

▶ **Root Cause Analysis**





Approach

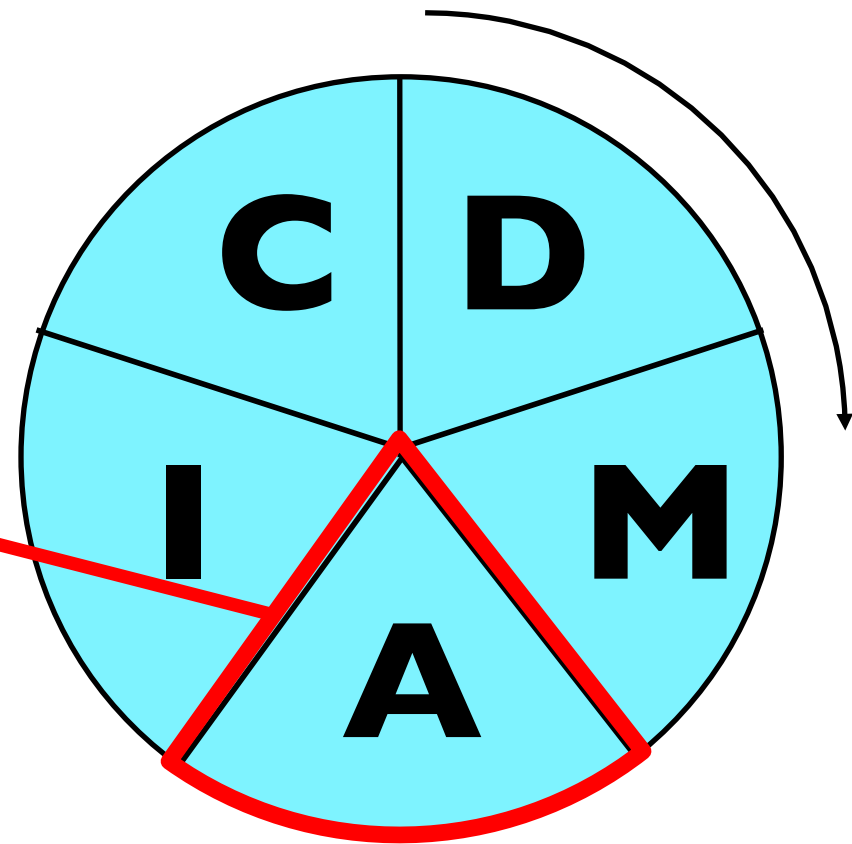
Define

Measure

Analyze

Improve

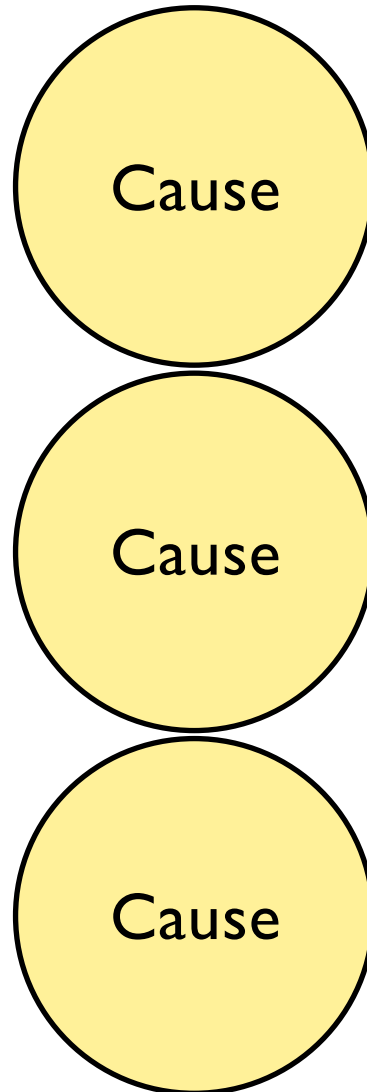
Control



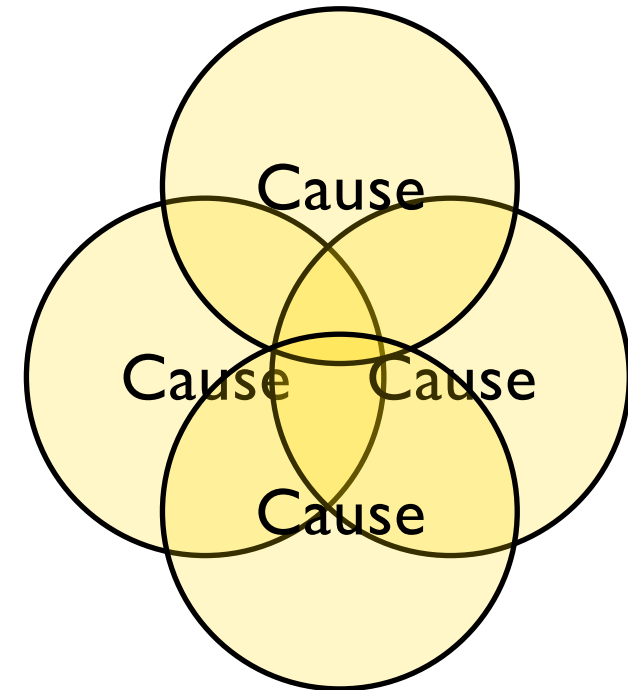


Three types of causes

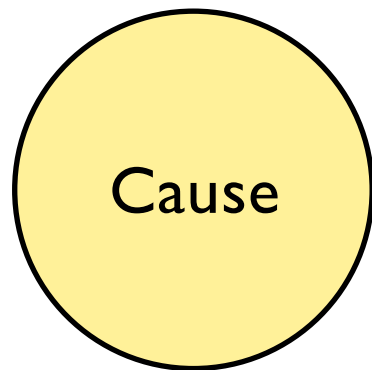
Multiple causes



Multiple, complex and combinatory causes



Single cause





7QC

The seven basic tools of quality

- The Ishikawa diagram
- The Check sheet
- The Control chart
- The Histogram
- The Pareto chart
- The Scatter diagram
- Stratification



