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Learning from incidents starting improvement

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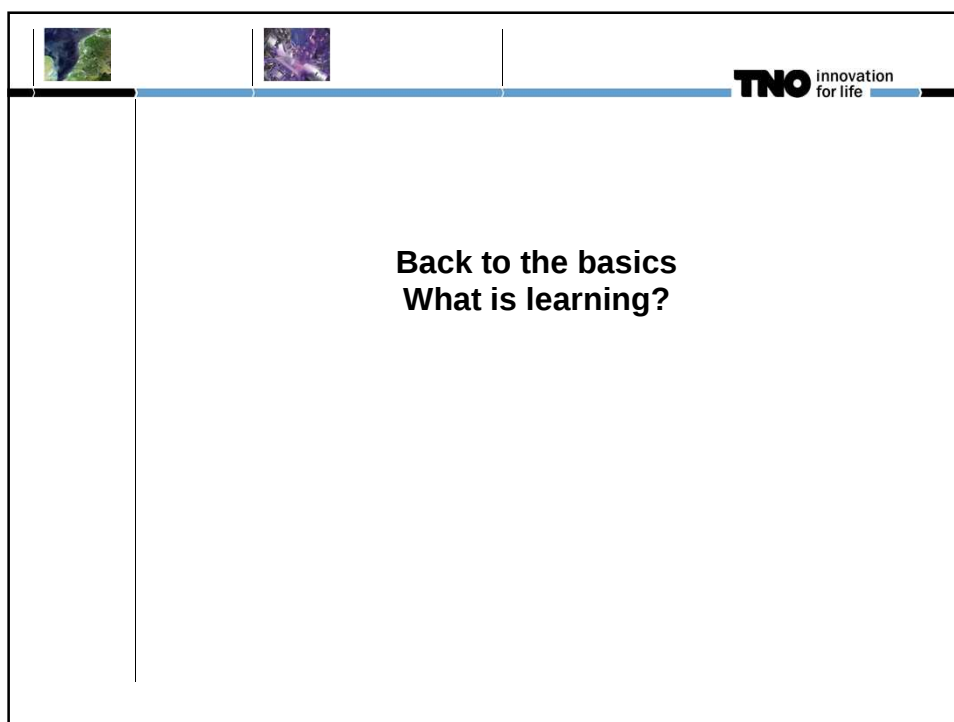
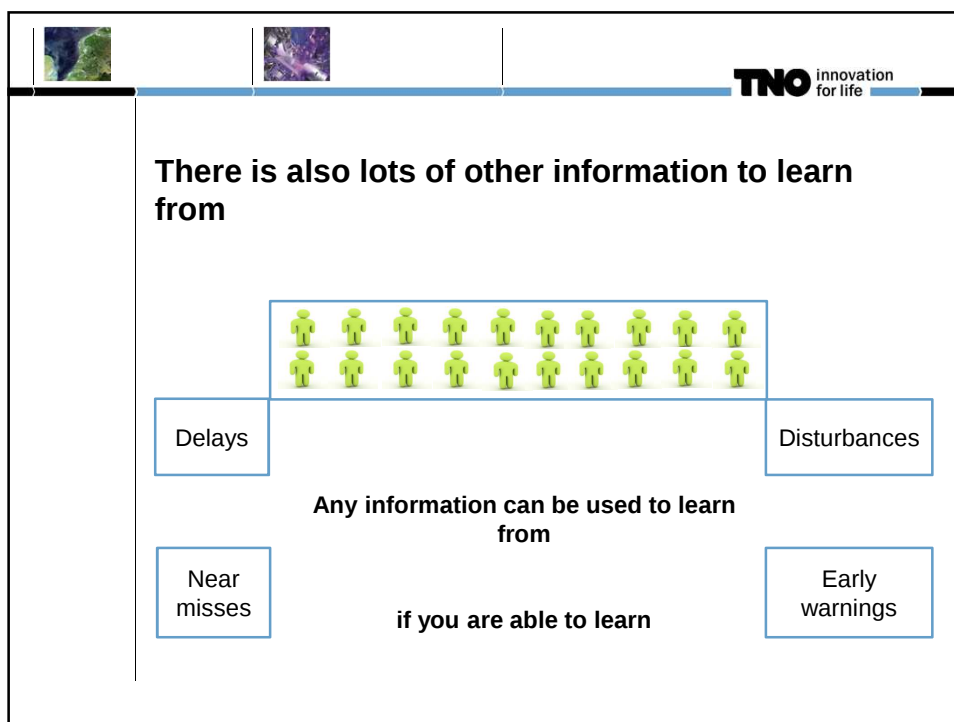


