



WHITE PAPER

# Event Insights<sup>©</sup>

Making minor incidents matter





# CONTENTS

1	SUMMARY	3
2	INTRODUCTION 5 Whys Predetermined Lists	4
3	WHAT IS EVENT INSIGHTS? Event Insights When to use Event Insights Benefits	6
4	CONCLUSION	13
5	ABOUT THE AUTHORS Mark Alston Jop Havinga	14
6	REFERENCES	15



Event Insights promotes a forward-looking approach that builds organisational resilience, adaptability, and community while moving towards a safer future together. This paper emphasises a shift from blaming individuals to fostering organisational learning from minor incidents. It challenges traditional

investigation methods like root cause analysis and the 5 Whys, suggesting they often lead to finger-pointing rather than genuine learning. Instead, it introduces the concept of Event Insights, a structured yet flexible inquiry process that focuses on learning potential, not just severity.

## KEY TAKEAWAYS



Figure 1: Key Takeaways

Safety traditions argue that organisational learning is crucial to managing risk and includes learning from incidents. Practically all organisations have processes for classifying and investigating significant accidents, and it is easy to justify spending a lot of time and effort on these events. Not getting a satisfactory answer is not acceptable. For minor incidents, however, there is no blank check to investigate, and efforts to learn from these incidents can be limited at best and token at worst.

## 5 Whys

It is common in small to medium incidents to use a lightweight version of root cause analysis like the “5 Whys” or a drop list of predetermined root causes. However, the severity criteria and the investigation methods are a poor choice when strategically spending organisational resources.

Root cause analysis, predetermined lists, and the 5 Whys are helpful because they can drive investigators beyond the surface but they are also built on misleading causation models. The term “root cause” suggests there are some factors more fundamental than others in causing the event, and in turn, these are the factors that should be addressed. In reality, many factors constantly come together, and none have to be sufficient or necessary by themselves (Dekker et al., 2011). In addition, the most fundamental factors, like the laws of



gravity, will often be silly to list, as they are so fundamental that they cannot be changed.

The 5 Whys method goes even further in misdirecting attention. Even in its shining moment, investigating the deterioration of the Washington Monument – the case heralded by its proponents – did not lead to a desirable solution (Card, 2017). Asking “why” 5 times led to the finger pointing to the statue’s lights, as they attracted bugs. This cause was real, influential, and counterintuitive. However, the solution was short lived, as the lamps were soon turned back on. While turning off the lights had stopped the monument’s deterioration, people started complaining. Without the lights, tourists could not see the monument anymore,



## INTRODUCTION

defeating the purpose of having the monument in the first place. The method's simplification of the problem had pushed the monument's purpose out of consideration.

To spend our time and efforts well, it is time to bid farewell to these methods. Event Insight offers a better way to spend time and resources to learn. It remains lightweight, versatile, and tuned towards the reality of work or opportunities to learn from it.

### Predetermined Lists

A prevalent investigation practice involves relying on a pre-determined checklist of root causes. It is a quick route to resolution, where an investigation culminates by picking a cause from a list, typically composed of five to eight options. The specifics of these lists may vary, with many leaning towards ICAM categories or variations of it. The inherent limitation of pre-determined lists is that they limit the possible conclusions. In turn, this instructs investigators what is worthwhile to investigate. The limitation of the conclusions gets in the way of the opportunity to discover and learn something new. Surprising results are ruled out.

Some might point out that this limitation is a deliberate trade-off. The limitation comes from standardisation, which facilitates aggregation and trend analysis. However, this raises a

crucial question: What exactly are organisations trending here? Events always include many factors coming together, which means it comes down to subjectivity when only one 'root causes' must be chosen. Individual investigators have their biases, preferring some explanations over others. Since investigators tend to have their own domains or area, their biases can create trends for departments or locations. Even more concerning are the organisation-wide biases. Some causes might be preferred by most, for example, because they require less evidence or follow-up work.

The ever-intriguing 'human error' serves as a prime example, raising questions about whether its increased frequency indicates a change in operator behaviour or a shift in the social acceptability of attributing events to this cause. It's a reminder that trends can emerge just as easily from the biases in identification as from the inherent characteristics of the incidents investigated.