RCA tools

Pareto chart

- Initial sorting

Five Whys

- Simple Root Cause Analysis

Ishikawa diagram

- Causality mapping

Failure Mode and Effects Analysis

- Risk estimation

Fault Tree Analysis

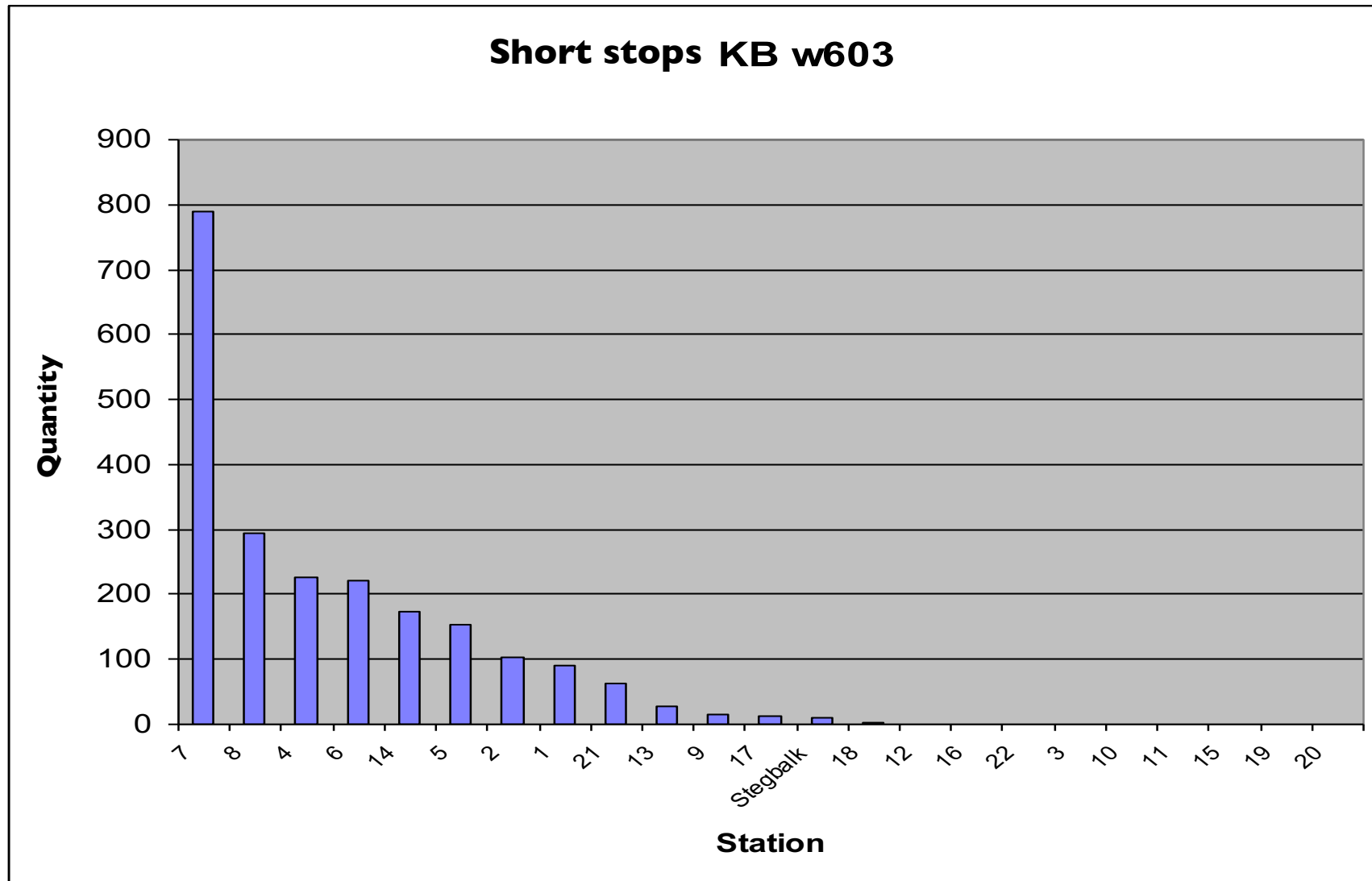
- Cause and Effect Analysis

PM-analysis

- Advanced Root Cause Analysis



Pareto chart





Five Whys

Why is there a high reject rate of widgets?

- Because the plastic is stained.

Why is the plastic stained?

- Because there is excess oil in the cutting machine.

Why is there excess oil in the cutting machine?

- Because it is clogging as it is months since it was cleaned.

Why is it so long since it was cleaned?

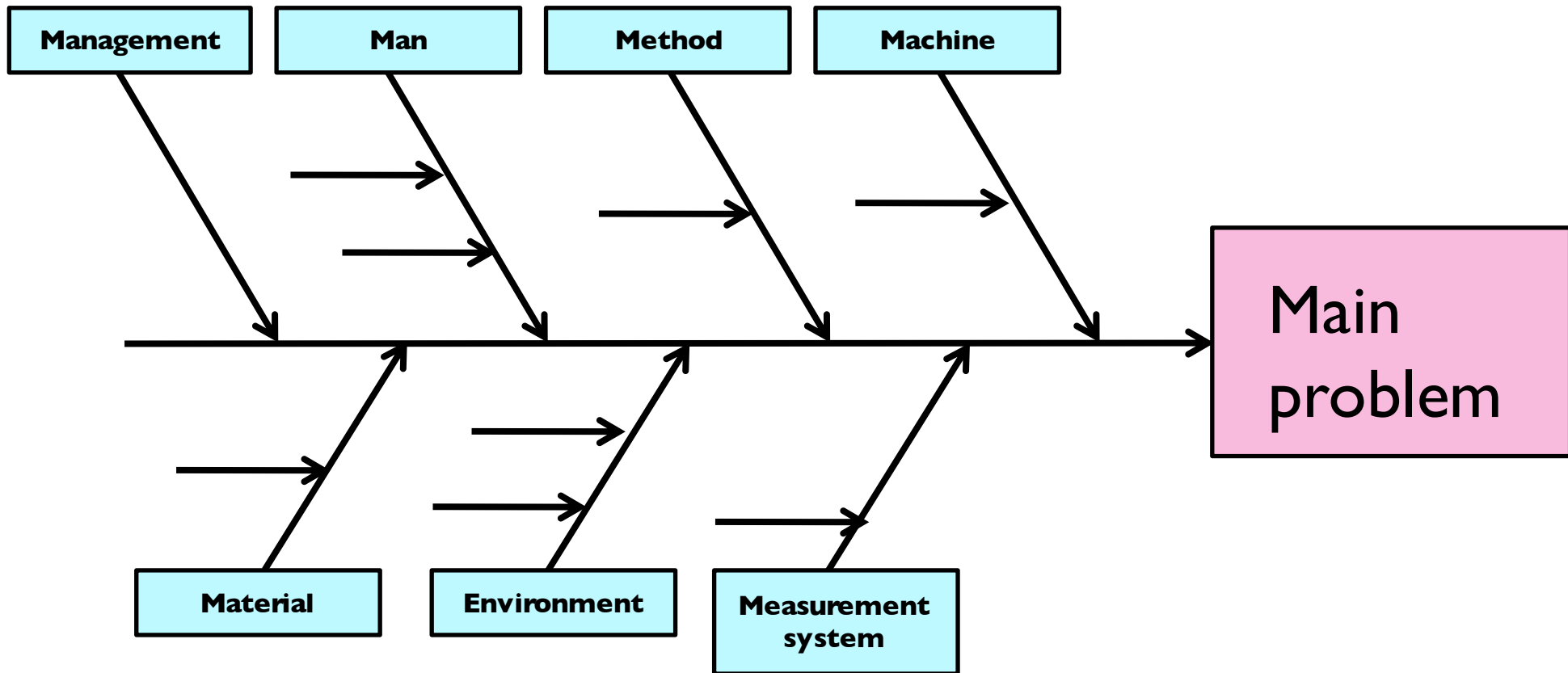
- Because we only service machines when they break down, not on a preventative basis.

