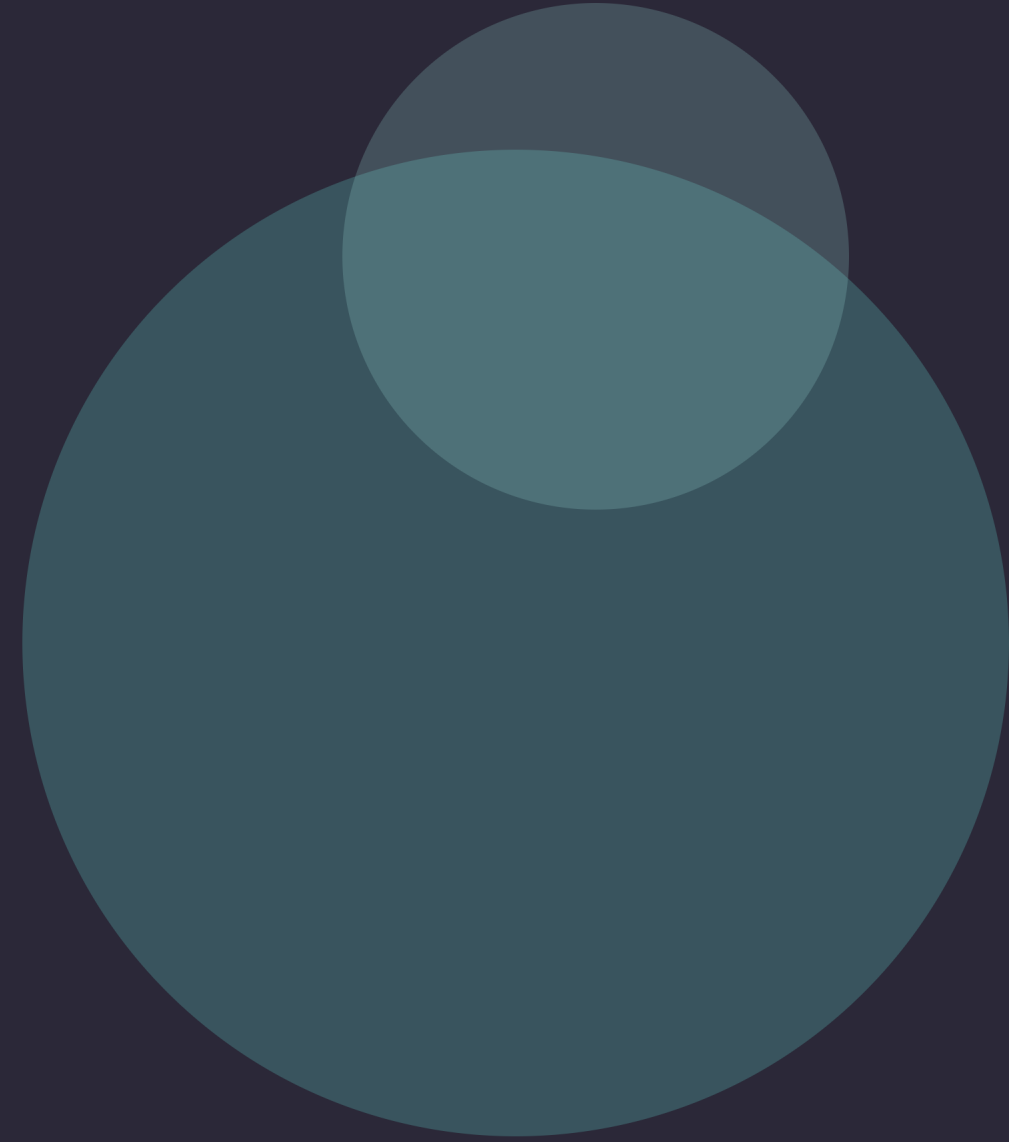


COMPLIANCE INVESTIGATIONS

Beyond Blame

Root-cause analysis in compliance investigations

Jaime McNair-Benn



Finding "who" is where an investigation starts. Finding "why" is where it pays off.

If we only fix the person, the system will continue to produce the problem.



THE SHIFT

Two questions, two different investigations

	Who did it?	Why did it happen?
Focus	The individual and their conduct	The conditions, systems, and incentives around them
Typical output	A finding and a discipline decision	Findings plus corrective actions
What happens next	The issue often returns with a new person	This underlying issue was not addressed

Root-cause analysis doesn't replace accountability. It makes sure accountability isn't the only outcome.

Just Culture sorts behavior into three kinds

TYPE 1

Human error

An inadvertent slip, lapse, or mistake.

Response: Console, and fix the system

TYPE 2

At-risk behavior

A choice where the risk wasn't recognized or seemed justified, often a shortcut that became normal.

Response: Coach, and remove the reason for the shortcut

TYPE 3

Reckless behavior

Conscious disregard of a substantial and unjustifiable risk.

Response: Hold accountable, including discipline

HUMAN FACTORS

People work inside systems that shape their choices



Unclear policy

Rules people can't find, read, or apply.



Time pressure

Deadlines that reward speed over steps.



Training gaps

People never taught the process, or taught it once.



Workaround tools

Systems that make the wrong way easier.



Mixed incentives

Goals that quietly reward the shortcut.