On the surface, pre-determined lists appear as a practical, lightweight tool that helps to get some level of learning from each event. However, their true contribution to risk management, whether on a per-event analysis basis or in the aggregate, are both questionable. These lists do more to provide a façade of orderliness than inform safety decisions.





## WHAT IS EVENT INSIGHTS?

Event Insights is a “humble inquiry” learning process involving curated questions for specific events. The event is the initiator, but it is not about pointing fingers or mechanical cause-and-effect relationships. Instead, it’s about gaining a deeper understanding of the broader tasks and the risks dealt with. This avoids obsessing over details and trying to prevent the specifics of the accidents that have already happened; it avoids analysing failures while losing sight of the context and purpose of the work. The goal is to get smarter about managing work and risk tomorrow.

**The goal is to get smarter about managing work and risk tomorrow.**

Event Insights is a lightweight and flexible tool. The questions can be written down on paper or recorded electronically. Safety advisors, line management, or operational team-mates can be facilitators. There is no need to spend hours preparing; only the question list is needed. Any facilitator familiar with curiosity-driven, as opposed to blame-focused, inquiry methods are able to achieve great results with this method.

The questions are designed to be asked by a frontline leader, usually a supervisor or safety advisor, to workers involved in the event. There is no assumption that the staff

involved were at fault. They are not treated with suspicion; they are treated as the most likely source of relevant knowledge and ideas. They are the people who have the most direct experience of the event and know the work (Dekker, 2016). This can be shared with others to inform them how the work is organised. Facilitators can use Event Insights questions with individuals in multiple separate interviews or with a group all at once.

After the interview, the facilitator works out a follow-up plan. The question of improvements is deliberately kept separate from the analysis questions to create more distance between them. Naturally, not every possible improvement is feasible to implement in practice; however, when we put a “no can do” sticker on things as people reflect, we limit the scope of the analysis. If the goal were to do a fly-fix-fly type of safety management, this would be no problem. It would mean your conclusions are limited to what is currently considered feasible and acceptable.

**For Event Insights, the goal is to inform managing risk in the long term.**

For Event Insights, the goal is to inform managing risk in the long term. What might seem an out-of-proportion response today might be considered a worthwhile avenue to





## WHAT IS EVENT INSIGHTS?

explore tomorrow. By listing the analyses separately, they can be revisited in the future.

### Event Insights:

The Event Insights question list consists of seven questions a facilitator asks the involved workers; the questions are followed by a translation of the analysis into improvements. The questions are divided between learning about the event and learning about the task.

**Walk me through what happened.** Although self-explanatory, it is vital to understand what happened from the perspective of those involved in the event. It allows workers to recount the event through their lens, shedding light on what they deem significant. This is the first question for good reason. Previous questions can shape responses to subsequent questions in a variety of ways (Kahneman, 2011). The lead-up to a question can provide a framing from which a question is understood



Figure 2: Event Insights Questions



## WHAT IS EVENT INSIGHTS?

or put things front of mind. In addition, people try to maintain consistency between their answers.

Giving operators the freedom to narrate their accounts from the outset minimise the influence of the investigator. It makes it more likely the story goes in a direction the investigator had not foreseen (Fetterman, 2010). Such surprises are at the foundation of learning.

**What surprised you about the event?** Surprise is at the core of what makes something an incident and the learning process. Incidents, by their definition, include unintended and unexpected outcomes. Something about what happened must have surprised people in the organisation (Turner, 1976); otherwise, they would not have considered it an incident. Surprise also highlights a mismatch between what we know and expect on one hand, and what we experience on the other. This result prompts a

search to better understand what has transpired and update our beliefs (Peirce, 1908). Surprise guides us to where the event starts being understood as an incident and where more can be learned.

**Could things have gone worse? And why did that not happen?** Variation is constant and inevitable. Sometimes, things improve or worsen. However, not all variation is random. Some things cannot happen, and others are more likely to be avoided. For example, experts often allow minor mistakes to prevent major ones (Farrington-Darby & Wilson, 2006). Asking people how things could have been worse illuminates what could have happened or might have been prevented. With this, a larger picture emerges to provide context and highlight the task's complexity and hidden interactions. This question may confirm our controls' effectiveness and clarify whether we were good or just lucky.

