

### RISK ANALYSIS



### Qualitative Risk Analysis

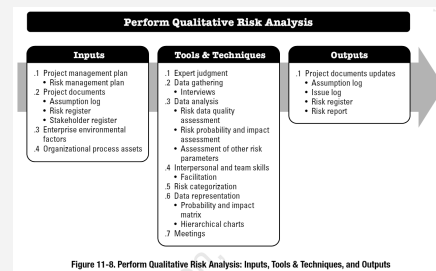


Figure 11-8. Perform Qualitative Risk Analysis: Inputs, Tools & Techniques, and Outputs

### RISK ANALYSIS

**Risk Analysis** - Involves examining identified risks; Deciding on risk treatment options; and Evaluating the effectiveness of existing risk control measures.

**Quantitative Analysis** - Uses numerical data and calculations. Assigns values to consequences & their probabilities to calculate a numeric indication of the level of risk.

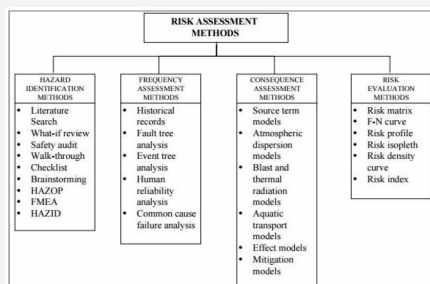
**Qualitative Analysis** - Measures risk based on the significance of its consequences.

*Subjective and uses ratings such as high, medium, low. Should include a clear explanation of the bases for each rating.*

**Traditional Accident Analysis** - Help risk mgrs identify the causes of accidents and choose the best risk control techniques.

*Basic causes of most accidents incl. Poor Management, Safety Policy, and Personal or Environment factors.*

### Risk Assessment Methods



### MONTE CARLO SIMULATION

Used to model the probability of different outcomes in a process that cannot easily be predicted due to the intervention of random variables; It is a technique used to understand the impact of risk and uncertainty in prediction & forecasting models.

A computerized statistical model that simulates the effects of various types of uncertainty.

*Model focuses on specific variables in a project, such as revenues, interest rates, gross margins, and costs*

*Results are compiled into probability distributions representing possible outcomes*

### RISK IDENTIFICATION: Team Approaches:

**Facilitated Workshops:** Group discussions facilitated by risk mgmt professionals who meet with the firm's leaders, key employees, and other stakeholders.

*Facilitator encourages brainstorming and follow up discussions. A neutral party administers a risk workshop & propels group to achieve its goal.*

**Delphi Technique:** Group of experts make independent projections through anonymous questionnaires that should move towards consensus - group members do not meet face-to-face.

**adv (+):** cheaper, anonymous responses avoid group bias and encourage honest answers

**disadv (-):** experts' opinion are limited to their own thinking and may not produce forward thinking.

### RISK IDENTIFICATION: Team Approaches: (cont)

**Scenario Analysis:** Identifies risks & predicts the potential consequences of those specific risks.

**adv (+):** identifies a range of potential consequences and helps risk managers prioritize risk

**disadv (-):** analysis could miss key risks, results are limited by members' imaginations

**HAZOP (Hazard & Operability Study):** Comprehensive review of a system or process.

Team of experts and stakeholders meets in a facilitated workshop to identify the risks associated with a process and to recommend possible solutions.

*Ideal for when all risks need to be eliminated*

**SWOT Analysis:** Assesses the firm's internal strengths & weaknesses and the firm's external opportunities & threats.

*Team approach used for analyzing specific new projects/products; Should conclude with a go or no go recommendation.*

### ACCIDENT ANALYSIS TECHNIQUES

**Change Analysis** - Projects the effects of a proposed change or combination of changes on the safety and reliability of an existing system.

*Appropriate for EXISTING systems, not proposed systems.*

ex) Before changing a trucking fleet from gas to diesel engines, project new safety hazards for drivers, mechanics, service suppliers, and general public.

**Job Safety Analysis (JSA)** - Dissects a repetitive task into steps & identifies potential hazards for each step, focusing on human error.

*Appropriate for repetitive human tasks performed in a stable environment or where a person must act safely to avoid accidents, not appropriate for to entirely mechanical tasks.*

**Sequence of Events (Domino Theory)** - Holds that accidents result from human failings.

### ACCIDENT ANALYSIS TECHNIQUES (cont)

#### Domino Accident: Chain of Events

1. Ancestry & Social environment - Person's genetic background &/or environment cause undesirable character traits (recklessness, stubbornness).
2. Fault of Person - Person's undesirable character traits cause him to commit unsafe acts or to create physical or mechanical hazards.
3. Unsafe act or physical/mechanical hazard - The unsafe act (horseplay, ignoring safety requirements) or hazard (open flames near flammable substances, lack of proper lighting) causes an accident.
4. Accident - The accidental event (falling persons, uncontrolled fire) causes injury.
5. Injury - The undesirable final event (fractures, lacerations, burns).

**Technique & Operations Review approach (TOR)** - An approach to accident causation that views the cause of accidents to be a result of mgmt's shortcomings.

*Holds that accidents result from management failures.*

**TOR approach:** (7) categories of Management faults:

1. Inadequate coaching;
2. Failure to take responsibility;
3. Unclear authority;
4. Inadequate supervision;
5. Workplace disorder;
6. Inadequate planning/organization;
7. Personal deficiencies.

