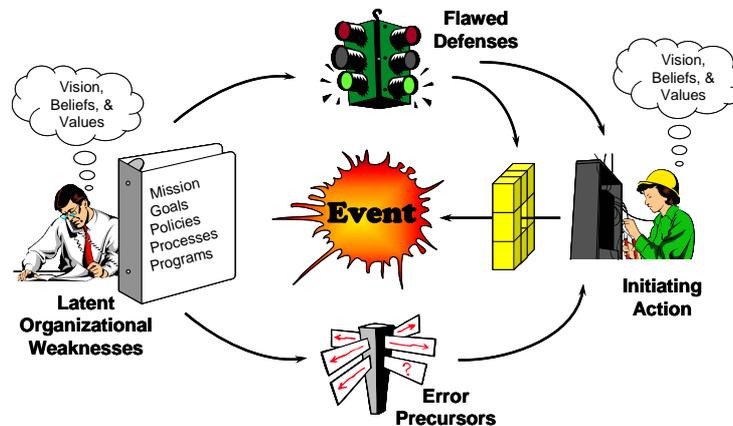


ISSUE INVESTIGATION AND HUMAN PERFORMANCE:

KEY TO WORK FORCE ENGAGEMENT, BUY-IN AND IMPROVEMENT



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BIO

Rod Rabon has a Bachelor's Degree in Mechanical Engineering from Clemson University and has worked for the Savannah River Site for 29 years in a variety of technical and operations assignments. Currently assigned as Program Manager for the Savannah River National Laboratory Research Operations Engineering Department.



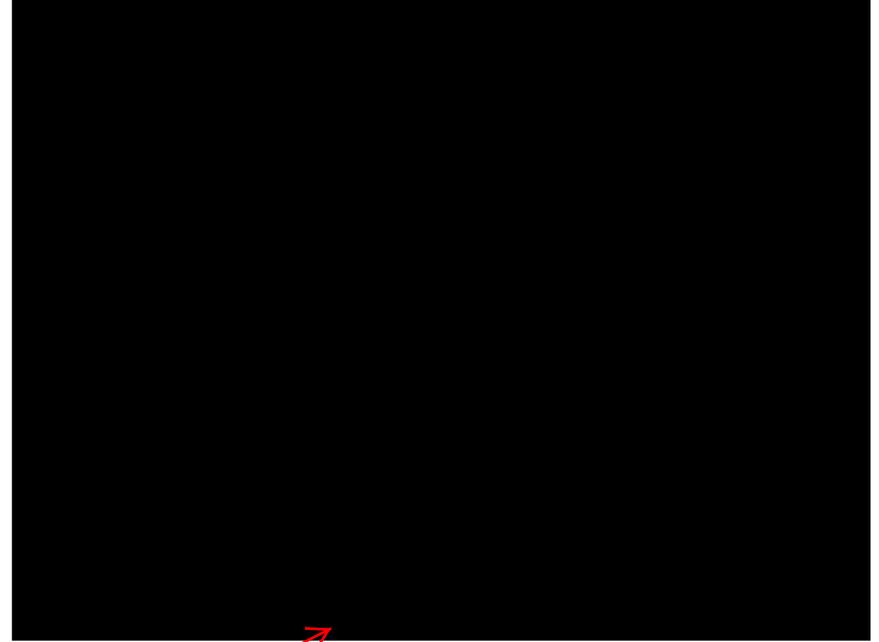
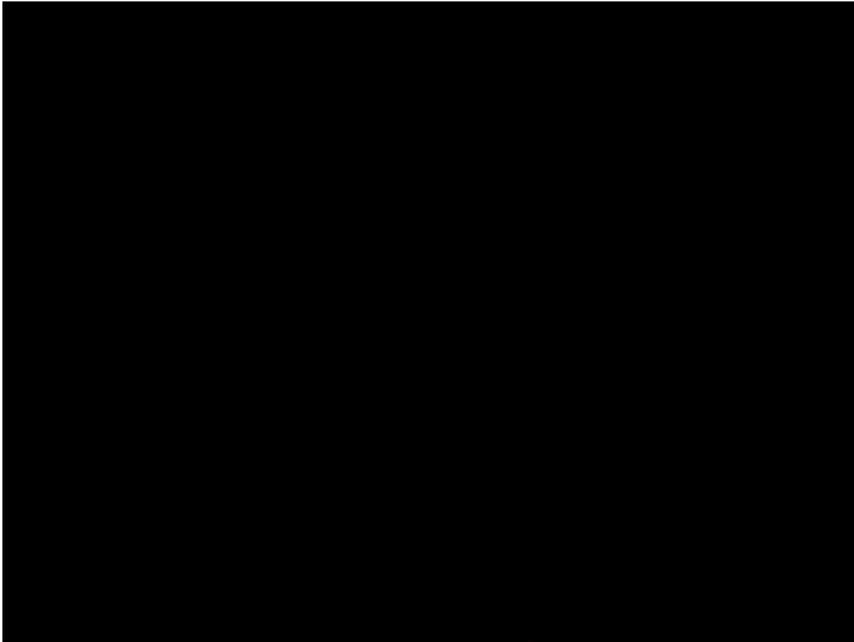
My Purpose Today

To review the Human Performance Improvement (HPI) changes the Savannah River Site has made relative to site Issue Investigations.