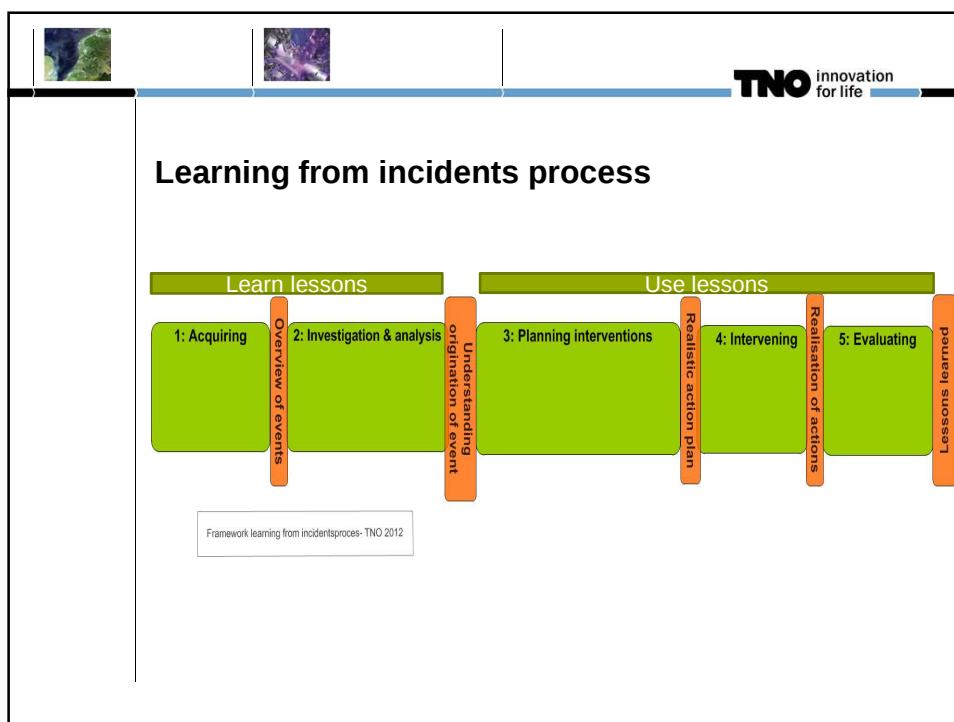


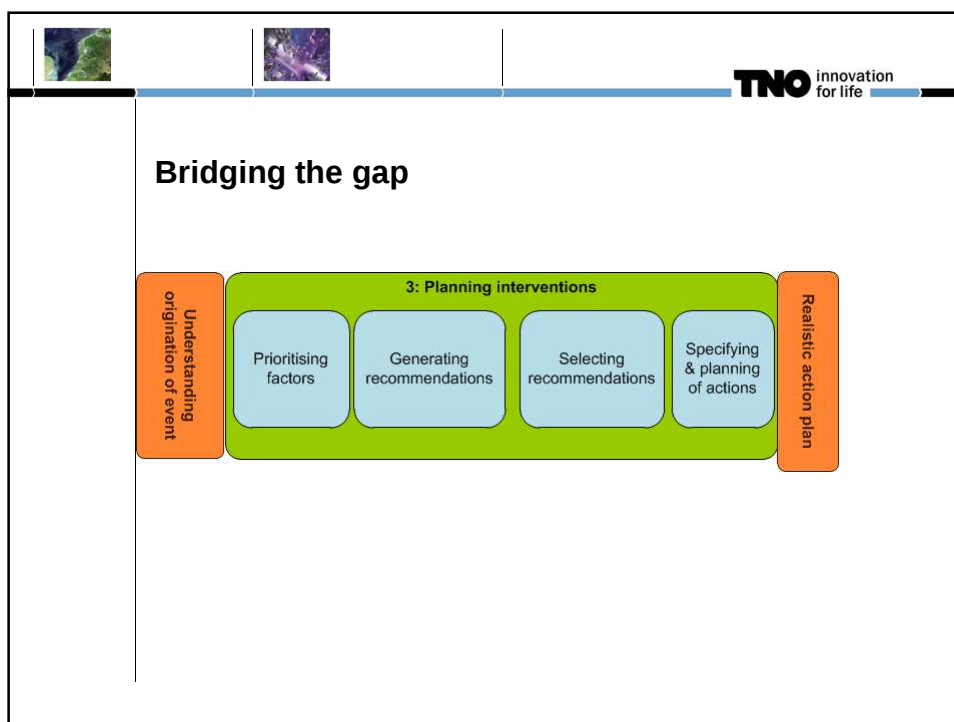
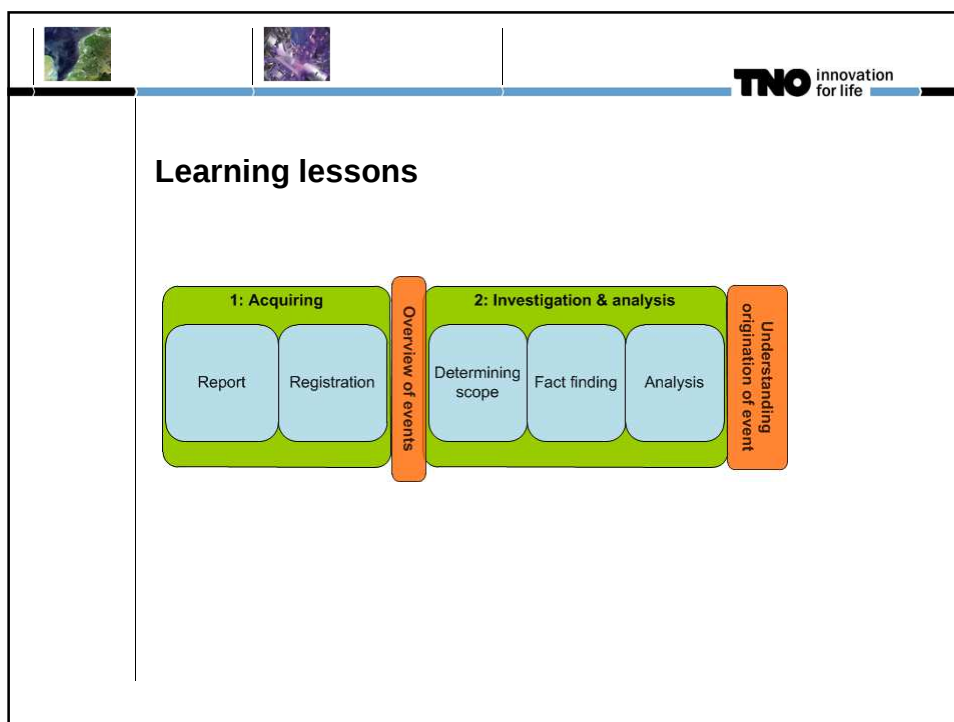