Why only service after breakdowns?

- Because maintenance says it is cheaper (but what about the cost of rejects and rework?).

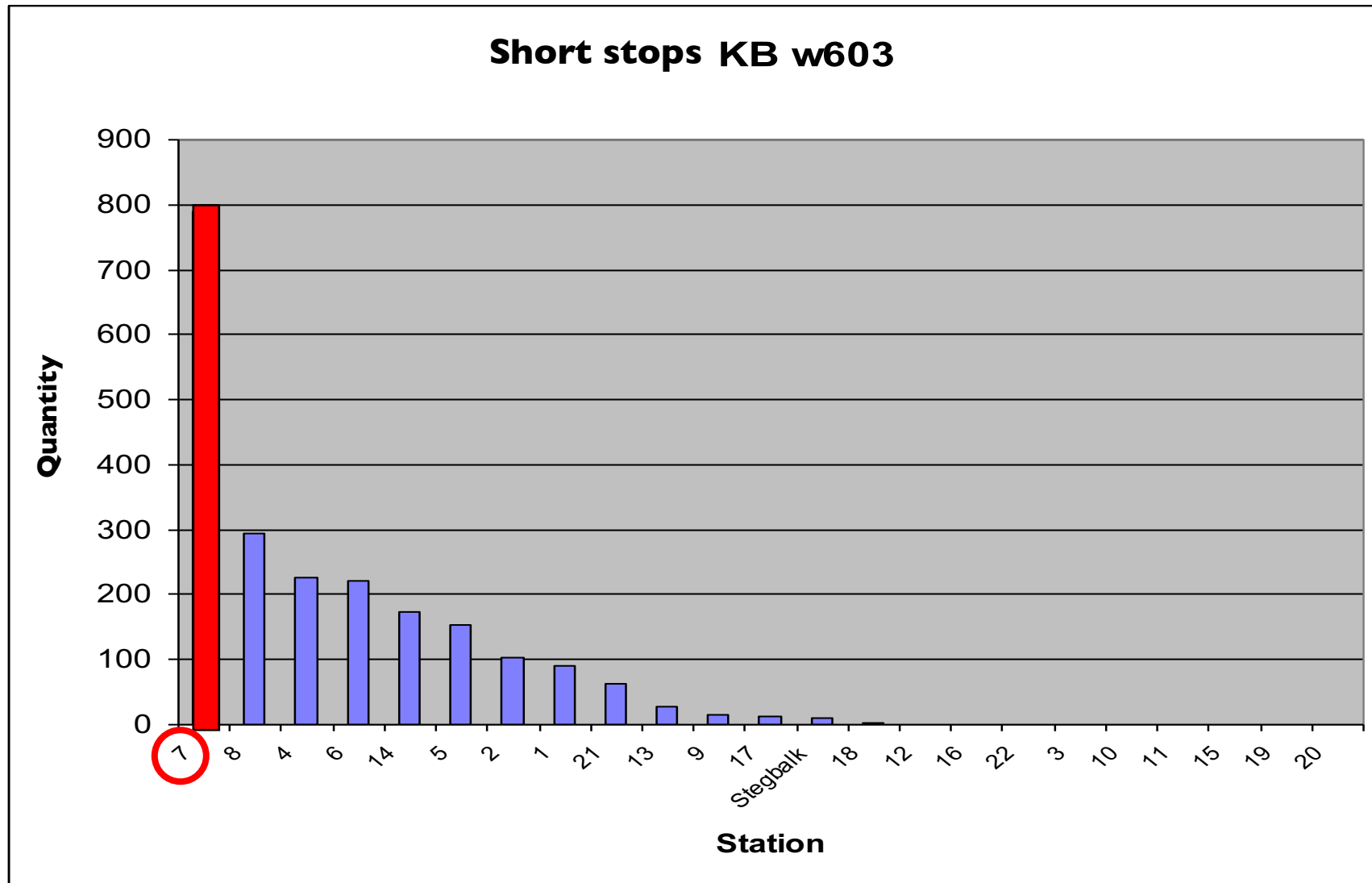


Ishikawa diagram



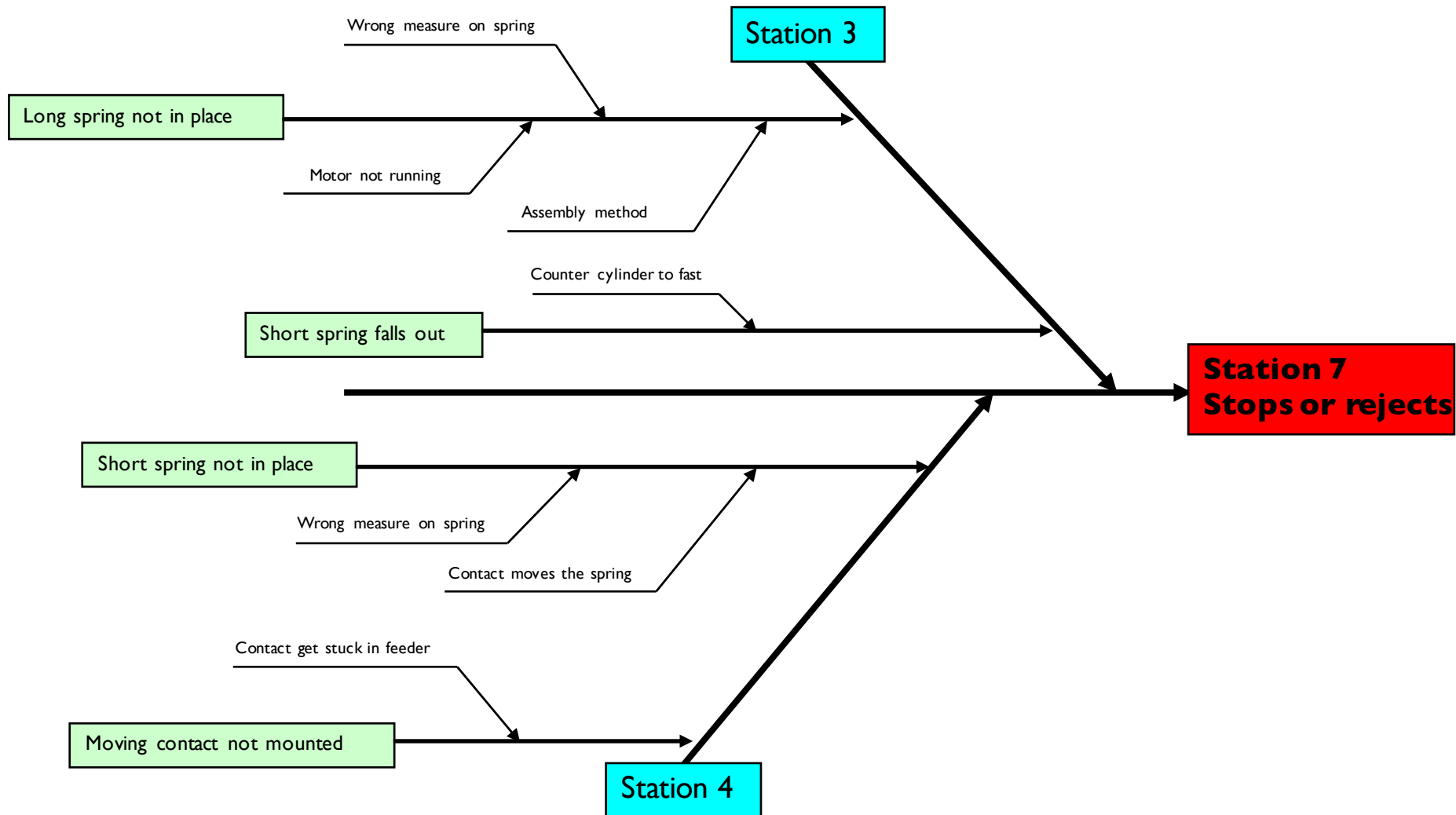


Example from ABB Cewe-Control





Example from ABB Cewe-Control





Failure Mode and Effect Analysis

FMEA is a systematic method for identification and analysis of a system with respect to possible failure modes, their causes and their effects, plus the consequences on the functions of the system



Failure Mode and Effect Analysis

FMEA is performed in order to...

- ...identify failure modes with non-wanted effects on the system's functions
- ...improve the dependability and availability of a system
- ...identify the need for deeper diagnosis
- ...improvement of the maintainability of a system



Failure Mode and Effect Analysis

