicable regardless of the size of the event. One person can use LCA on a very small event. A group of people can use it on an event that affects them, or it can be used on a complex, significant event that needs a principal investigator with an evidence team. Events affecting an individual, group, or entire organization can be addressed using the same process. The only things that change are the resources and the rigor applied to the process. Intuitively, the resources and the rigor should match the consequence of the event. The more complex the event, the more we'll spend time, and we'll use more people. That's a given. What I love about Latent Cause Analysis is that regardless of the event, they always follow the same process. They all use evidence. They all identify physical, human, and Latent causes. This process truly helps people understand what it is that's causing problems.

LCA can be broken down into three fundamental parts. The **first** part is the beginning of an investigation. How do you start? It's critically important to take control because people depend on you to lead the incident investigation. This is not a time to be timid. Take control. We do that by always starting with the five items. We want to understand what happened, when it happened, and where it happened. This is where we define what we will answer during the investigation. That is the quickest way to take control and launch an investigation.

The **second** part is where we spend most of our time, and that's with the evidence. Do you remember the 3 P's? I remember the first time I went through the 4-day class. Bob Nelms would stand in the middle of the class seated in a 'U' and dramatically say, "People, Physical, and Paper! People, Physical, and Paper!" He had the class repeat "People, Physical, and Paper" with him. The goal was to remember the 3 P's.

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We talked about why it's in that order and on and on and on about evidence. We learned evidence is the lifeblood of any investigation. We learned to let the evidence lead us to conclude why something went wrong.

In the **third** part, we defined the causes of the incident based on the evidence. The thing that is incredibly unique about Latent Cause Analysis is the Stakeholder meeting. This is where we introduce the evidence to the stakeholders that were involved with the event, and we ask them to determine the causes of the event, and what they would like to do about it moving forward. The stakeholder meeting doesn't just address the physics of an event, that is the parts and pieces that failed. The stakeholders also address the gaps identified in their management systems; the policies, processes, and procedures that need to be addressed to prevent similar events in the future. The stakeholders aren't finished there. They look at the sliver of culture that also contributes to our problems. That's what we call latency or latent causes. And when latency is made visible, *then* people can address it and act on it.

Most processes never get to this depth, which unfortunately leaves latency lurking, hidden, and veiled. It is still alive and powerful and affects everything we do. One recognizes this in the frustration exhibited by the people of an organization. **People get extremely frustrated with latency because there's nothing one individual can do about it.** It is often misplaced as frustration with people. 'Why doesn't management fix this?' or 'Why won't people follow procedures?' It is only when latency is identified that we can address it. This is profound learning and is the ultimate goal of the entire process.

The four-day LCE covers the three basic parts of LCA, starting with the five items, what evidence is and how to gather it, and then leading a stakeholder meeting to determine the causes. The seven essential elements of LCA cover all of this in more detail. This is where attendees learn the simple and effective process of Latent Cause Analysis.

If this brought details to mind, then it's probably time for you to reschedule another four-day Latent Cause Experience at your site. We hope to hear from you soon.

*"What we ignore grows, and what we condone multiplies."*