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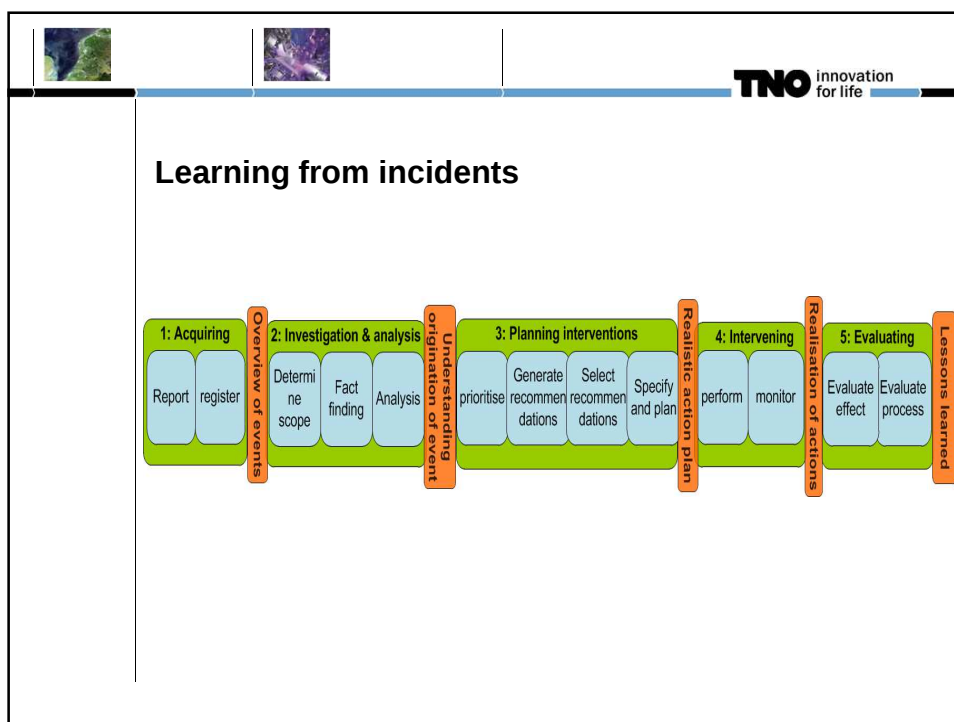
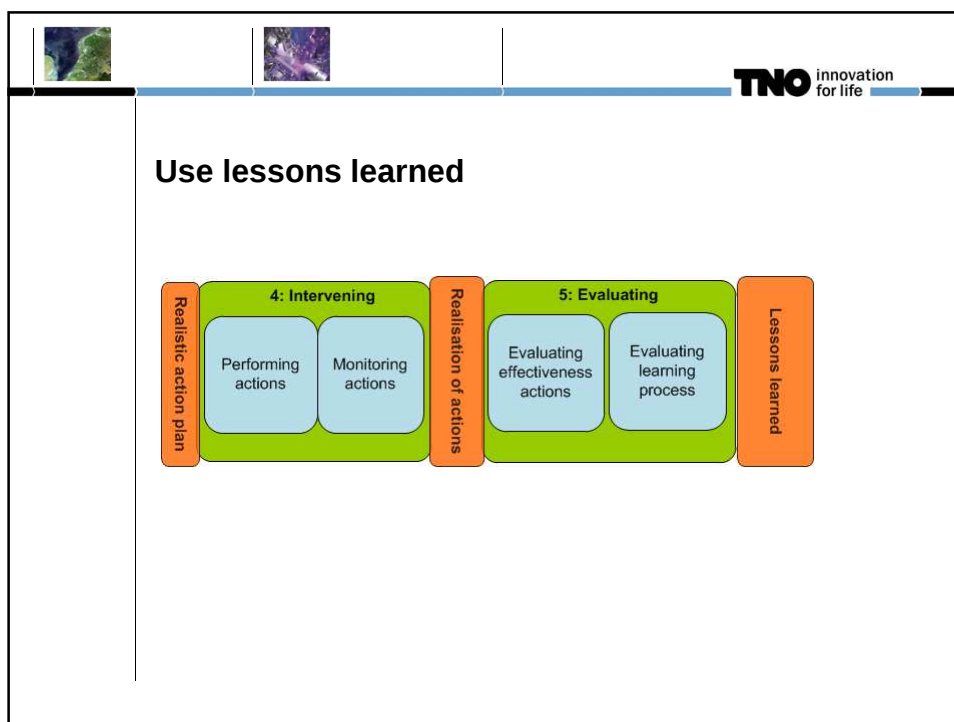
According to the ILO “Every **15 seconds**, a **worker dies** from a work-related accident or disease. And every **15 seconds**, **160 workers** have a **work-related accident**.”