- FMEA should be performed in groups, preferably cross functional
- Limit the analysis to smaller systems or processes
- Use the same grading system for different FMEAs
- Include "soft" deficiencies e.g. usability, ergonomics, etc.



Failure Mode and Effect Analysis

FMEA should not be used when:

...a system has high amount of redundancies

...a system have a high degree of common cause failures

For such systems FTA might be a better method



Fault Tree Analysis, FTA

- FTA is:
- a qualitative and quantitative method for analyzing complex systems
 - a logical process that might be transferred into reliability block diagrams
 - a top-down technique in which a possible event on system level is analyzed and broken down to component level
 - developed in the aero-space industry and the nuclear power industry



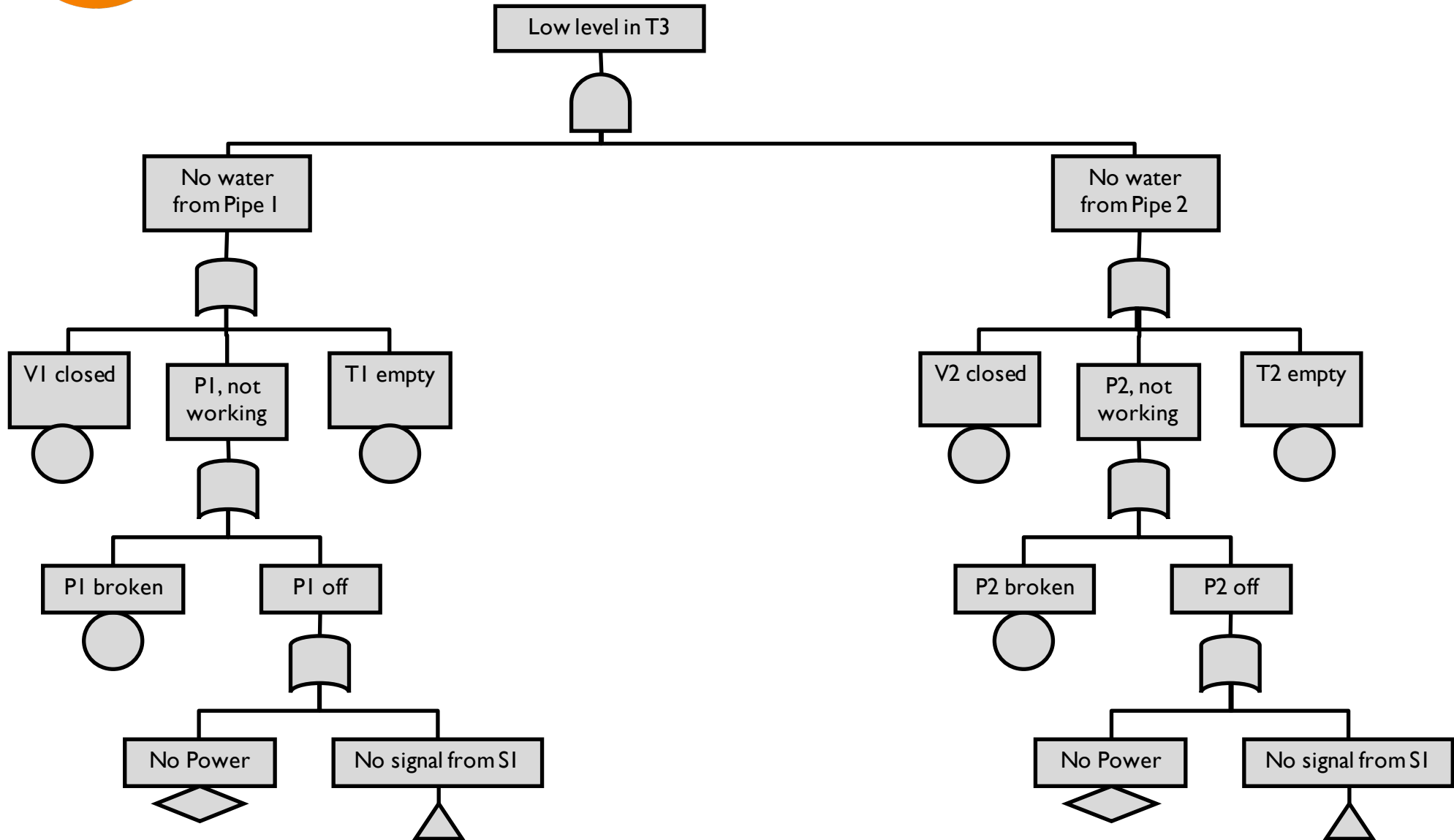
Fault Tree Analysis, FTA

FTA is performed in order to:

- analyze and show the connection between non-wanted events in the system and the root causes to these events
- identify the events (human, environmental, technological) that might be difficult to calculate mathematically
- increase the understanding of the structures and relations in a system
- identify critical failure modes and weaknesses even in the absence of component data



Fault Tree Analysis, FTA

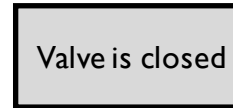




Fault Tree Analysis, FTA



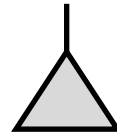
The OR-gate indicates that the output event occurs if any of the input events occur



The Comment rectangle is for supplementary information



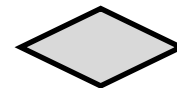
The AND-gate indicates that the output event occurs only when all the input events occur



The Transfer-out symbol indicates that the fault tree is developed further at the occurrence of the corresponding Transfer-in symbol



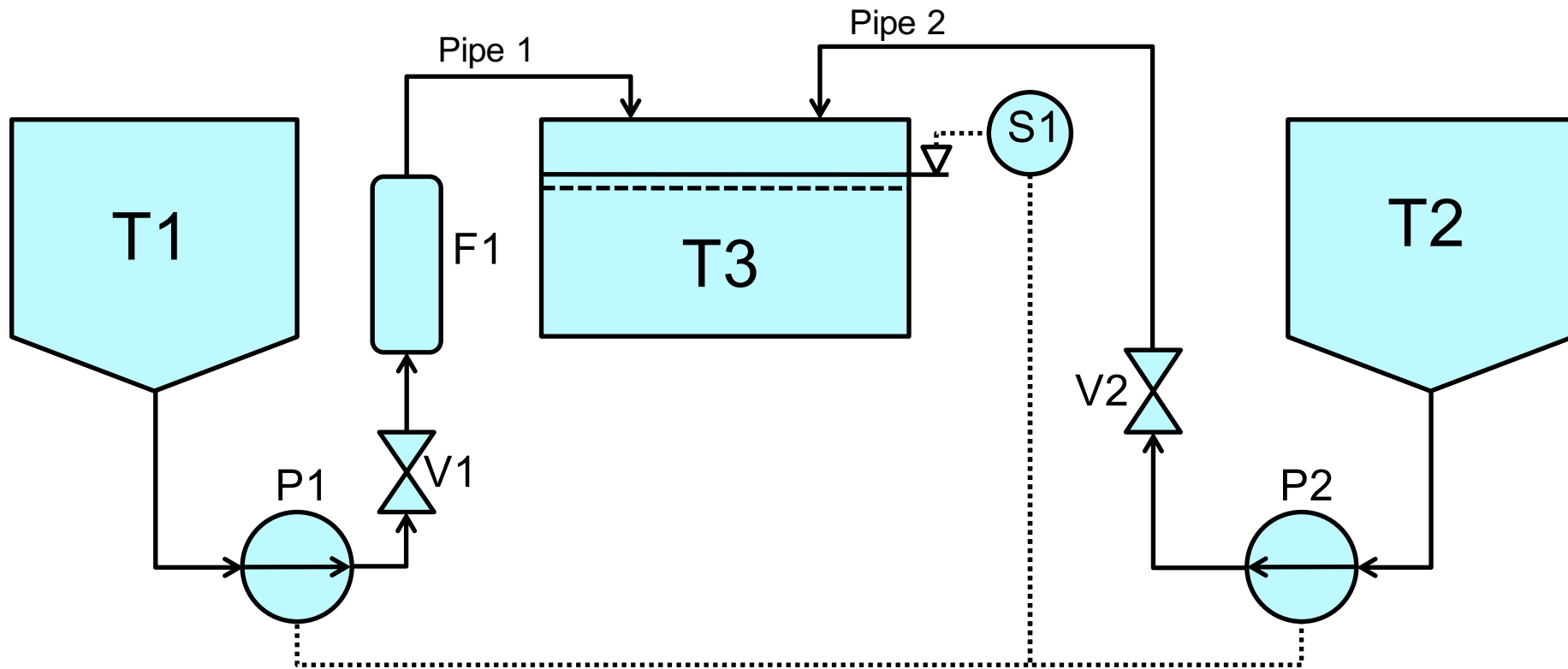
The Basic event represents a basic equipment failure that requires no further development of failure causes



The Underdeveloped event represents an event that is not examined further because information is unavailable or because its consequence is insignificant