**When this task works well, what must go right?** Designing work around avoiding failure is insufficient. As seen with the 5 Why Analysis, just avoiding failure can cause one to neglect the purpose of the situation (Card, 2017). The goal is to contribute to the organisation of work and management of risk. People refine what they do around understanding what it takes to succeed. People come to





## WHAT IS EVENT INSIGHTS?

work to excel, and as such, will adapt and innovate where needed to make it work. Asking what it takes to succeed helps capture the effort taken and could be supported for adaptations away from failure without disregarding success.

**Is there anything that frustrates you with this task?** Typically, people try to do a task well and get frustrated when they cannot. If people are frustrated, something outside their control is making the work more difficult. These are things worth sharing and at a different level, more might be possible to prevent or mitigate such reflecting on a larger organisational scale, as frustrations. Even if the frustration itself is not hazardous, it can take up attention and resources, reducing the capacity to respond to other concerns (Rasmussen, 1997). Frustration can reduce safety margins

**What could management better understand about this task?** Learning only takes place if someone's understanding is shaken up. If that learning is to make a difference, it must influence future work or the conditions that influence the work. Management is a group that shapes many work conditions, but its distance from operations often makes it hard to keep an up-to-date understanding of it (Dekker, 2016). This distance makes potential gaps in management's knowledge a worthwhile finding. Even if the operator's

answer is mistaken about management's actions or beliefs, this still points to a disconnect in information flow from management towards operators.

**How can we improve the way we do this?** The workers have the direct experience about the event and the work (Dekker, 2016). Usually, workers will have already considered what changes would have improved things. They often need more authority to make it happen. Solutions developed by those who do the task are more likely to be implemented, sustained, and effective. Even when a worker-suggested solution is not feasible at the time, the solution gives insight into how the worker understands the problem.



The analysis questions are followed up by a translation to action with the following questions:



## WHAT IS EVENT INSIGHTS?

- What ideas should we implement?
- Who should implement ideas?
- When should we check up on the progress of the implementation?

When and how should we assess whether this idea is working?



### When to Use Event Insights:

Event Insights is a tool designed for events of minor and medium significance. Investigating such events significantly strains organisations, often with few results. There is a need to be strategic about investigating these events. This strategy goes beyond how to investigate, to incorporating what to investigate. Questions include what events are worthwhile to spend time on and which provide an excellent learning opportunity.

**Some events provide more of a learning opportunity than others.**

Learning opportunities are something that organisations rarely screen for. At first sight, it might seem impossible to know whether there is something worth learning from an event before conducting the investigation.

To learn, you must find something you have yet to learn, which is impossible to formulate, let alone recognise once you have looked well into the event. While technically true, this does not mean learning is equally likely for all events. Some events provide more of a learning opportunity than others.

Factors that make it more likely that the organisation will learn from investigating the event:

- **Have there been recent changes in the task or conditions surrounding the event?** The newer something is, the more likely people's routines around it are also changing (Feldman et al., 2016). Changes in one spot often trigger unexpected ripples elsewhere as people adapt to the new environment. These ripples are not always understood or communicated.
- **Did the event involve multiple controls?** The more parts involved, the trickier it is to see how they work together. Most controls are designed and planned to occur in isolation, and



## WHAT IS EVENT INSIGHTS?

- their interaction flies under the radar. An event involving multiple controls provides a case of learning something that rarely gets considered otherwise.
- **Are there multiple stakeholders involved in this task?** Incident arising from different stakeholders' joint actions can have an added degree of complexity. Different groups have different priorities, and that can lead to working at cross-purposes (Woods & Branlat, 2011). Inquiry into these events can help provide reflection and adjustments that separated individuals cannot easily do alone.
- **Can others outside the team benefit from learning about this event?** Learning goes beyond the factors of the incident itself; it is about how relevant the insight is for others in the organisation. If an event links to something already on someone's agenda, they are likely to benefit from learning about the event (Cohen et al., 1972).

The more "yes" answers there are, the more significant opportunity the event presents for learning.