These are the numbers that we would like to reduce, but it is also a number of events that we could learn from







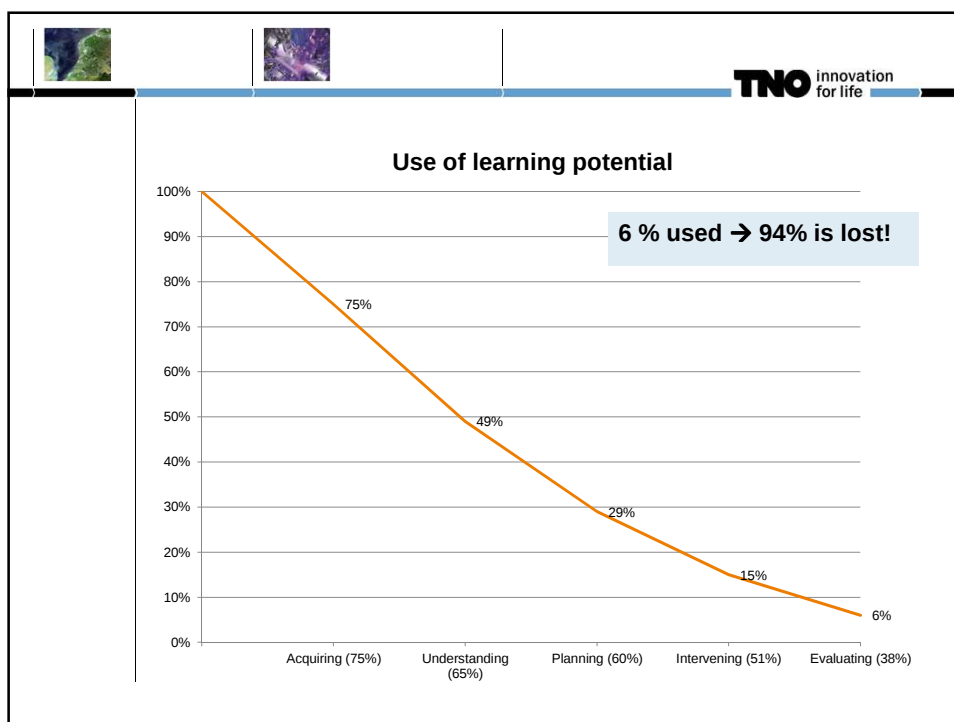




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The learning from incidents process

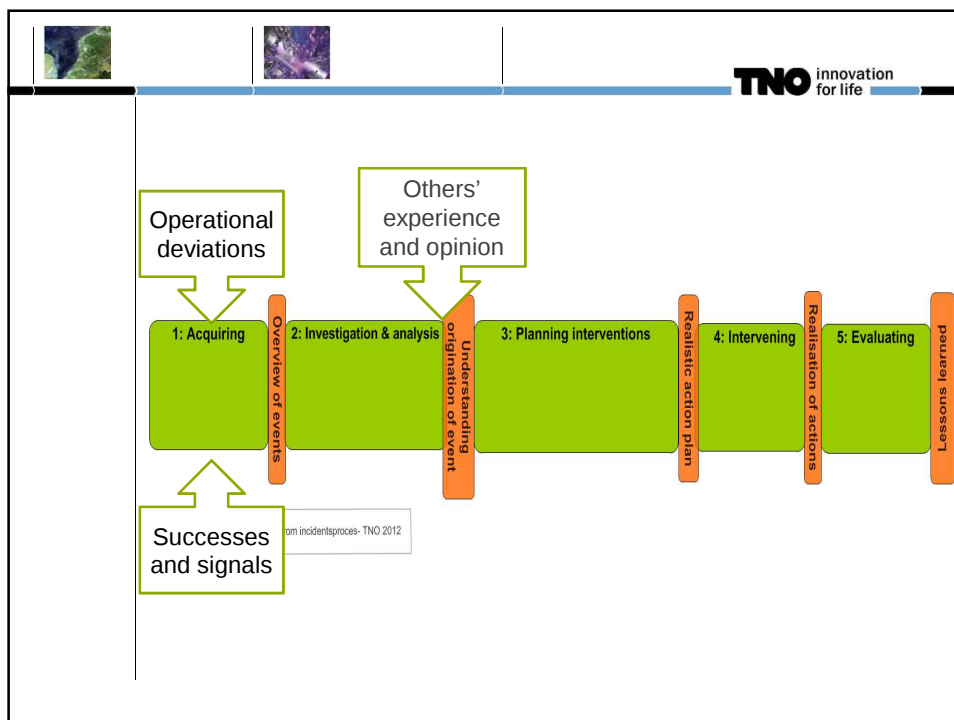
- › One process
- › Five phases
- › 13 steps





