



**Pantex**



# **Causal Factors Analysis (CFA) a Tool to Assess the Effectiveness of the HRO**

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Richard S. Hartley ([rhartley@pantex.com](mailto:rhartley@pantex.com))

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Larry Supina & Janice N. Tolk

# High Reliability Organization

- A High Reliability Organization (HRO) is one in which in spite of the fact that it deals with hazardous, high consequence operations, does so successfully
- A key attribute of being an HRO is to learn from the organization's mistakes
  - Causal Factors Analysis (CFA) key tool to systematically learn from events that occur when HRO efforts fall short



# Pantex's HRO Journey

- **2007**

- Senior Managers embarked on an HRO journey
- Developed a new Causal Factors Analysis (CFA) Investigation Process
  - Explore “Information-Rich” Events provide feedback on HRO
  - Beta-tested CFA process using 4 investigations

- **2008**

- Continue to hone HRO & CFA processes
  - Publishing HRO & CFA Texts
  - Developing HRO & CFA training for second level managers
- Supporting DOE with safety culture initiatives



# Why Is Being an HRO So Important?

**Some types of system failures are so punishing that they must be avoided at almost any cost.**

**These classes of events are seen as so harmful that they disable the organization, radically limiting its capacity to pursue its goal, and could lead to its own destruction.**

*Laporte and Consolini, 1991*



# Let's Think for a Moment...

- We produce and fabricate high explosive components
  - Using some of the most powerful explosives in the world
- We disassemble weapons of mass destruction
  - With safety features disabled
- We will use lethal force to protect DOE assets
- Daily we wrap large amounts of high explosives around plutonium triggers for the world's most hazardous weapons
  - At the crossroads of America's Heartland!

Pantex has no choice except to be a  
**High Reliability Organization!**

# HRO-CFA Challenge - Goal

- Take HRO Attributes to fundamental level
- Develop a practical approach to HRO
- Use HRO framework to integrate HPI, ISM, SCWE, VPP, BBS
- Implement HRO program Plant-wide
- Refocus on systems accident
- Supplement with CFA to provide feedback



# Systems Accident vs. Individual Accident

## Systems Accident

System accident, system fails allowing threat (individual errors) to release hazard and as a result many people are adversely affected.

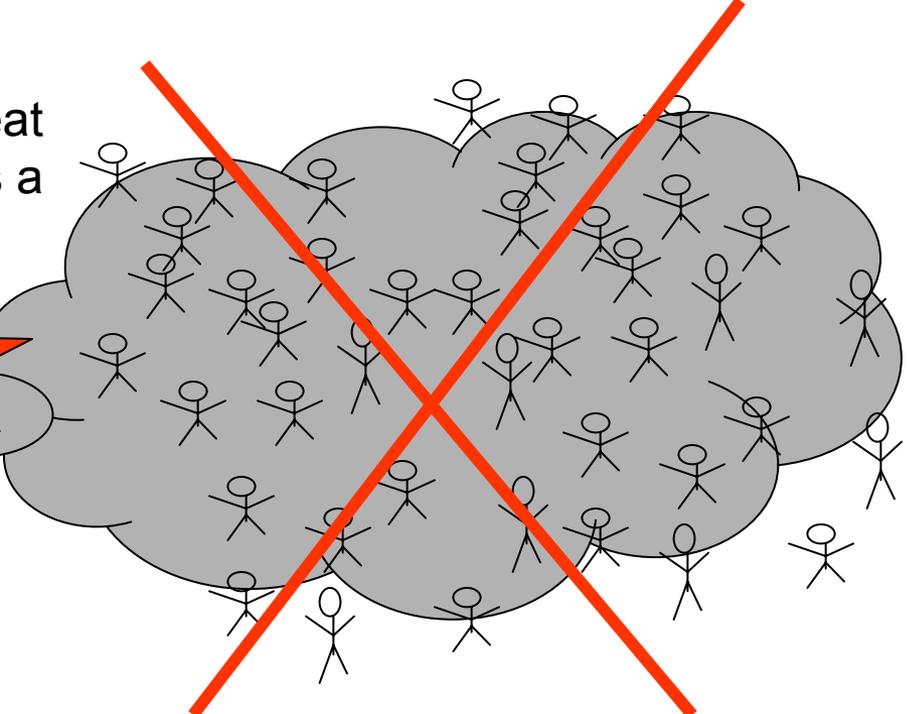


**System**

**Boom!**

**Individual Errors**  
(threat)

**Plant**  
(hazard)

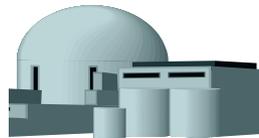


## Individual Accident

Individual accident, the worker is not protected from the plant and the worker gets hurt (e.g. radiation exposure, trips, slips, falls, industrial accident, etc.).