*\*To learn more about organisational learning, please read our white paper: "Event learning assessment: Being smart about what to investigate."*



Figure 3: Event Insights Benefits

Event Insights provides a new tool for inquiring about minor and medium impact incidents. The different approaches around which incidents we can learn from, what to look and ask for, and how to use these findings make Event Insights

**Optimised for learning.** Choosing what and how to investigate guides where current understanding is incomplete or wrong. Rather than exclusively dwelling on an accident that has already happened, Event Insights directs attention towards what can inform future risk management. By being strategic, the



## WHAT IS EVENT INSIGHTS?

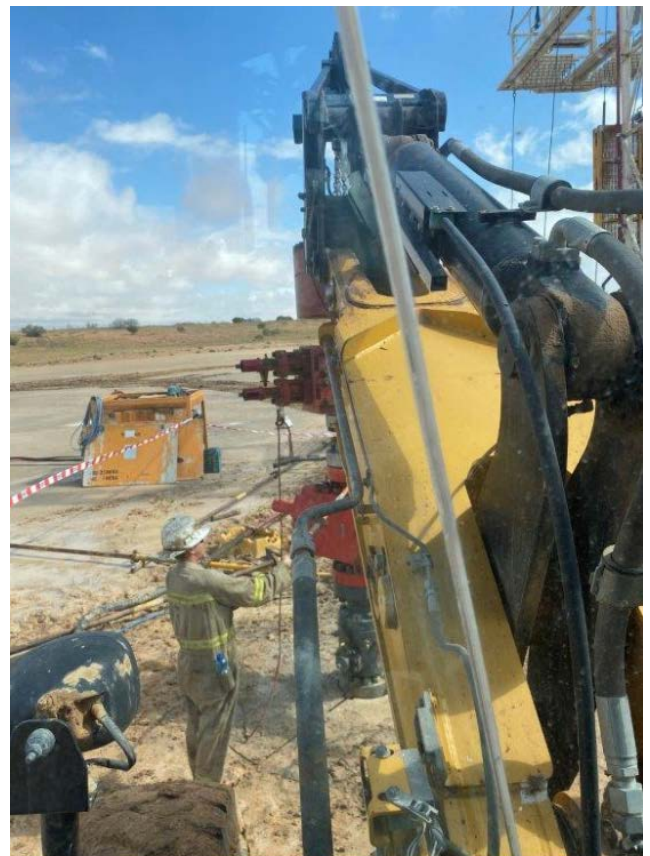
method can remain simple, quick, and easy to use. This minimises the costs of conducting the method and auxiliary costs, like training, administration, and the stress on those involved.

**Constructively focussed.** By focusing on what can be learned and avoiding the framing of what was wrong, Event Insights are set up to be constructive. None of the questions are about what those involved did (wrong) and do not put them under scrutiny. The questions create opportunities for people to contribute to how things are done. This is beneficial for the investigation itself, as well as fostering a culture of openness, trust, and collaboration.

**Staff engaging.** Event Insights actively involves those at the event and makes them part of the solution. They are best positioned to provide insights into the event and general task. This leads to informed solutions and fosters a workplace culture where people are included. Rather than ostracising and cutting people off from their support network, Event Insights reinforces trust, reaching out, listening to, and valuing the people who do the work and are involved in the event.

**Operationally aligned.** By engaging staff and considering operations in the questions, the analysis and solutions are informed by knowledge of what work is like. This makes it

less likely that interventions will add to safety clutter and hinder operations. As seen with the 5 Whys example, solutions that prevent accidents but nullify the work's purpose are self-defeating.





## CONCLUSION

Any safety tradition urges an organisation to learn about itself, whether you believe accidents come from unsafe behaviour, holes in Swiss cheese, failures in information management, or cultural concerns. Whether safety is created through organisational mindfulness or sustained adaptive capacity, an organisation needs to understand its operations, including the possible risks and incidents. The reality is that learning takes time and effort but cannot be done infinitely.

**The reality is that learning takes time and effort but cannot be done infinitely.**

Organisations have many minor incidents requiring significant resources to investigate and administer. In practice, however, very little is learned from them. This inefficiency

harms an organisation's objective of risk reduction, as it drains resources that could have been spent on safety directly. One challenge is knowing what

**One challenge is knowing what to investigate; another is knowing how to investigate.**

to investigate; another is knowing how to investigate. Current lightweight investigation tools like root cause analysis and 5 Whys are unsuited for this task as they are built on false causality models and are insensitive to operational needs. Event Insights offers

guidance on what events to spend time on and a simple, effective method for learning from these events.

The Event Insights tool recognises the reality that minor to medium-impact incidents are time-consuming. Event Insights does this efficiently by focusing on where learning is most likely, avoiding efforts focussed on blame and not limiting analysis to preventing the incident that has already happened.

