

THE ANALYSIS OF A 112-HELPLINE FAILURE, THE COTHINK APPROACH



Interview Ron Vonk

When the 112-emergency number was out of order June 24, 2019, it was clear to everyone how dependent we have become on complex digital systems. Systems make it easier for us. But if it goes wrong, they are also difficult to understand. How do you handle such a comprehensive analysis? CoThink founder Ron Vonk facilitated this for KPN and explains how he did it.

WHAT MADE THE ANALYSIS OF THE 112-OUTAGE DIFFERENT THAN USUAL?

"As a trainer and facilitator of faults and root cause analyzes, I have been facilitating the analysis of national telecom and energy failures for years. This was especially because of the impact, a case apart. The approach to the analysis is the same as in a smaller incident. I use the same methods, ask the same questions and let the process run its course. The difference, in my view, is mainly in the huge social consequences. In a smaller scale problem, the analysis can be technically very challenging and have a major impact on the customer in terms of cost or customer satisfaction. This one involves human lives. That gives us a different dynamic."

WHAT WERE THE BIGGEST CHALLENGES?

"The 112-outage analysis was carried out there are many topics, many events and several parties involved. And with that, a lot of information to unbraiding. That was quite a job. This type of analysis is not just about technical failure, but also about the effect, process and communication during the incident."

'IN THE ANALYSIS OF THIS 112-HELPLINE OUTAGE, THERE WERE A LOT OF TOPICS, MANY EVENTS AND DIFFERENT PARTIES INVOLVED. AND WITH IT, LOTS OF INFORMATION TO UNBRAIDED. THAT WAS QUITE A JOB.'

Technology, [impact](#), [process](#) and [communication](#) are closely linked and intertwined. During the analysis it is important to untangle this and combine it again in a transparent way. For example, a technical failure may not have been detected in time, due to a procedure not being followed properly. Or there has not been properly communicated. One is not separate from the other. In addition, large national incidents always involve many more parties. This means that you will facilitate in groups of 25 to 30 people. That is, of course, more challenging than when it comes to one group of 4 substantive experts.

In practice, this means that you need multiple sessions to gather the input of different experts on all these topics. In addition, you need to distinguish the causality (cause-effect chain) from chronology (follow-up of problems, actions, decisions, etc.). For this we apply our [RATIO Event Mapping method](#). The added value of this methodology is that we always investigate cause-effect with questions like: "Does this cause always automatically lead to this consequence? What circumstance was needed or contributed to this? What should have prevented this? What else? Every time it is surprising how much insights and improvements this delivers."

ALL EXPERTS WITH DIFFERENT EXPERIENCE, REFERENCE FRAMEWORKS AND KNOWLEDGE, WORK TOGETHER TO GET THE MOST CONCRETE AND SPECIFIC INFORMATION. THIS WILL CREATE A DIRECT CONSENSUS AMONG THE PARTIES



HOW DID YOU DEAL WITH DEFINING THE SCOPE?

"If you have an event of incident with national consequences, you can easily lose yourself in the details. Up to the consequences for the individual citizen. It is more efficient to keep the objectives in mind. In an incident like this, there are normally three goals, you want to know what the consequences are for society; the [security](#), [costs](#) and [image](#). You want to take measures to manage the consequences. Finally, it is essential to analyze the chain of cause and effect. Problem owner KPN will not recognize much added value in an analysis with many details about the consequences.

The seriousness of the situation was clear to everyone. In addition, KPN was only able to take temporary, mitigating and preventive measures to a limited extent because they did not have an influence on everything. In the case of the 112 fault, for example, the failure to send a proper NL-Alert was with another party. This too gives limits to the scope."

AS A FACILITATOR, HOW DO YOU ENSURE THAT ALL PARTIES INVOLVED ARE HEARD?

"With our approach we bring all content experts together in one session and we do the analysis as a group. This is much more efficient and effective than conducting individual interviews. All experts with diverse experience, reference frameworks and knowledge, work together to get the most concrete and specific information available. In doing so, we immediately create [consensus](#)

among those involved. To monitor this constantly, I make sure that there is attention to communicating everyone's role. You do that by personal attention. From the table setup to name plates and the active way of facilitation. I don't believe you're very successful if you're sitting at the table behind a laptop. That is why we always facilitate standing and walking. This will help enormously in guiding group dynamics. In addition, we [visualize](#) all the information on flipcharts and special large Event Map post-its. The participants thus have a continuous overview of the content and status of the analysis. This helps focus and collaborate during these sessions. We also present a complete visual representation of the analysis in an Event Map. Visualization makes it much easier to understand what happened exactly than a text written in a bulky report."

GROUP SESSIONS CAN ALSO CAUSE STRESS IN PARTICIPANTS. WHAT ROLE DOES EMOTION PLAY IN THIS KINDS OF EVALUATIONS UNDER TIME PRESSURE?

"Of course, that danger is always lurking. Before you know, you have a situation of 'blaming and shaming'. Or people don't dare to speak out because they are afraid of the consequences. Our whole approach and methodology therefore rests on [creating safety and focusing on facts](#). This means, that there is no attention to opinions, assumptions or questions of guilt.

My experience is that experts in a safe environment, with a facilitator who plays his role well, are very happy to participate actively, honestly and openly in a session. It is always very nice to hear, after a session has ended, that participants are surprised at what they have all heard and how much they have learned from their colleagues from other disciplines. Organizations don't see for nothing, like Alliander and TenneT, these kinds of evaluations are disguised training."

WHAT IS YOUR ADVICE FOR OTHER FACILITATORS WHO WANT TO BE WELL PREPARED FOR EVALUATIONS OF INCIDENTS WITH NATIONAL IMPACT?

"As far as I am concerned, that is mainly to gain as much experience as possible. There's a rule of thumb that you're only really proficient in anything after practicing it for 10,000 hours. I last calculated it for myself and came about 17,000 hours.

It is a pity when trained facilitators wait to use the [RATIO](#) methods and skills until there is a major incident, because then the practice suddenly turns out to be quite difficult. Skilled you become by practicing a lot and the smaller incidents and problems are especially suitable for that. This way you build your confidence until it no longer matters how complex the problem is. You will then rely entirely on the methods and your skills and you know that you can always get the most out of the information and the team. It also helps to ask for feedback.

At CoThink you get [lifetime support](#). That is also in our interest. The success of internal facilitators among our customers ultimately also radiates to us."

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