

**TEAM 4**

Method	Phase	Self-supporting		Graphical Output		Accessibility			Learning easiness			Scope of investigation 1 - the work and technological system; 2 - the staff level; 3 - the management level; 4 - the company level; 5 - the regulators and associations; 6 - the Government level	Duration of the investigation			Replication		
		Yes	No	Yes	No	Yes	To some extent	No	Yes	To some extent	No		days	weeks	months	Yes	To some extent	No
<b>Example: STEP</b>	Phase 1	X		X				X										
<b>Example: Tripod Beta</b>	Phase 2 and 3	X				X												
ESReDA Cube				x		x					x	1-6		x	x		x	x

*Note: The methods shown in the table above are just examples. Please fill in the form according to the methods you use during the analysis. Please keep in mind to indicate also in which Phase the method is applied.*

**S.W.O.T. Analysis Table** Please provide a SWOT analysis of each method that you used (to the best of your availability)

Method	Strengths <i>(Positive aspects of any kind, e.g., ease of use, results, logic used, etc.)</i>	Weaknesses <i>(Negative aspects of any kind, e.g., ease of use, results, logic used, etc.)</i>	Opportunities <i>What kind of positive outcomes may result from the strengths?</i>	Threats <i>(What kind of negative outcomes may result from the weaknesses?)</i>
<b>Example:STEP</b>	Very easy to use with just pencil and paper	Very simplistic. Only provides a timeline and list of actors	<ul style="list-style-type: none"> <li>• Easy choice for any safety expert no training needed</li> </ul>	<ul style="list-style-type: none"> <li>• Another method is required to analyse what caused each</li> </ul>

	Very simple output, transparent		<ul style="list-style-type: none"> <li>Provides a timeline of events as a starting point for analysis</li> </ul>	event on the timeline
<b>The ESReDA Cube</b>	<p>Emphasizes learning. What may be learned from the individual facts of the event and who could benefit from the learning?</p> <p><a href="#">A communication tool. Facilitates discussions amongst stakeholders on identified topics. It assists the user to use a systematic approach to look at an accident and discuss about it.</a></p> <p><a href="#">Integrated and systematic way of looking at an event (near miss, incident, accident), taking stock of the organisational context, level of stakeholder responsibility and depth of learning required.</a></p>	<p>Results depend on the scope of the analyst(s). Analyst(s) must be clear of his/her viewpoint and goal of analysis at all times. <a href="#">If a team of analysts, convergence is needed in understanding chronology of events and related causes.</a></p> <p>Should not be used as a stand-alone method, but as a supporting method, as it is more like a model, rather than a method.</p> <p><a href="#">Does not include timeline of events or causality</a></p>	<p><a href="#">Model may be used before the investigation as a planning tool.</a></p> <p>Model may be used during the investigation to identify what has been missed in the investigation so far.</p> <p>Model may be used at the end of the investigation to pinpoint recommendations to specific stakeholders.</p> <p>Model may be used after the event to analyze the event or to analyze the investigation process itself.</p>	<p>When planning resources, use of the Cube will also require another method for chronology and causality to be used beforehand. <a href="#">This must be catered into the decision on whether or not to use the Cube.</a></p>

ADDITIONAL COMMENTS (if any)