With the premise of providing a process that fosters improvement and is supportive of a Just Culture environment.

Issues: They Can (and Do) Occur

- Watch a Couple of Videos:



Click here to watch
Clip #1.

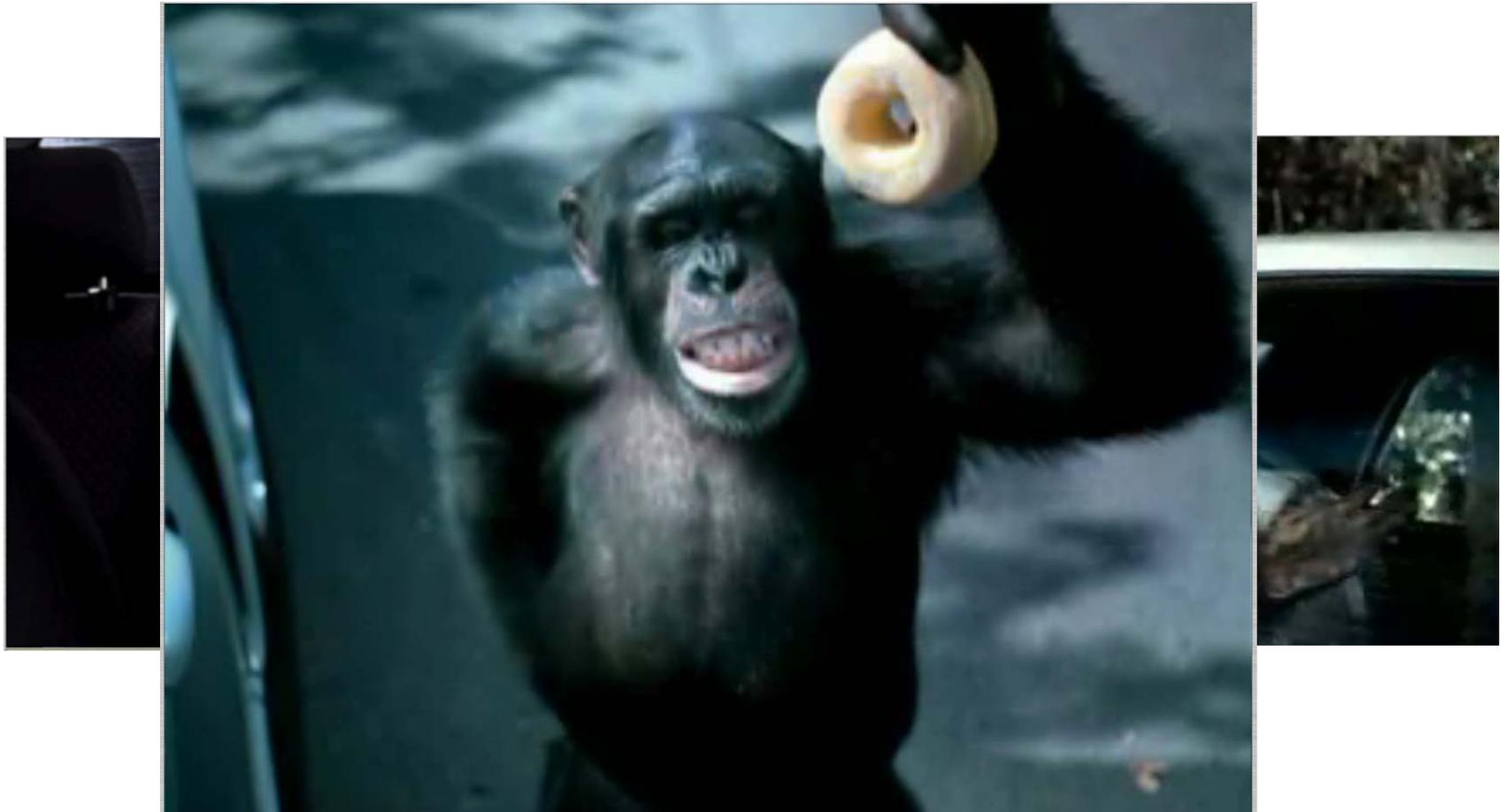
Click here to watch
Clip #2.

* With the approval of Suburban Auto Group, 7/29/2010

Let's Evaluate The Issues

- What were the issues?
- Who were involved?
- What were the results of these issues?
- Was “Just Culture” achieved?
- From whose point of view?

How have the critiques gone for your sites?