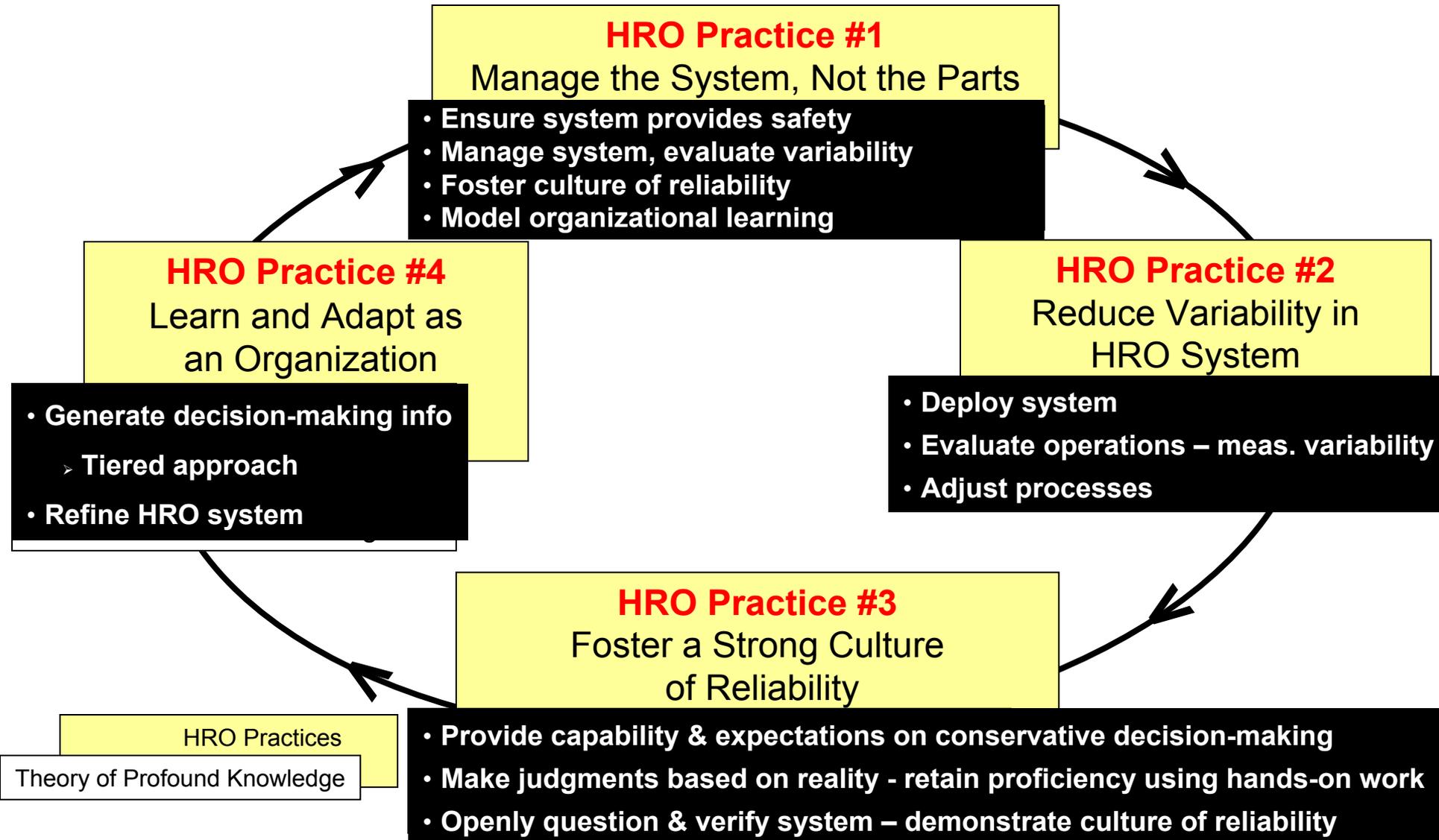
**Individual Errors**  
(receptor)



