CHALENGING YOUR BUSINESS CONTINUITY PLAN
IS IT BULLET PROOF?
USING PRO-ACTIVE FAILURE ANALYSIS™

You've just focused your attention on the why and how of putting together your disaster preparedness plans so that you can be ready for a potential weather, terrorist, or some other business threatening situation. Now… How can you make sure that everything has been considered?

Let's first think about how we developed our action plan. We tried to consider all the potential situations that might occur, how they might affect our business, and then we made some prioritized choices about protecting, storing, and recovering our records or other vital functions of our business. We may have made a conscious choice not to do everything that we might do, but we did it knowing all the potential inputs and consequences. Or did we?

Let us share with you one last thinking process for doing a double check on your plans and scenarios. The normal way we develop alternatives and checklists (to which we respond) is to ask the question, "what"? In other words, what would we do if we had no power for 5 days? What would we do if we lost Email capability for 3 days? If we had no employees for a week? If my entire management staff contacted bird flu on an overseas trip? Then we respond to our answers to these questions and develop an action plan. In the vast majority of cases, this kind of analysis is sufficient. Now when we have done this kind of analysis and we chose not to do what was intuitively obvious to do, no further analysis could have been of benefit. In our minds we made an economic trade-off between the cost of preparing and the impact cost of disaster impact. And in the famous words of someone, "sometimes the bear gets you"—but you knew you left the gate open in a conscious decision.

There are hundreds of industrial fires, explosions, business interruptions, and loss of life situations where "not choosing" to do something was not the root cause. We did not roll the dice and loose. We didn't know which dice to roll. Let's explain with some examples and you can easily make some analogies.

A few years ago, a major chemical manufacturing facility handling liquid sulfur dioxide had a major release of this very hazardous gas. This release went beyond the plant fence line, caused the evacuation of an elementary school, and an overall public relations disaster for the company. They had emergency plans. They had done their industries' checklist process (known as HAZOP in the chemical industry). Yet they still had a major accident. In another case, a major refinery, during a shut down for maintenance of one of its units, had a major fire and explosion within a unit that was supposedly shut down. This should not have happened either (how can you have a fire in a process which is not running?) with all the checklists they went through, but it did. In an even more tragic case, hospital patients, being transported from New Orleans to Houston after hurricane Katrina, were killed after their smoking on the bus combined with venting oxygen from

their breathing cylinders. In a hospital in Sarasota, Florida, a patient died when transfused with the wrong blood.
How did these unfortunate accidents happen? To some extent, there were contributing factors from not following procedures, but then why was this the case? Because the checklists were based on reviewing the processes as they existed and asking the question: "What happens if these design conditions are not met?" Don't we do the same thing in getting ready for a flood or hurricane? We have a checklist that we compare our actions against and if we do everything we're supposed to, we're covered.

In all of these cases, a root cause for a release of material was there but not identified by whatever "check listing" was done. After these tragedies, the checklists will now be longer and we may prevent some future accidents and fatalities. Then we'll have another unforeseen accident and the list will again grow longer. Eventually we'll figure out ALL the ways to prevent these accidents.

What if we could do this NOW? Well, there is such a way and it's an analysis process known as Predictive Failure Analysis™. Instead of just going through a checklist and asking ourselves the question, "what could go wrong?" we ask HOW could we deliberately make something go wrong. Now that may sound like a very subtle distinction, but it's not. Think about how our brains work around these two questions. One is reactive, and the other pro-active. If you were asked to go through a checklist created by someone, you would do your best to read through it and use its prompting to think of error possibilities, but even if you had enough caffeine to keep you awake during these long and structured checklist processes, you are still relying on the knowledge of whoever put the list together in the first place. And as we have already seen, that list is not necessarily complete.

Now let's get pro-active and saboteurial with the PFA™ process algorithm;

1. State the problem: We want to prevent transported hospital patients from being injured in any way.
2. Invert the problem: We want the patients being transported to be harmed in some way.
3. Exaggerate the inverted problem: We want every patient being transported to die enroute and everyone involved with planning the transportation process to spend life in prison for negligent homicide.
4. How would we accomplish #3?
5. What resources are required?
6. Are these resources and conditions present? If so, eliminate them!

If we look back at the unfortunate hospital transport accident, here is what steps 4-6 would have looked like for the fire situation that occurred (You could do the same thing for a driving accident or collision):

What resources are required to cause the bus to catch on fire EVERY SINGLE TIME it is transporting patients? We need to complete the fire triangle. We need fuel (clothing, bus

seats, gowns, etc.), an ignition source (cigarette smoking on the bus), and air (air is already present in the atmosphere, but oxygen is 5 times more concentrated in the element that actually combines with fuel and an ignition source). It is inevitable that we will have a fire. We eliminate any one of these three items and we will NEVER have a fire. Since it's impractical to eliminate the clothing and the oxygen for some of the patients, we MUST eliminate smoking (or any other source of ignition for that matter—vapors from filling the bus's gas tank?). We know how smoking is a strong addiction for many elderly patients, so we would not assume that a warning to the patients would be sufficient. We would do whatever was necessary (strip searches as well as baggage searches) to absolutely guarantee there was no source of ignition.

Now take this kind of thinking into your emergency and failure analysis thinking. How would I make sure that my back up plan did not work? What resources and conditions would be necessary to have them not work as planned. With this kind of thinking in addition to your first two steps of planning, you'll be SURE that you'll be covered.

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