

# 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?

|                                    | <b>Many Traditional Investigations</b>   | <b>Event Reviews</b>   |
|------------------------------------|--|--|
| <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  | Event Reviews   |
|-------------------|--|---|
| Process           | <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> |
| 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](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)

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