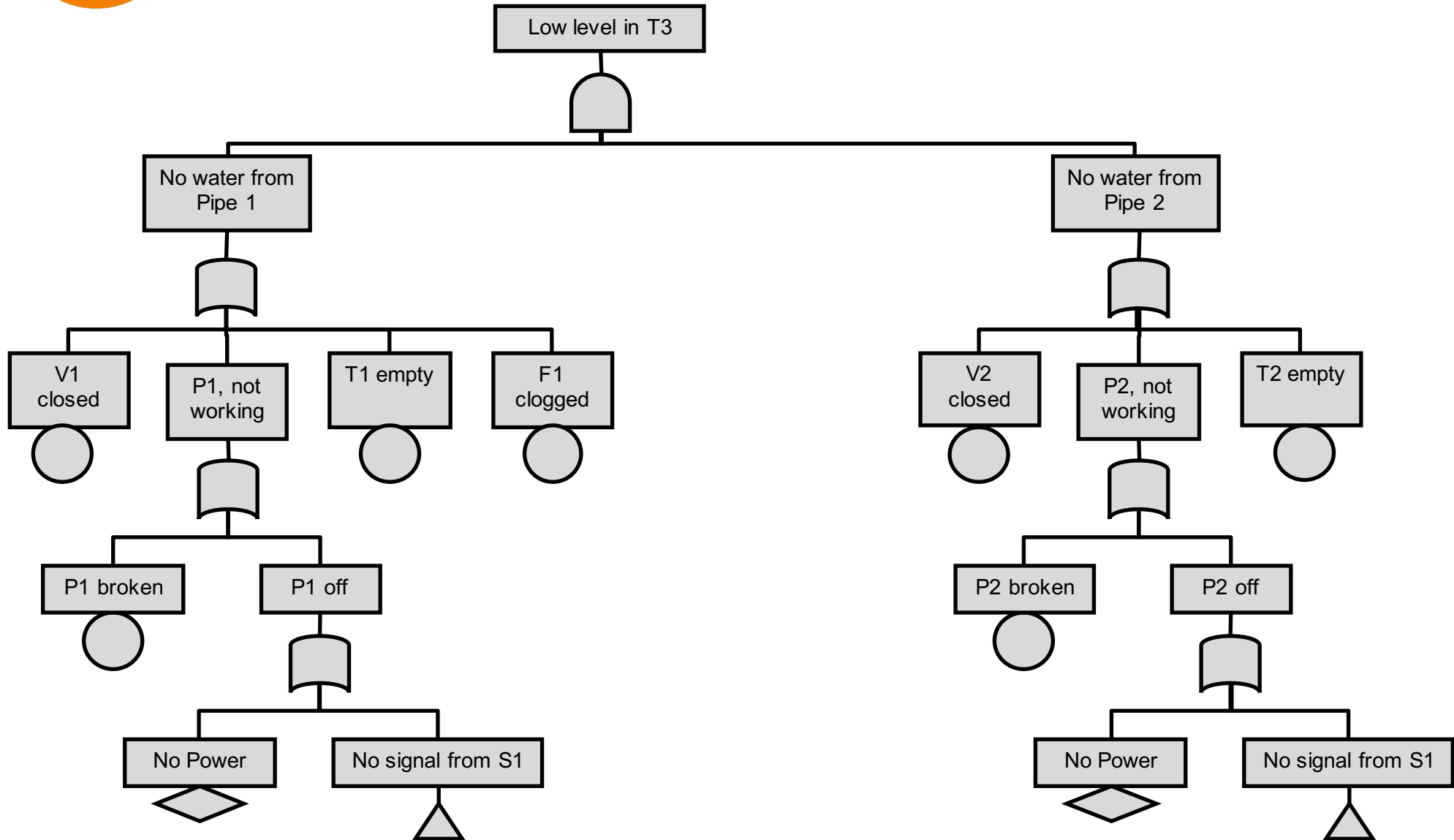
Fault Tree Analysis, FTA



What causes are there for low level in tank T3?



Fault Tree Analysis, FTA



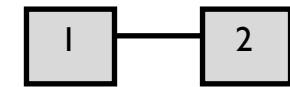
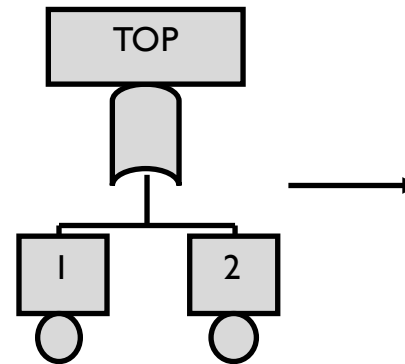


Fault Tree Analysis, FTA

**How to convert
FTA into reliability
block diagrams:**



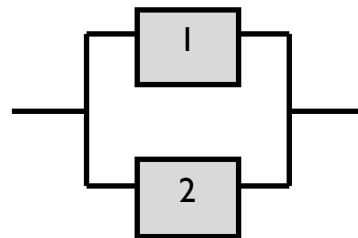
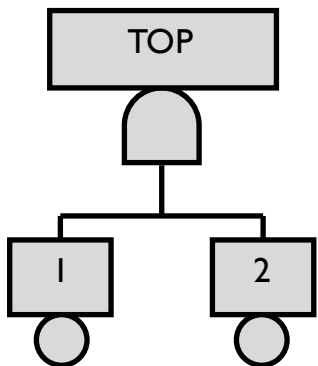
OR-gates are converted into a series structure.



$$R_s(t) = R_1(t) \times R_2(t)$$



AND-gates are converted into parallel structures.