Same process, different input

- › Zero accident vision:
Learning from **others** (good and bad practices)
- › Operational excellence:
Learning from **deviations** from the operational processes
- › Resilience:
Learning from **successes and early warnings** (resilience)





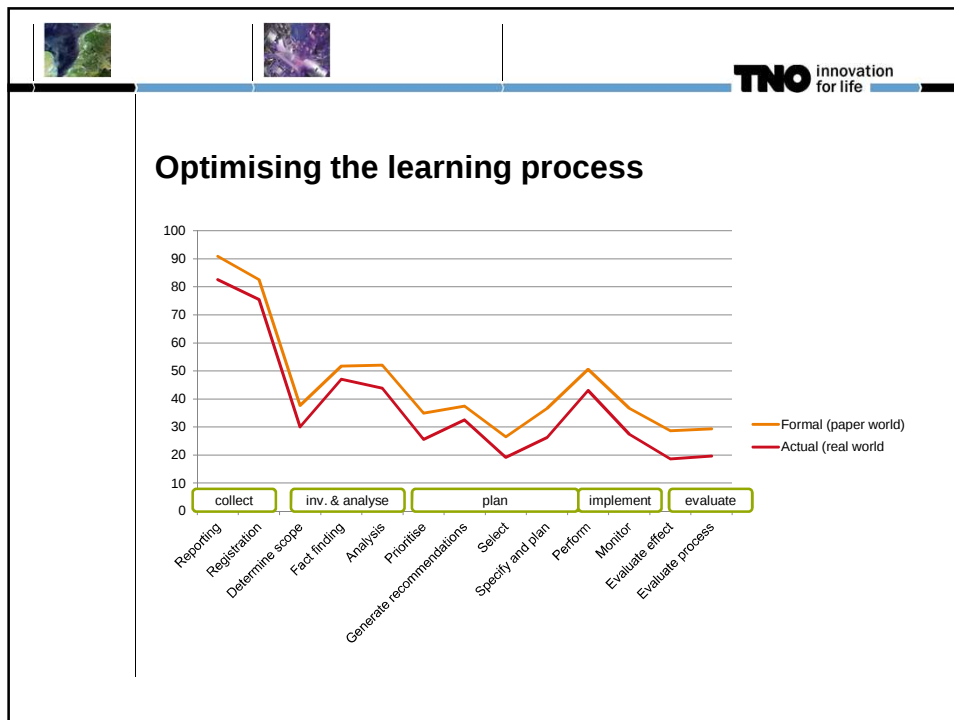
How can we improve learning?

- › First you need to know what your problems are: learning well in itself is not something you can fix



Quickscan

- › <http://quickscan.learningfromincidents.com>
- › How well is this step formally organised?
- › How well does it work in daily practice?
- › Result: weak steps and weak phases



What do you aim to improve?

Problems

- lack of trust
- not recognised as relevant
- "won't be used anyway"

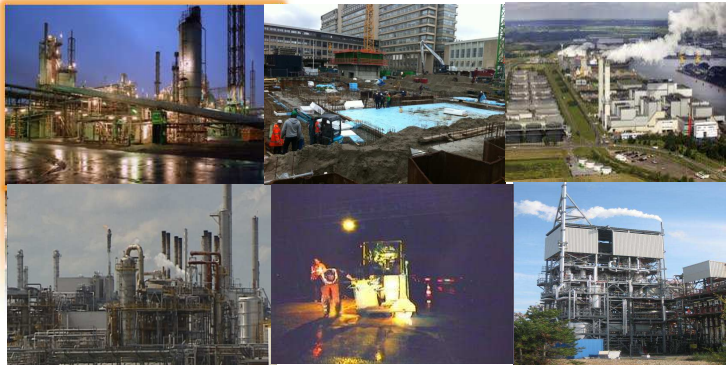
Problem
e.g. incident not reported

Problem
ineffective learning






Case studies:
how do organisations learn from incidents?








