Learning from Errors and Failures Framework

1. Purpose

Organisations will make errors or mistakes when carrying out their functions. Not all errors are equal and treating every failure in the same way limits the ability to learn and improve. Errors can be due to:

- Preventable failures in routine work.
- Complex failure caused by multiple interacting factors.
- Intelligent failures that occur during experimentation and innovation.

An investigative approach that aims to learn from errors allows us to understand whether issues arise due to:

- Human error
- Capability gaps
- Process weaknesses
- At risk-behaviour
- Reckless or deliberate violations.

This framework will be used to investigate errors with the aim to:

- Understand why errors occur,
- Identify root causes
- Promote learning.
- Apply accountability fairly and consistently.
- Reduce the likelihood of repeat errors

This framework is based on Amy Edmondson's research on organisational learning and failure, particularly the concept that not all failures are equally blameworthy and that organisations should focus first on understanding and learning from mistakes before considering accountability. Edmondson's "Spectrum of Reasons for Failure" provides a structured approach for distinguishing between process failures, capability gaps, human error and deliberate non-compliance.

The approach supports learning, continuous improvement and fair accountability. It supplements and does not replace the council's corporate policies. Matters involving significant financial loss, material failures, fraud, misconduct or reputational risk will be escalated through the appropriate governance arrangements.

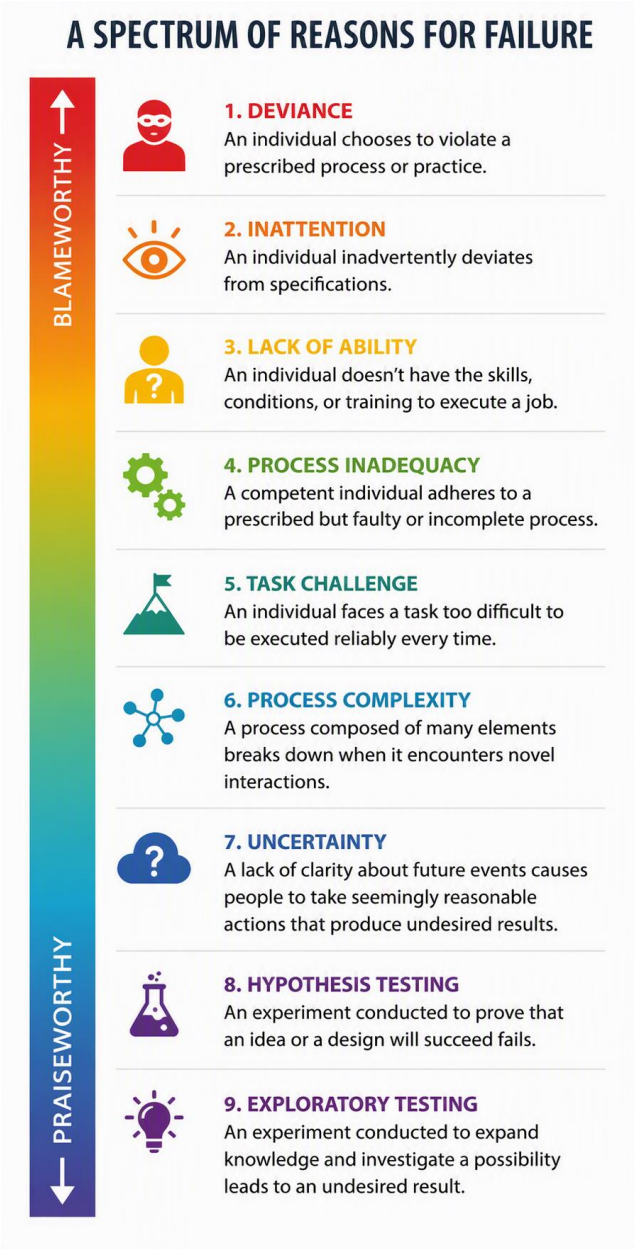
Core Principle

> The purpose of an investigation is to understand and learn before applying accountability.

Most errors arise from process weaknesses, complexity, training gaps, workload pressures, or uncertainty rather than deliberate misconduct. We should focus first on understanding the cause of failure before considering individual accountability.

2. Spectrum of Failure

Failures exist on a spectrum ranging from blameworthy actions such as deliberate deviation from agreed procedures, through to valuable learning generated from experimentation and innovation. We should determine where on the spectrum failure sits before deciding the appropriate response.



3. Investigation Process

A four-stage response will be used to investigate errors:

Stage 1 – Define the error

What happened?

- Description
- Date
- Discovery Date
- People Involved

What was the Impact?

- Financial
- Customer
- Reputational
- Operational

Stage 2 – Gather Evidence

Consider:

- Procedures
- Training Records
- Case records
- System Logs
- Witness Accounts
- Previous Incidents
- Potential points of failure within the process.

Stage 3 – Identifying Contributing Factors

Process

- Was there a process?
- Was it clear?
- Was it accessible?
- Was it current?

Training

- Was training provided?
- Was competence assessed?

Workload

- Was workload reasonable?
- Were deadlines achievable?

- Were the temporary or permanent pressures on workload?

Systems

- Did technology or ICT systems contribute?
- Were controls effective?

Behaviour

- Did the employee intend to follow the process?
- Was the deviation deliberate?

Stage 4 – Identify the Root Cause

We will identify underlying causes of the error rather that immediate outcomes and consider how the primary cause relates to the “spectrum of failure”.

4. Decision Guide

Where possible errors will be categorised against the spectrum of failure, and the table below outlines the typical management responses will be considered.

Failure Type	Typical Response
Deviance	Formal Management Review
Inattention	Coaching and Support for employee
Lack of Ability	Training and Development
Process Inadequacy	Redesign the process
Task Challenge	Simplification of the work
Process Complexity	Review of the system
Uncertainty	Review learning
Hypothesis Testing	Capture learning
Exploratory Testing	Capture learning

Significant errors will be referred to the appropriate management team and, where necessary, relevant corporate governance arrangements.

5. Fairness Test

Before any formal management action is taken, we will consider:

1. Was there a clearly documented process?
2. Was training and support adequate?
3. Would another competent employee have made the same mistakes in similar circumstances?
4. Was the action deliberate, reckless or dishonest?

If the answer to questions 1 to 3 indicates issues with processes, procedures, training, support, workload or controls then system improvements should normally be considered before individual accountability measures.

6. Investigation Outcome

A record of investigations will be completed and document

- Summary of Error
- Investigation notes
- Root cause
- Failure category
- Fairness Test outcome
- Immediate corrective action
- Long-Term Improvement Action
- Action Owner
- Review Date

7. Learning Log

A learnings log will record the outcome from investigations; this will allow for recuring themes to be identified and the service to identify:

- Unclear procedures
- Excessive workloads
- Training gaps
- System weaknesses

Date	Issue	Failure Type	Lessons Learned	Action Taken