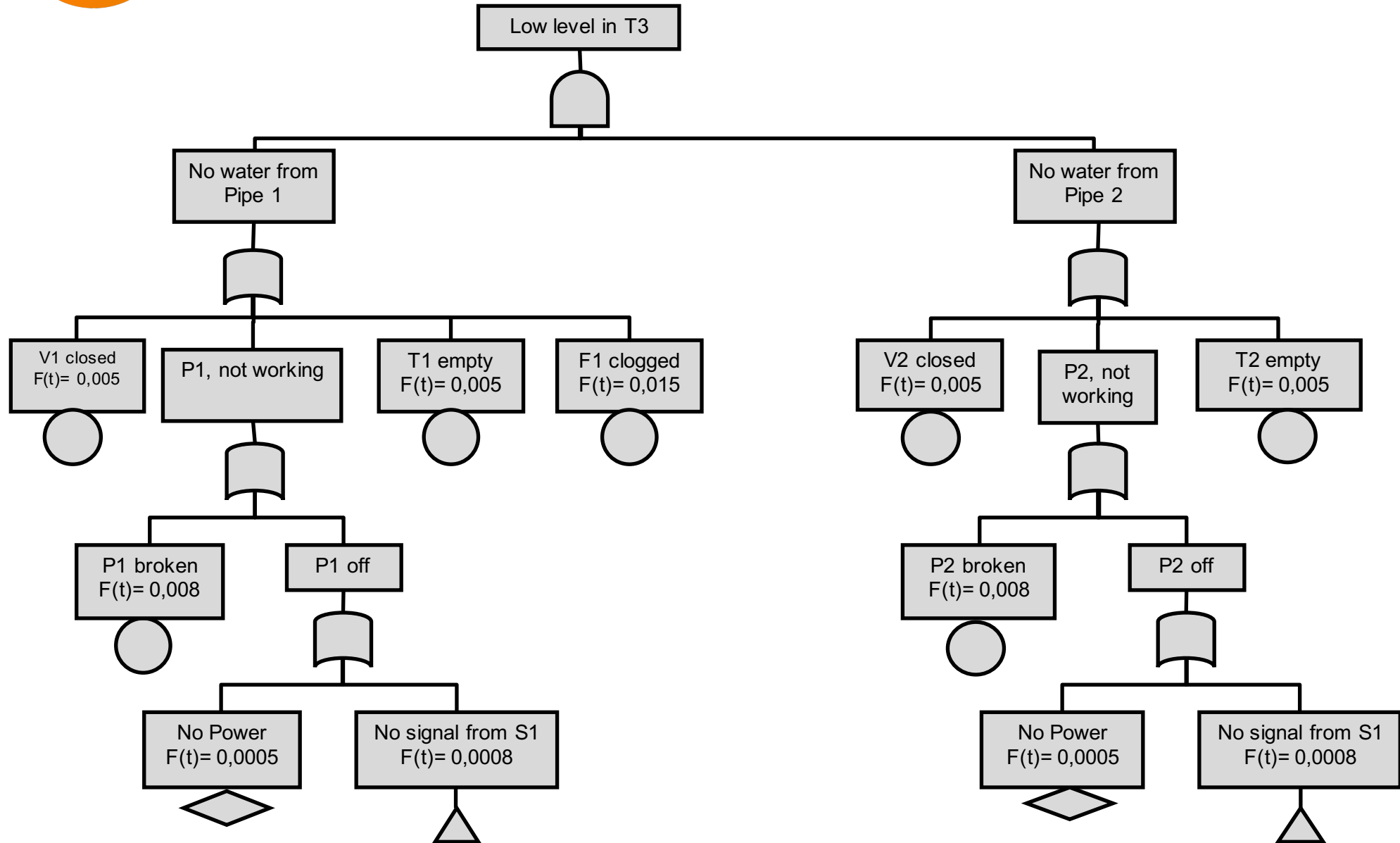


$$R_p(t) = 1 - (1 - R_1(t)) \times (1 - R_2(t))$$

Cont.

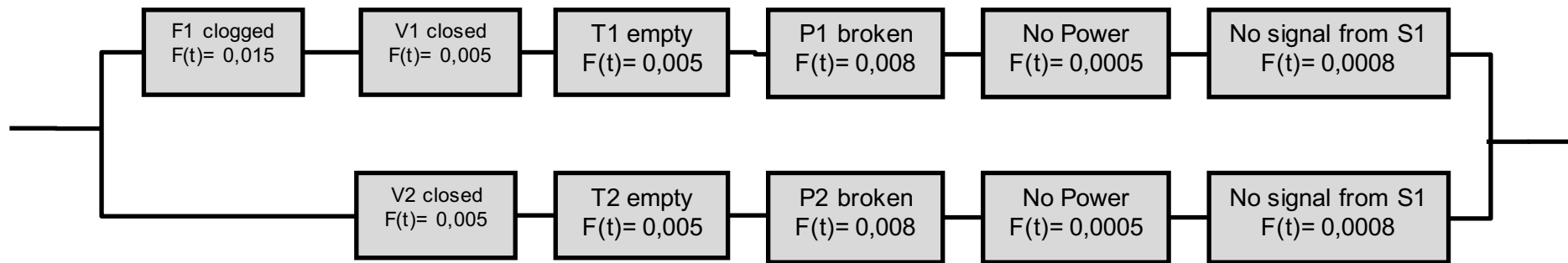


Fault Tree Analysis, FTA





Fault Tree Analysis, FTA



$$R_{\text{sys1}}(t) = 0.985 \times 0.995 \times 0.995 \times 0.992 \times 0.9995 \times 0.9992 = 0.966$$

$$R_{\text{sys2}}(t) = 0.995 \times 0.995 \times 0.992 \times 0.9995 \times 0.9992 = 0.981$$

$$R_{\text{sys1+2}}(t) = 1 - (1 - 0.966)(1 - 0.981) = 0.999$$



PM analysis

Aiming at reducing chonical loss to zero

Accomplished by:

- An analytical and systematic view on every phenomenon
- A study of a every thinkable factor that may cause the phenomenon
- Identification of every deviation and reduction of these to zero



PM analysis

Aiming at reducing chronic loss to zero

P: - Physical
- Phenomena

M: - Mechanism
- Machine, Man, Material, Method



PM analysis

The eight steps of PM analysis:

1. Clarify the Phenomenon
2. Conduct a physical analysis
3. Identify constituent conditions
4. Study 4M for causal factors
5. Establish optimal conditions (Standard values)
6. Survey Causal Factors for Abnormalities
7. Determine Abnormalities to Be Addressed
8. Propose and Make Improvements



PM analysis

I. Clarify the Phenomenon

The phenomenon occurs when a failure happens, and may be defined as "the difference between a normal and an abnormal state"

A precise clarification of the phenomenon is the key to successful problem solving

1. Eliminate preconcieved ideas
2. Study the equipment
3. Classify the phenomenon
4. Study and identify the deviations



PM analysis

PM Analysis sheet **Length variation in cut tubes**

Physical analysis	Constituent conditions	Primary 4M	Secondary 4M	Established optimal conditions	Abnormalities	Suggested improvements
Step 2	Step 3	Step 4.1	Step 4.2	Step 5	Step 6	Steps 7 and 8



PM analysis

2. Conduct a physical analysis

Apply a physicist's view on the equipment.

Define physical entities for measurement of the phenomenon

1. Identify the principles of the studied operation
2. Identify the standards of the operation
3. Identify interacting relations between equipment and products
4. Quantify physical events



PM analysis

PM Analysis sheet: Length variation in cut tubes

Physical analysis	Constituent conditions	Primary 4M	Secondary 4M	Established optimal conditions	Abnormalities	Suggested improvements
Step 2	Step 3	Step 4.1	Step 4.2	Step 5	Step 6	Steps 7 and 8
The distance (A) varies between the edge (B) of the cutting tool and the end position (C) of the pipe						