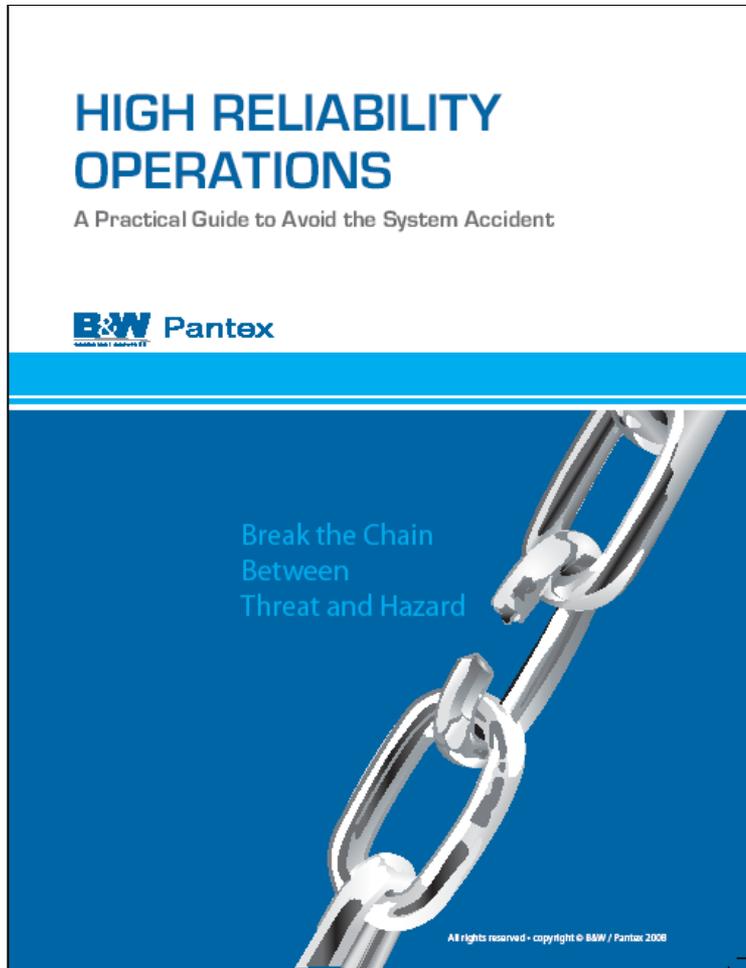
**Plant**  
(hazard)

# HRO at the Fundamental Level

## Adaptation of Deming's Theory of Profound Knowledge to Frame the HRO



# HRO Text



**Practical guide to implement high reliability concepts.**

**Provides foundation for B&W Pantex CFA process.**

## **Contains:**

- High Reliability Theory
- Normal Accident Theory
- Break the Chain Framework
- How organizational accidents occur and how to investigate
- Ties CFA as feedback to HRO



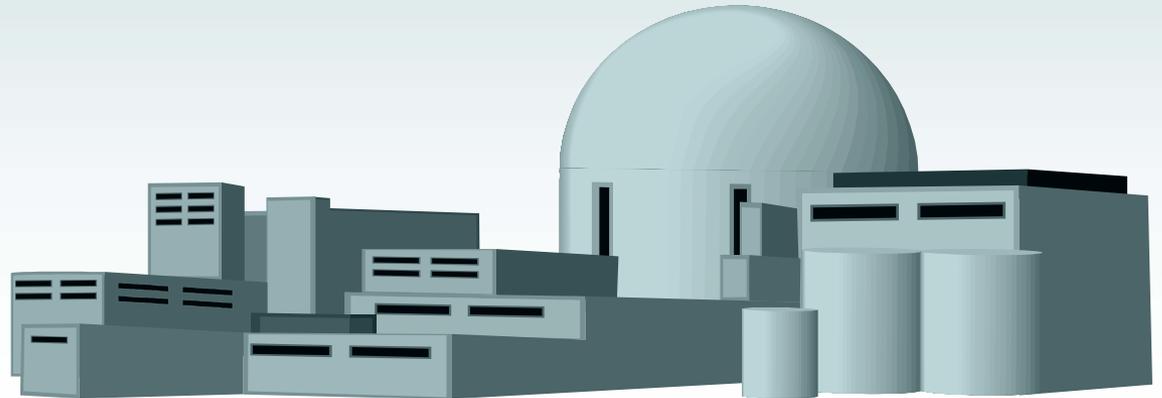
# HRO Improvements

- Puts HRO into logical frame-of-reference
- Break the Chain framework minimizes consequences of systems accidents
- HRO process is physics-based vs. social science-based
- Requires a systems approach to gain consistency
- Neither systems nor people are infallible → optimize organizational learning
- DOE consequence reduction model, more than INPO's HPI
- Framework to integrate ISM, HRO, HPI, SCWE, VPP, BBS

