

# Human Performance Event Review



- 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 a Fortune 500 electric power utility

### HOW DOES IT COMPARE?

	Many Traditional Investigations	Human Performance Event Review
<b>Goal</b>	Identify what (or who) caused the problem	Identify high-value, low-cost, non-obvious process improvements
<b>Focus</b>	Employee actions	Systemic, latent and organizational issues
<b>Most problems occur because</b>	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
<b>Best for</b>	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

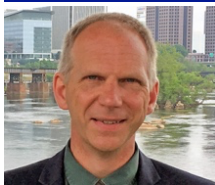
	Many Traditional Investigations	Human Performance Event Review
<b>Process</b>	<ol style="list-style-type: none"> <li>1. Get relevant data &amp; facts from people involved</li> <li>2. Look for causes, effects &amp; procedural violations</li> <li>3. Assign Root Cause(s) and Corrective Actions</li> </ol>	<ol style="list-style-type: none"> <li>1. Engage people involved as respected experts</li> <li>2. Identify gaps between Work as Imagined (WAI) vs. Work as Done (WAD) on this job</li> <li>3. Ask 6+ levels of questions to identify high-value, low-cost process improvements</li> </ol>
<b>Deliverable</b>	Root Cause(s) and ~12-36 Corrective Actions	3-7 core process improvements
<b>Can Feel Like</b>	A criminal trial	A process improvement team
<b>Based On</b>	Cause & effect analyses used to solve complex engineering problems	Non-punitive After Action Reviews (AARs) used by: US Army, Navy, Marines and fire & rescue teams to continuously learn & improve
<b>Long-Term Effects</b>	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](http://www.reliableorg.com)

### Jake Mazulewicz, Ph.D.

Director of JMA Human Reliability Strategies, LLC  
[jake@reliableorg.com](mailto:jake@reliableorg.com) -- 804-301-2063 -- [reliableorg.com](http://reliableorg.com)



To find out if the Human Performance Event Review is right for you, just call, scan or email to schedule your free, no-pressure discovery call.