The forward-looking focus of Event Insights avoids harm to incident investigations like tendencies to blame and single out. Including operators involved rather than ostracising them adds to an organisation's resilience. It maintains a sense of community and reinforces support networks and connections people rely on for problem-solving. It allows organisations to remain flexible and manage disruptions while helping organisation members move forward together.

Remember, the goal is not to prevent the same thing from reoccurring but to learn from every event and continuously improve organisational risk management.



## ABOUT THE AUTHORS

### Mark Alston

Mark Alston, Director of Investigations Differently, has over two decades of experience and has established himself as an innovative leader in investigations and risk management. He is known for his progressive approach, leveraging modern safety concepts to assist organisations in reducing risk.

With a strong operational background, his mission is to encourage organisations to adopt proactive data-driven processes, challenge conventional paradigms and embrace a more adaptable and resilient approach.

Mark's extensive expertise spans global organisations in the mining, construction, government, defence, health, and utilities industries. It includes Australasian and International clients such as the Royal Australian Airforce, Mitchell Services, the Office of Industrial Relations, ABB, Perenti, Airservices Australia, NZ Corrections, KFC, and Asplundh.

Mark's engaging speaking style, combining extensive industry knowledge with groundbreaking concepts, has made him a sought-after figure in investigations and risk management discussions.



### Jop Havinga

Dr Jop Havinga works as a research fellow at Griffith University's Safety Science Innovation Lab and as a consultant in various industries. Having his feet in both industry and academia often made him provide a bridge between the two worlds, highlighting the realities of organisational life and challenging taken-for-granted practices and beliefs. Driven by a conviction in the power of curiosity and being honest with ourselves, Dr Havinga is dedicated to uncovering the nature of workplace dynamics and challenges.

With this curiosity, Dr Havinga delves into understanding the perspectives and rationalities of individuals within organisations, from frontline operators to top management, the environment they find themselves in, and explores what follows from this. He has been at the forefront of exploring how to learn from what goes on in an organisation for safety purposes. He has developed academic and industry methodologies for this purpose, which have become standard within consultancies. He is often sought out for projects that cover unfamiliar ground in this space.





## REFERENCES

Card, A. J. (2017). *The problem with “5 whys”*. 671–677. <https://doi.org/10.1136/bmjqs-2016-005849>

Cohen, M. D., March, J. G., & Olsen, J. P. (1972). A Garbage Can Model of Organizational Choice. *Administrative Science Quarterly*, 17(1), 1–25. <https://doi.org/10.2307/2392088>

Dekker, S. W. A. (2016). *Just Culture: Restoring Trust and Accountability in Your Organization* (3rd ed.). CRC Press.

Dekker, S. W. A., Cilliers, P., & Hofmeyr, J. (2011). The complexity of failure: Implications of complexity theory for safety investigations. *Safety Science*, 49, 939–945. <https://doi.org/10.1016/j.ssci.2011.01.008>

Farrington-Darby, T., & Wilson, J. R. (2006). The Nature of Expertise: A Review. *Applied Ergonomics*, 37(1), 17–32. <https://doi.org/10.1016/j.apergo.2005.09.001>

Feldman, M. S., Pentland, B. T., Adderio, L. D., & Lazaric, N. (2016). Beyond Routines as Things: Introduction to the Special Issue on Routine Dynamics. *Organization Science Publication*, 27(3), 505–513.

Fetterman, D. (2010). *Ethnography step-by-step* (3rd ed.). Sage.

Kahneman, D. (2011). *Thinking, fast and slow* (p. 499). Farrar, Straus and Giroux.

Rasmussen, J. (1997). Risk management in a dynamic society: A modelling problem. *Safety Science*.

Woods, D. D., & Branlat, M. (2011). Basic Patterns in How Adaptive Systems Fail. In E. Hollnagel, J. Puriès, D. D. Woods, & J. Wreathall (Eds.), *Resilience Engineering in Practice: A Guidebook* (pp. 127–144). Ashgate.



Mark Alston

+61 400 18 17 16

[info@investigationsdifferently.com.au](mailto:info@investigationsdifferently.com.au)

[investigationsdifferently.com.au](http://investigationsdifferently.com.au)

[linkedin.com/in/alstonmark](https://linkedin.com/in/alstonmark)