**Energy Transfer Theory** - An approach to accident causation that views accidents as energy that is released and that affects objects, including living things, in amounts or at rates that the objects cannot tolerate.

### RISK CONTROL

**Risk Control:** A conscious act or decision not to act that reduces the frequency and/or severity of losses or makes losses more predictable.

#### (5) Basic Principles:

- Accidents & unsafe acts/conditions reveal management system failures;
- Certain controllable circumstances produce severe injuries;
- Mgmt should manage safety like any other function, by setting and achieving goals;
- Mgmt procedures for accountability produce effective line safety;
- Safety's function is to locate and define accident causing operational errors by tracing accidents to their root causes & controlling them.

### RISK CONTROL GOALS

**Pre-Loss Goals:** Aims to reduce the amount or extent of damages or injuries incurred in a single event. *Applied before a loss occurs.*

- Economy of Operations
- Tolerable Uncertainty
- Legality
- Social Responsibility

**Post-Loss Goals:** Focuses on emergency procedures, salvage ops, rehabilitation, public relations, and legal defenses. *Applied after a loss occurs.*

- Survival
- Continuity of Operations
- Profitability
- Earnings Stability
- Social Responsibility
- Growth

#### Techniques used to support these goals:

- Ensure Business Continuity
- Implement Effective & Efficient risk control measures
- Comply with Legal Requirements
- Promote Life Safety

### Root Cause Analysis (RCA)

**Root Cause: Basic Characteristics:** Specify; Identify; Control; and Recommend.

1. **Specify** - Root cause is expressed as a specific underlying cause, not as a generalization.

ex) operator removed safety guard, NOT operator error.

2. **Identify** - Root cause can be reasonably identified by understanding the reason why it happened.

3. **Control** - Root cause must be expressed as something that can be modified.

ex) Failure to maintain a backup generator, NOT lightning that caused power failure.

4. **Recommend** - Root cause must produce at least 1 effective recommendation for preventing future reoccurrence of the event.

#### (RCA) Weaknesses (-):

- Only looks backwards (doesn't consider future causal factors)
- Can fail to identify all root causes
- Can only be done or reviewed periodically (not continuous)

### Root Cause Analysis (RCA) (cont)

**Root Cause Analysis (RCA)** - Used in proactive management to identify predominant cause of loss.

Uses a step by step evaluation to identify the underlying cause of an unwanted outcome.

*A 'factor' is considered the root cause of a problem if removing it prevents the problem from recurring.*

*A 'causal factor', conversely, is one that affects an event's outcome, but is not the root cause.*

\*Typically used after an event has occurred, but it can be used to predict events and to solve problems proactively, rather than only retroactively.

#### Root Cause Analysis Process - (4) steps:

1. **Collect Data** - Risk Mgr must obtain complete info about the circumstances, the facts, and causes of the event.

2. **Chart Casual Factors** - The agent that directly results in one event causing another event.

3. **Identify root cause/causes** - Once all the casual factors are identified, the risk Mgr uses mapping or flow charting to determine the underlying reasons for each casual factor.

4. **Implement recommendations** - Risk Mgr identifies & implements achievable recommendations for preventing recurrence of the event.

*Final product is a root cause summary table that incl. recommendations for each root cause identified for each casual factor.*

#### Root Cause Analysis: (5) Approaches:

1. **Safety-based RCA:** Arose from accident analysis & occupational safety and health.

2. **Production-based RCA:** Arose from quality control procedures for industrial manufacturing.

3. **Process-based RCA:** Similar to production based RCA, but also includes business processes.

4. **Failure-based RCA:** Arose from failure analysis and is used mainly in engineering and maintenance.

5. **Systems-based RCA:** Combines the other 4 approaches w/ concepts from change mgmt, risk mgmt, and systems analysis concepts.



### LOSS CAUSE: Physical, Human, and Organizational

**Physical Cause** - The failure of a tangible or material item, such as a defective part.

**Human Cause** - Occurs when human error or inaction is the root cause of an accident, such as operator error or improper maintenance.

**Organizational Cause** - Results from faulty systems, processes, or policies.

### CH.3 VOCAB

**Energy Transfer Control:** approach to accident causation that views accidents as energy that is released and that affects objects, including living things, in amounts or at rates that objects cannot tolerate.

**Technique of Operations Review (TOR):** approach to accident causation that views cause of accidents to be a result of management's short-comings

**Change Analysis:** analysis that projects the effects of a given system change is likely to have on an existing system

**Job Safety Analysis (JSA):** analysis that dissects a repetitive task, whether performed by a person or a machine, to determine the potential hazards if each action is not performed

**Monte Carlo Simulation:** model that stimulates the effects of various types of uncertainty may have on a process. Another approach to solving complex problems and predicting outcomes.

**Delphi Technique:** decision-making technique in which group members do not meet face to face but respond in writing to questions posed by the group leader

**Scenario Analysis:** identifies risks and predicts the potential consequences of those specific risks

**Causal Factors:** agents that directly result in 1 event causing another

**Facilitated Workshops:** a risk workshop administered by a neutral party and propels group to achieve its goals

**HAZOP (Hazards and Operability Study):** team of subject matter experts and stakeholders identifies the risks associated with a given process and recommends a solution (*ideal for when all risks need to be eliminated*)