With the approval of Suburban Auto Group, 7/29/2010

Site Critique History

- Implemented critiques in 1990s
- “Inattention to detail” – people as cause
- Corrective Actions based on consequence
- HPI principles began appearing last five years

The Site HPI Charge

- HPI would not occur unless **visibly** seen as important (as a value) to Line Management

Management's reaction to critical incidents or crisis conveys the values of the leader and the organization. (INPO HP Reference Manual)

"You only truly value that which calls you to action." (Charles Nickell, SRNS Director NMDP, Leadership Forum Speaker)

- SRS HPI Strategic Plan action:

Revise the site's existing Critique investigation process consistent with HPI initiatives

Our Journey

- Formed cross-cutting organizational team, 4/2008
- Benchmarks
 - INPO Commercial Nuclear Practices
 - Other DOE Complexes
- Team cast vision for change
- Developed major change to site “critique” procedure
- Reviewed with stakeholders
 - Site orgs/customers
 - Employee feedback (Site Safety Conference)
- Trained personnel
- Rolled out and implemented new *Issue Investigation* process 9/2008

Previous Process: Critiques

Governed by Site Manual 2S,
Procedure 5.2, Rev 8

Investigation of Abnormal Events

Critique Process

- Field investigation
- Critique
- Some HPI
- Causal Analysis
- Corrective Action identification and assignment



Corrective Action Program (CAP) Process

- Sig Cat ID
- Causal Coding

Big Picture Facts

- Rewrote site procedure (Revision 9)
 - New Procedure Title, **Issue Investigations**
 - Reduced procedure size from 30 to 12 pages
- Fact-Finding Meetings vice Critiques
- Issue Investigation and Improvement Involves:
 - **Field Work** (2S, 5.2): Investigate, Evaluate, Take Immediate Actions, Determine Facts & Probable Causes
 - **Corrective Action Program (CAP)** Process: Line/Facility MRT/CARB Review for Further Causal Analysis and Corrective Actions

Graphic of the Change

Manual 2S, 5.2, Rev 8

*Investigation of
Abnormal Events*

Manual 2S, 5.2, Rev 9

Issue Investigations

Critique Process

- Field investigation
- Critique
- Some HPI
- Causal Analysis
- Corrective Action identification and assignment

CAP Process

- Sig Cat ID
- Causal Coding

Fact Finding Process

- Field investigation
- Fact finding Meeting
- HPI techniques and review
- Probable Causes

CAP Process

- Significance Category ID
- Causal Analysis
- Corrective Action identification and assignment

Field
Work

CAP

Investigation and Review Process

Investigate Issue



RM Evaluate Issue



Conduct Review



Document Review

----- Pause -----

Conduct CAP Review

- Implement Immediate actions
- Ensure Safe State
- Investigate scene of issue
 - Personal Statement
 - Data, procedures, work packages, etc...

- SIRIM Reportable review per Manual 9B
- Determine type of Review required
 - FFM
 - PJR
 - No Review required

- Facts and Chronology/Sequence
- Immediate actions taken & add'l immediate actions
- Operating impacts and Extent of Condition
- Evaluate per HPI
- Review what went well
- I. D. Probable Causes

- Per Procedure 5.2, Attachment D
- Submit In STAR

Stop and Excuse Review Meeting, Convene Management/SME Team to review per CAP

- Evaluate per Causal Analysis
- Identify CAs and Assign Responsibilities
- Document in STAR

While “the Hood” was Up

Implemented Additional Core Functional Improvements (Tools)

- Hyper linked major forms/tools to support Issue Investigations personnel and process
 - HPI Checklist and Personal Statement
 - Anatomy of an Event Worksheet
 - Template for Initial Fact-Finding Meeting Checklist
 - Attendance Sheet
 - Template for Fact-Finding/Post-Job Report
- Improved consistency in implementing the HPI tools in our Issue Investigations process and in documenting results
- Simplified Post-Job Reviews (more prevalent)

Status and Actions Taken to Implement

- Procedure in affect for two years 9/2/2008
- Established and completed Fact-Finding Director and Responsible Manager Training:
 - Training Classes (FFD)
 - Web-Based Delta Training (RMs & Critique Directors)
- Implemented Coaching and Mentoring by Team for early roll-out of process
- Periodic Assessments conducted

How's It Been Going?

- 46 assessments on Fact-Finding (FF) (past seven months)
- 12 spoke specific to overall FF process:
 - All positive
 - “identified that the fact-finding process worked to get a complete understanding of the issue.”
- Example improvement areas in FF Meeting preparations:
 - FF Director and Responsible Manager field prep for FF Meeting
 - Preliminary time line development prior to FFM, etc...

What It Takes to Make It Work

Commitment of Everyone (All of us)

- Execute the Procedure
- Openness to addressing Issues
- Openness to look internal for Error Precursors, Flawed Defenses and Latent Organizational Weaknesses
- Implement the Improvements necessary

Summary:

WHAT DID WE GET?

I believe we got:

A sound Investigation process that is supportive of a Just Culture environment fostering *work force engagement, buy-in and improvement*.

- Fostering Accountability (Management and Employees)
 - Trust
 - Credibility with our employees (Not cast blame game)
 - Ownership of the issues and problems throughout organization
- Reinforces our commitment to Improving
 - Values Employees that value ownership and improving
 - Demonstrates openness to raising/receiving issues and changing what really needs to be fixed
- Couples well with the Site CAP Process