FAILSAFE NETWORK
Helping you learn from things that go wrong

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The Relationship Between Latent Cause Analysis and Human and Organizational Performance

By Rob Statham

They both share the core philosophy that learning is beyond blame. LCA moves beyond immediate "root causes" (like human error or equipment malfunction) to uncover the deeper, systemic, often hidden factors that contribute to incidents. We call this Latency. It is critical that we seek to understand *why* the conditions existed for the error or failure to occur. HOP seeks to understand how humans perform in complex systems, recognizing that human error is largely a symptom of systemic issues, not the primary cause. It advocates for moving beyond individual blame to examine the organizational context. Both reject the simplistic "blame the individual" approach and focus on the system instead.

LCA is a process based on the same principles as HOP, that "error is normal" and "the problem is the system." LCA provides a practical methodology for *identifying* those systemic "problems" or "latent conditions" within an organization. When a HOP practitioner investigates an event, they're not just looking for a procedural violation; they're asking, "What were the systemic factors that made it make sense for someone to deviate, or for that error to occur?" This is precisely what LCA aims to uncover. The context people find themselves in is the key to understanding. Many shortcomings, like inadequate training, poor equipment design, conflicting goals, insufficient resources, faulty communication channels, or a culture that incentivizes shortcuts, may be involved.

Both processes focus on Learning and Improvement. They are geared towards organizational learning and sustainable improvement, rather than just incident closure. By uncovering latent causes, LCA provides the necessary insights for organizations to make meaningful, systemic changes. This aligns perfectly with HOP's emphasis on designing more resilient systems where human performance is supported, not just controlled.

Traditional Causal Analysis methods often stop at proximate causes, e.g., "An operator failed to follow procedure." Both LCA and HOP push beyond this. LCA answers, "Why did the operator fail to follow the procedure?" leading to latent causes. HOP provides the theoretical framework but lacks a specific repeatable process to reveal latent causes.

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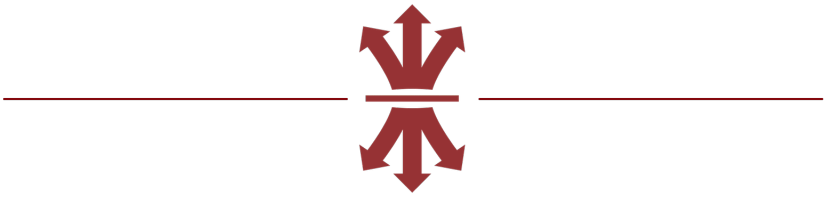
In essence, **LCA helps an organization apply HOP principles by providing a structured way to investigate** beyond the immediate actions of the frontline worker, allowing managers, engineers, and leaders to take responsibility for the latent conditions they may have inadvertently created or tolerated. It's about moving from "who messed up?" to "how did our system set people up to fail?" and **"what is *our* role (as an organization) in creating those conditions?"**



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