Repair on wrong pipeline

- › More important: why was not learned from it?
- › Repair work had to be done at a specific pipe that was exactly located at the cross section of two plants. The work was prepared by people from plant 1, and executed by people from plant 2. However, the work was by mistake performed on the wrong pipe. A solution was thought out after an earlier, similar incident but this hadn't been implemented yet.



Case 1

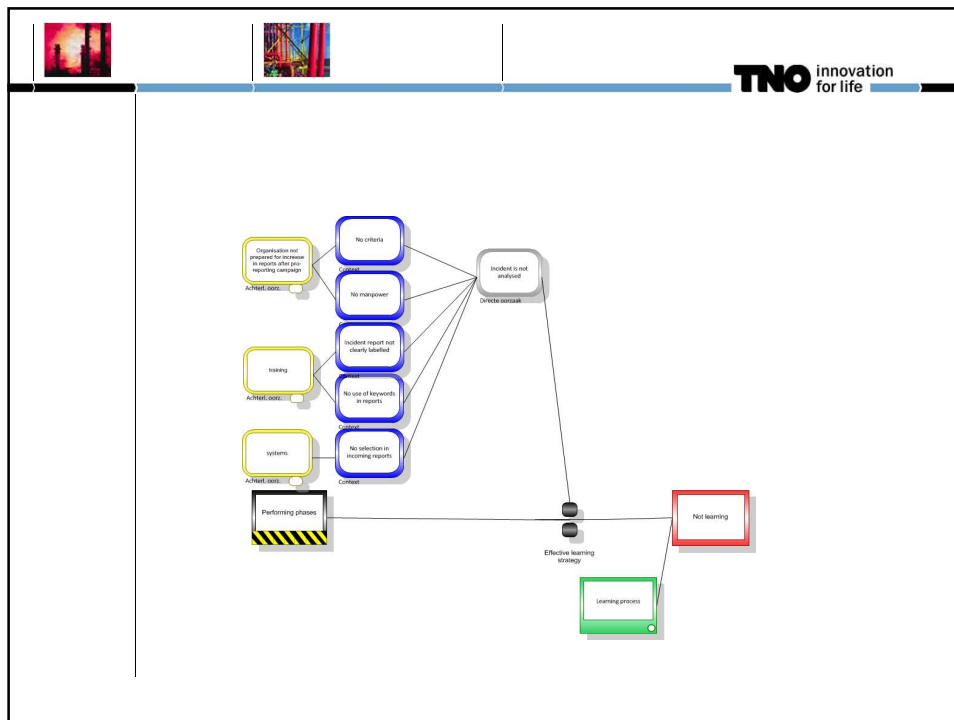
- › Inefficient learning from incident 'repair pipeline'
- › Remedial actions not performed
- › Too many actions, too little budget
- › No prioritization, no ownership
- › etc



