

In Safety-II the purpose of investigations changes to become an understanding of how things usually go right, since that is the basis for explaining how things occasionally go wrong.

(Hollnagel et al 2015)

Investigation Quality Review	Y/N
Injuries, if any, were managed in the best interest of injured persons.	
The investigation was conducted according to the principals of a restorative just culture.	
The persons involved in the event were included in the investigation.	
The investigation team included a variety of other workers who normally complete the task.	
The investigation was focused on systems that affected workers actions.	
A learning team or other tools were utilised to learn about the normal work.	
The differences between work as intended (imagined), work as normal and the event were examined.	
The conditions positively affecting normal work were identified. (Variability, innovation, experience.)	
The conditions negatively affecting normal work were identified. (Constraints, trade-offs, resources, etc.)	
The investigation did not stop at the "Worker failed to follow a procedure". (The why, the how etc.)	
The investigation identified when/where controls were effective. (Enabled us to fail safely.)	
Actions were recommended and prioritised based on risk to the organisation.	
The actions were focused on the work/task and not creating bureaucracy.	
Workers performing the task were involved in the development of the actions.	
The actions are specific, measurable and will be effective at addressing the conditions identified.	

Report Quality Review	Y/N
The incident classified correctly.	
The scope of the investigation was commensurate with the potential risk to the organisation and its workers.	
The report gives the reader the context to understand how an event occurred.	
The investigation was completed within the organisations time frames.	
All relevant information has been attached to the report. (Statements, timelines, photos, maps etc.)	
The report was accurate, factual and complete.	