**High Reliability  
Theory**



**High Reliability  
Practicality**



# Break the Chain Framework



HPI+

Learn from Small Errors

Threat from Individual errors

Human Performance Error Precursors

Barriers Defense-in-Depth

Hazard to Protect & to Minimize

The Big One

Step 3

Step 4

Step 2

Step 1

Safety Culture

SCWE, VPP, BBS

challenge, fix, trust & police safety system

Step 5

# CFA Feedback to the HRO Practices

**HRO Practice #1:**  
Manage the System, Not the Parts

**HRO Practice #3:**  
Foster a Strong Culture Reliability

**6**

**HRO Practice #4:**  
Learn and Adapt  
as an  
Organization

**HRO Practice #2:**  
Reduce Variability in HRO  
System (Reduce Hazard, Place  
Barriers to Mitigate)

**HRO Practice #2:**  
Reduce Variability in HRO System  
(Reduce Human Error Precursors, Barriers to  
Prevent)

**3**

**4**

**2**

**1**

**1**

**HPI+**

Threat → Error Precursors

Barriers

Hazard

Barriers  
Consequence

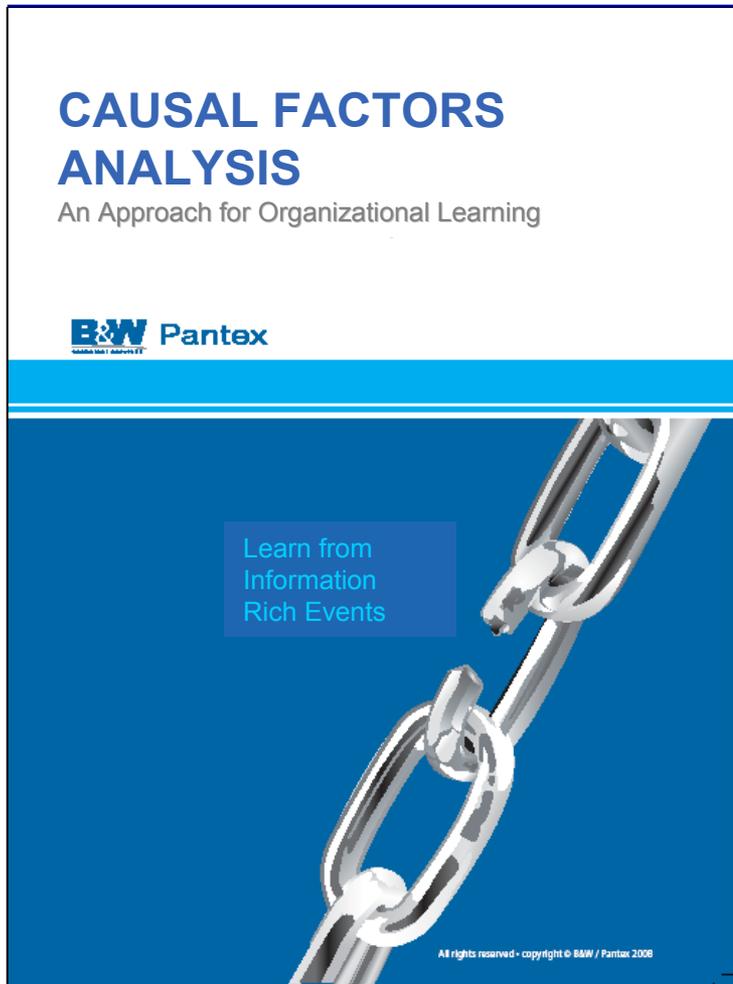
**5**

**Safety Culture**

## Steps in CFA Investigation

- 1** Identify Event
- 2** Determine gaps between “work-as-imagined” vs. “work-as-done”
- 3** Identify Human Performance Error Precursors
- 4** Identify Flawed Barriers
- 5** Identify Latent Organizational Weaknesses & Unhealthy Safety Culture
- 6** Review HRO Programs with insight gained from steps #1 - #5

# CFA Text



**Guide to conduct high quality & consistent CFA investigations to obtain root causes and understand organizational contributors.**

## **Contains:**

- Tools
- Step-by-step process
- Examples & templates
- Method to interpret results and provide feedback to HRO
- Provides outline for report
- Provides criteria for evaluating quality



# CFA Improvements

- Stronger connection between HROs and CFA
- Documented and validated CFA process flow
- Facilitates consistency and understanding
- HPI fully integrated into CFA investigations
- Consistent quality\*
- Provides feedback to HRO programs
- Standardized CFA report format
- Formal CFA report evaluation criteria
- Increased credibility of CFA investigations

