

Seeing the bigger picture

Paul Davison discusses the benefits of learning reviews for understanding adverse events

In many organisations, investigations into adverse events still concentrate on the final minutes or seconds before something went wrong. Yet those of us working in safety and human factors know the real story almost never begins at the moment of impact. It begins weeks, months, years and even decades earlier.

Safety is best understood not as a technical puzzle to be solved once and for all but as an open-ended challenge that's dynamic, relational and constantly evolving.

Learning reviews (LRs) offer an approach that matches this complexity. An LR is a structured, conversation-based inquiry that explores the full temporal story of an event, seeking to understand influencing system factors and why people's actions made sense at the time, rather than who's to blame for the events.

By combining temporal awareness with trauma-informed practice, LRs enable organisations to learn earlier, listen deeper and create safer conditions for the people who keep their systems moving.

Rising to the challenge

Safety is a form of 'wicked' problem with no clear beginning, no linear path to resolution and no single cause. While conceptually accurate, the term can feel abstract and inaccessible to practitioners who simply want to do safety well.

Describing safety instead as an 'open-ended challenge' makes the idea more usable. Open-ended challenges are those that evolve continuously and can't be permanently 'fixed'. They are dynamic and require constant attention, curiosity and humility.

LRs are expressly designed for this terrain. They widen the investigative lens, lengthen the timeline and help organisations understand the broader constellation of influences that shape work.

Conventional investigations are not inherently wrong. But by concentrating on what happened immediately before the event, they can obscure the slow build-up of pressures, adaptations and misunderstandings that shaped the path to the outcome. This can make complex systemic issues appear deceptively simple.

The result is often a narrative that feels neat but incomplete. They also result in individuals becoming the focus, with those involved potentially experiencing moral injury or fear, making them and others reluctant to share openly in future.

LRs approach events differently. Instead of starting with the outcome and working their way backwards, they begin with context, the environment in which the work took place, the cues people saw, the options they perceived as available and the pressures they were under.

They explore the long arc of an event's development. They consider staffing levels, shifts in informal practice, design constraints, training history, local culture, communications, equipment condition and the meanings that people constructed from the factors around them. They view performance not as isolated acts but as situated adaptations.

The reviewer's aim is not to judge, but to understand. The central question becomes: "Why did this make sense, what made this course of action reasonable, possible or necessary at the time?"

This shift moves organisations from criticising decisions to examining the conditions that shaped them.

Trust and support

Adverse events are rarely only operational. They are human experiences that can leave emotional traces and people may be deeply traumatised. Trauma doesn't always manifest immediately; it can unfold subtly through worry, rumination or a feeling of dread about the investigation and future events.

A trauma-informed LR recognises this continuum. It doesn't turn safety reviews into therapy, nor does it medicalise



normal reactions. Instead, it deliberately designs the process so it doesn't create further harm. This means providing clear information beforehand, allowing time for emotional settling, using language that avoids blame and facilitating conversations with care and respect. In practice, this approach improves the accuracy of recall, strengthens trust and generates richer insights.

An LR typically involves facilitated conversations with those closest to the work, supported by timelines, diagrams, operational data and narrative summaries. Reviewers ask open questions such as, "How did the situation look from where you were?" These questions help uncover not only what people did, but how they made sense of their surroundings.

The outputs of an LR are not lists of errors but stories of how work unfolded, why it unfolded that way and what system-level adjustments could make future work easier, safer and more resilient.

Support for participants begins before the review itself. People are briefed clearly on its purpose and assured that the aim is understanding, not judgement. During the review, the environment is kept psychologically safe, the pace is steady and the tone is compassionate. Afterward, reviewers check in, share progress and acknowledge the contribution individuals made. The participants are part of the solution.

This continuity reinforces trust and ensures that the review becomes part of people's recovery rather than another source of stress.

Seeing the benefits

By looking across time rather than focusing only on the moment of the event, organisations uncover opportunities for meaningful improvement. In rail, temporal insight has led to safer station flooring materials, redesigned electrical isolation procedures, more effective driver communications, better evacuation protocols and

more realistic approaches to fatigue and workload.

Just as importantly, LRs improve relationships. When people see the organisation is interested in understanding context, they speak up earlier and more freely. Psychological safety grows and, with it, the quality of learning.

LRs become a bridge between leaders and the frontline, between work-as-imagined and work-as-done, between procedural expectations and lived experience.

Seeing safety as an open-ended challenge invites a different mindset. It encourages organisations to stay curious, to listen closely to those who do the work, and to remain humble in the face of complexity. Safety becomes not a destination but a relationship.

LRs offer a way to nurture that relationship. They help organisations understand not only what happened, but also why it made sense at the time and what needs to change so people can succeed under their real-world conditions.

If we continue to treat safety as a puzzle to be solved through root causes, we will limit our learning and delay the implementation of that learning.

LRs give us a way to listen earlier, deeper and more humanely. They enable us to design our learning processes with the same care we devote to designing work itself. And when we do that, safety becomes not just a number to improve, but a commitment to honour. ■

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Case study

At a large urban railway station, a passenger suffered a serious fall on a wet platform. A conventional investigation initially focused on footwear, surface contamination and the individual's behaviour. But a learning review uncovered a more revealing story.

Over several months, the station's cleaning contractor had changed products and schedules in response to budget pressures. The new cleaning solution left a barely perceptible residue when used in cold weather. Staff had noticed a slight 'slickness',

but as workloads grew, informal reporting diminished. Meanwhile, a marketing initiative required a visually spotless concourse, prompting teams to prioritise appearance over surface drying time.

By tracing these small adjustments across weeks rather than hours, the LR revealed a system gradually drifting into vulnerability. The outcome wasn't a reminder for people to 'take more care', but a redesign of cleaning protocols, a revision to procurement criteria, improved contractor communication and clearer environmental monitoring.



About the author

Paul Davison is co-founder of human-centred performance group PPWD.