Case 2

Lye leakage from a supposedly empty tank

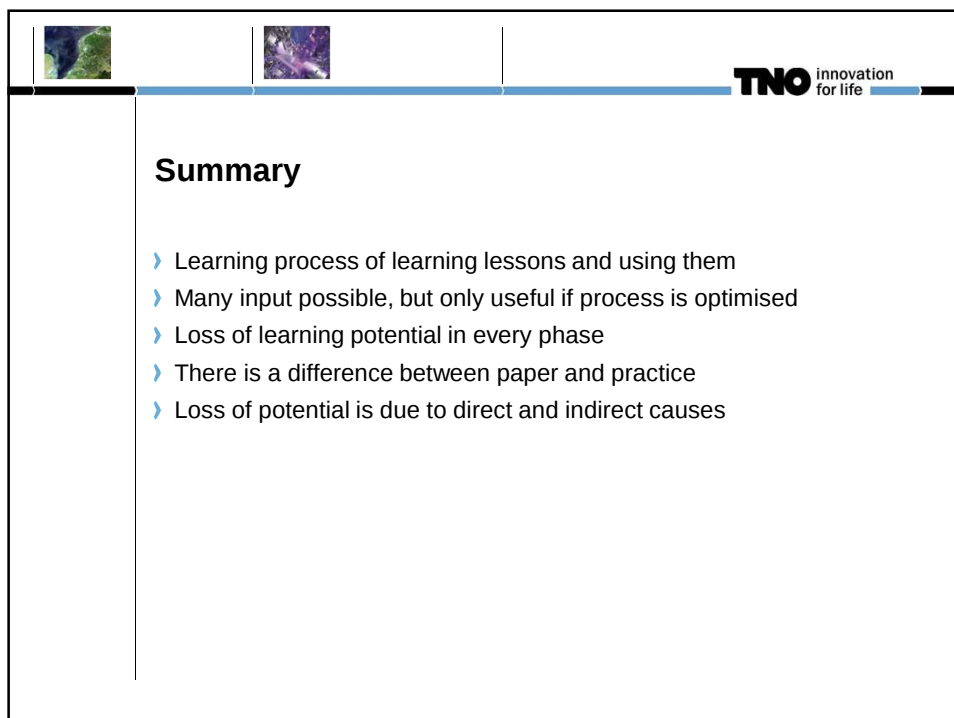
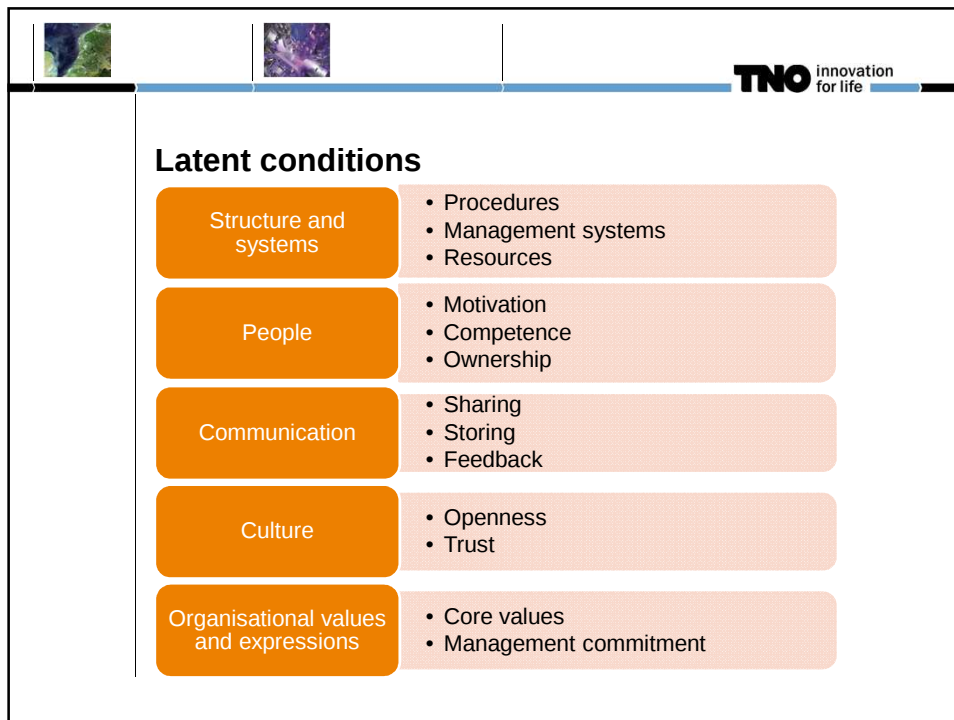
- The incident was not investigated
- This was not recognised as a relevant report
- Unclear title, high number of reports
- No manpower to process the reports, no criteria for selection, no labelling rules, successful reporting campaign



Direct causes (in the real world)

Not performed, not performed well or not effective

- › Incidents are not always recognized
- › Incidents are not reported
- › Plans are not related to outcomes of analyses
- › Many actions remain unaddressed
- › The effectiveness of actions is not evaluated





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There is no simple solution for ineffective learning



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However (conclusion)

You can start learning to learn, by:

- › Use your knowledge
- › Find the weaknesses
 - › quickscan, 'accident' analysis, case study
- › Optimising the full learning process

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FOR MORE INFORMATION		
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