PM analysis

3. Identify constituent conditions

Identify all fundamental causes to the problem

Find fundamental causes within all 4Ms: man, machine, method, material



PM analysis

PM Analysis sheet: Length variation in cut tubes

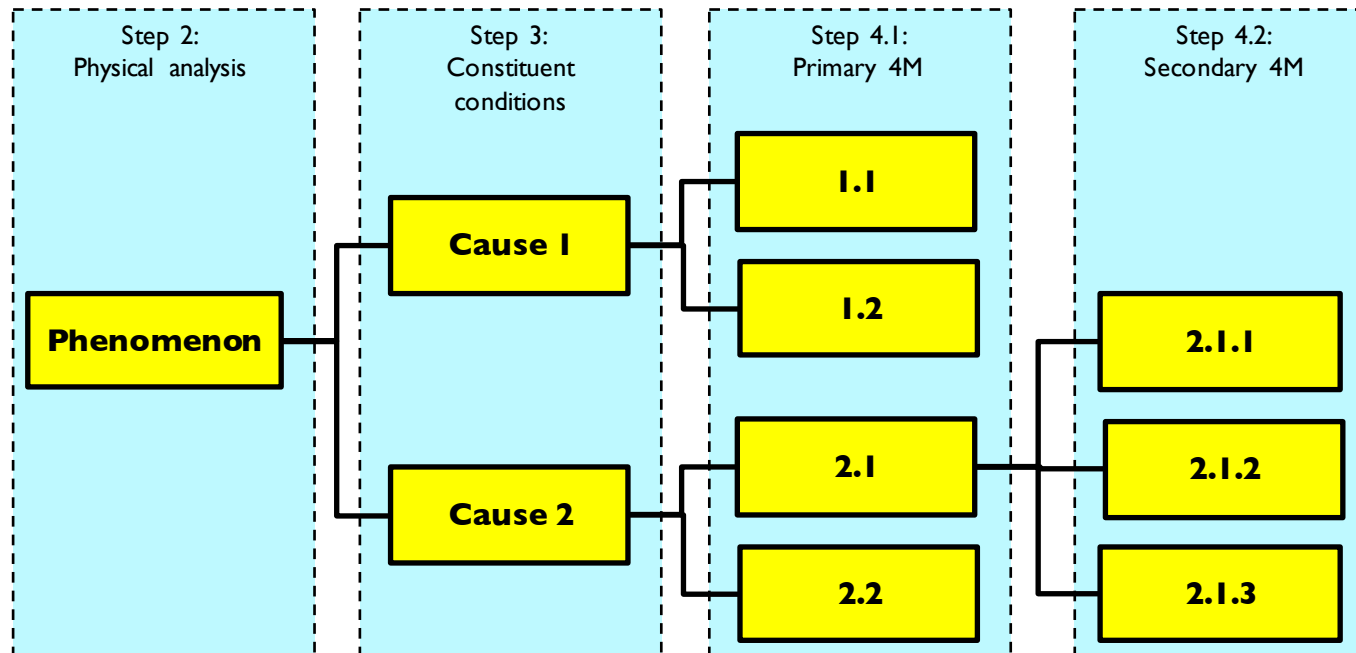
Physical analysis	Constituent conditions	Primary 4M	Secondary 4M	Established optimal conditions	Abnormalities	Suggested improvements
Step 2	Step 3	Step 4.1	Step 4.2	Step 5	Step 6	Steps 7 and 8
The distance (A) varies between the edge (B) of the cutting tool and the end position (C) of the pipe	3: The position of the pipe varies					



PM analysis

4. Study 4M for causal factors

Study the relations between the fundamental causes and the 4Ms in terms of cause and effect.





PM analysis

PM Analysis sheet: Length variation in cut tubes

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Step 2	Step 3	Step 4.1	Step 4.2	Step 5	Step 6	Steps 7 and 8
The distance (A) varies between the edge (B) of the cutting tool and the end position (C) of the pipe	3: The position of the pipe varies	3:1 The gripper don't pull the pipe to the right length				
		3:2 The gripper doesn't move the right distance				
		3:3 The position of the tube changes after the gripper has released				



PM analysis

PM Analysis sheet: Length variation in cut tubes

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The distance (A) varies between the edge (B) of the cutting tool and the end position (C) of the pipe	3: The position of the pipe varies	3:1 The gripper don't pull the pipe to the right length	3.1.1 Locking rolls are worn 3.1.2 Too low force in the locking piston 3.1.3 Oil on the locking rolls 3.1.4 High amount of oil on the pipes 3.1.5 The pipe is misaligned in the frame 3.1.6 Debris in the steering mechanism 3.1.7 High flexibility in frame 3.1.8 Debris on the door 3.1.9 Doesn't grip because of resistance in gripper mechanism			
		3:2 The gripper doesn't move the right distance	3.2.1 Play in slewing bracket 3.2.2 Loose bracket 3.2.3 Air pressure too low			
		3:3 The position of the tube changes after the gripper has released	3.3.1 The pipe bounce on the door 3.3.2 Skew pipe is pulled up 3.3.3 Resistance in the locking mechanism makes it pull the pipe 3.3.4 Pipe bounce when the cutter positions too late 3.3.5 Wear/grades on the top of the door			



PM analysis

5. Establish optimal conditions (Standard values)

”Optimal conditions” are the conditions that are required for the equipment to function and deliver according to requirements.



PM analysis

PM Analysis sheet: Length variation in cut tubes

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		3:2 The gripper doesn't move the right distance	3.2.1 Play in slewing bracket 3.2.2 Loose bracket 3.2.3 Air pressure too low	3.2.1 Max 2mm play 3.2.2 Fastened 3.2.3 Pressure 5KPa		
		3:3 The position of the tube changes after the gripper has released	3.3.1 The pipe bounce on the door 3.3.2 Skew pipe is pulled up 3.3.3 Resistance in the locking mechanism makes it pull the pipe 3.3.4 Pipe bounce when the cutter positions too late 3.3.5 Wear/grades on the top of the door	3.3.1 No Bounce 3.3.2 Max skewness 0.1mm/100mm 3.3.3 No resistance 3.3.4 Cutter should position when pipe is released 3.3.5 No wear or grades		



PM analysis

6. Survey Causal Factors for Abnormalities

Measure the differences between possible root causes, according to steps 3 and 4, and the optimal conditions, defined in step 5.



PM analysis

PM Analysis sheet: Length variation in cut tubes

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		3:2 The gripper doesn't move the right distance	3.2.1 Play in slewing bracket 3.2.2 Loose bracket 3.2.3 Air pressure too low	3.2.1 Max 2mm play 3.2.2 Fastened 3.2.3 Pressure 5KPa	3.2.1 Play exists 3.2.2 Loose 3.2.3 OK (if enough)	
		3:3 The position of the tube changes after the gripper has released	3.3.1 The pipe bounce on the door 3.3.2 Skew pipe is pulled up 3.3.3 Resistance in the locking mechanism makes it pull the pipe 3.3.4 Pipe bounce when the cutter positions too late 3.3.5 Wear/grades on the top of the door	3.3.1 No Bounce 3.3.2 Max skewness 0.1mm/100mm 3.3.3 No resistance 3.3.4 Cutter should position when pipe is released 3.3.5 No wear or grades	3.3.1 Not evaluated! 3.3.2 Skewness occurs 3.3.3 Some resistance 3.3.4 Occasionally 3.3.5 Damaged!	



PM analysis

7. Determine Abnormalities to Be Addressed

Based on the survey in step 6, define which factors that truly contribute to the problem and therefore should be dealt with.



PM analysis

8. Propose and Make Improvements

Propose improvements for correction of the identified deviations.
Prevent them from re-occurring.



PM analysis

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		3:2 The gripper doesn't move the right distance	3.2.1 Play in slewing bracket 3.2.2 Loose bracket 3.2.3 Air pressure too low	3.2.1 Max 2mm play 3.2.2 Fastened 3.2.3 Pressure 5KPa	3.2.1 Play exists 3.2.2 Loose 3.2.3 OK (if enough)	
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Time for a brake?