Event Reviews vs. Investigations

- A practical alternative to traditional blame-based, punitive investigations
- Designed to improve systemic, latent and organizational issues, not "individual actions"
- Ideal for events with multiple, complex human or organizational errors

> *"Your investigation and analysis was the most thorough and well-documented of any we have had to date... **the interviews and investigation were not threatening in any way, but you only tried to find the root cause of the error without pointing fingers."***
>
> ~ Manager of Electric Transmission System Operations
> in an electric power utility with 1+ million customers

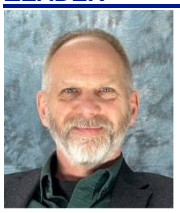
How Does It Compare?

	Many Traditional Investigations	Event Reviews
Goal	Identify what (or who) caused the problem	Identify high-value, low-cost, non-obvious process improvements
Focus	Employee actions	Systemic, latent and organizational issues
Most problems occur because	Employees don't follow rules & procedures	Modern jobs demand constant adaptation and expert judgment that sometimes does not work out as expected, even with the best intentions
Best for	Breakdowns in complex mechanical systems like factories, or when the goal is assigning blame or reducing legal liability	Events with multiple, complex human and organizational errors like miscommunications & misunderstandings, or when the goal is non-punitive process improvement

	Many Traditional Investigations	Event Reviews
Process	1. Get relevant data & facts from people involved 2. Look for causes, effects & procedural violations 3. Assign Root Cause(s) and Corrective Actions	1. Engage people involved as respected experts 2. Identify gaps between Work as Imagined (WAI) vs. Work as Done (WAD) on this job 3. Ask 6+ levels of questions to identify high-value, low-cost process improvements
Deliverable	Root Cause(s) and ~12-36 Corrective Actions	3-7 core process improvements
Can Feel Like	A criminal trial	A process improvement team
Based On	Cause & effect analyses used to solve complex engineering problems or criminal investigations	Non-punitive After Action Reviews (AARs) used by: US Army, Navy, Marines and fire & rescue teams to continuously learn & improve
Long-Term Effects	Fear, distrust & hostility. Too many Corrective Actions. They get shelved or "checkboxed" but don't improve the problem.	Increased trust, respect, and communication. 3-7 core process improvements are focused enough to manage and implement. They reduce risk of future events, and spark interest in more process improvements over time.

> ***"We needed a different lens from a Human Performance perspective,*** *a process of documentation that captured the whole event, and delivered clear and concise objects!* ***Thank you Jake for bringing that new perspective!"***
>
> ~ Brenda Houtz, MBA, NERC RC,
> Executive Director Grid Management, Consumers Energy

LEADER



- Helped analyze over 300 incidents and unwanted events
- Shows leaders why errors are signals, not failures, and how to address the deeper problem, so that everyone can work more reliably and safely
- 10 years experience in safety for an electric power utility
- Served as a firefighter, an EMT, and a military paratrooper
- To learn more click here, or visit www.reliableorg.com

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Contact me or schedule a free, no-pressure discovery call to learn more.