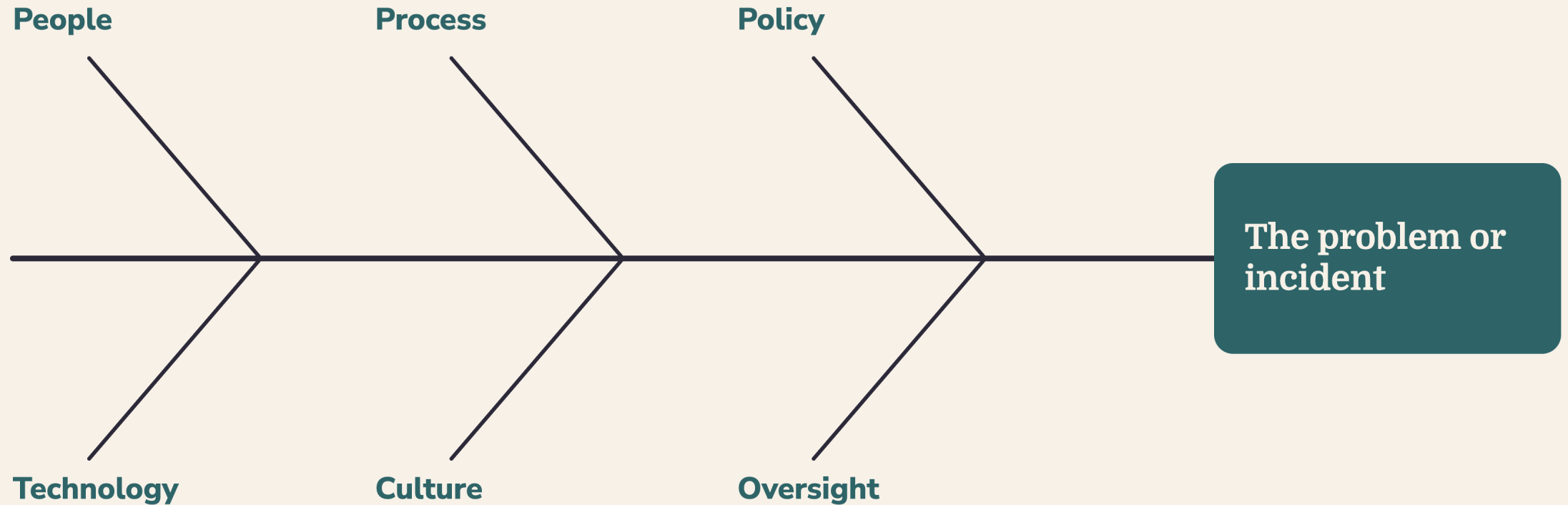


Shortcut habits

"That's how we've always done it."

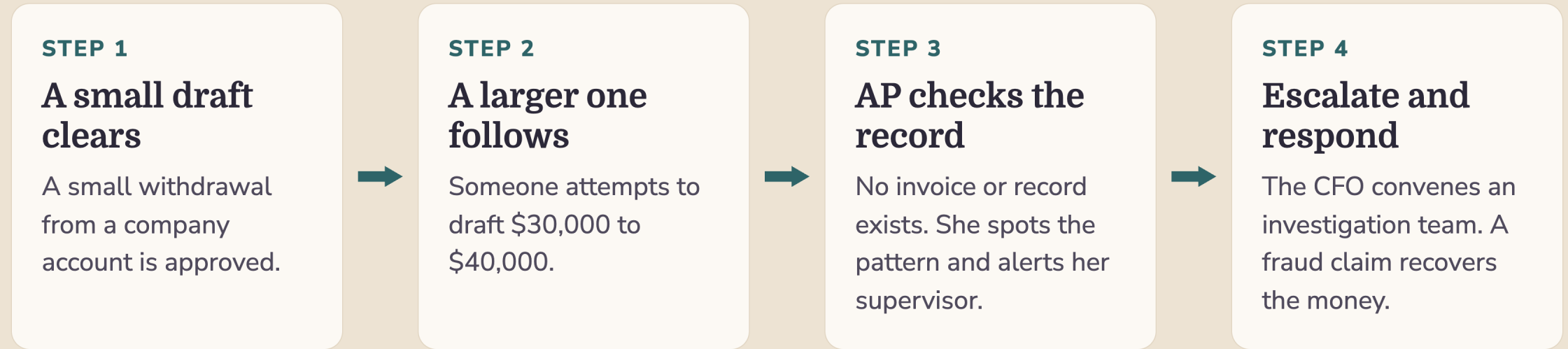
FISHBONE (ISHIKAWA)

The fishbone maps causes before anyone assigns blame



CASE STUDY, PART 1

An unauthorized draft, caught in time



Pause: where would you start looking for the cause?

CASE STUDY, PART 2

The cause was outside the building

HELD

People

AP noticed the pattern, checked for an invoice, and escalated.

HELD

Process

Invoice matching and the escalation path to the CFO worked.

HELD

Policy

The team quickly named a lead and the parties to involve.

ROOT CAUSE

Technology

A third party's system was hacked, exposing account access.

HELD

Culture

An AP specialist felt able to raise the alarm, and did.

CONFIRMED

Oversight

Protocols were re-reviewed and confirmed. The third party was alerted.

Build a fishbone for this scenario

SCENARIO

For the third quarter in a row, one department approved expense reports with no receipts attached. Each time, a different manager signed off.

STEP 1

Map it

Add at least one possible cause under each of the six categories.

STEP 2

Sort it

Label each cause: human error, at-risk behavior, or reckless.

STEP 3

Pick one

Choose the cause that, if fixed, would prevent the most recurrence.

ACCOUNTABILITY

Accountability without blame starts with one test

THE SUBSTITUTION TEST

Would another person with similar training and experience, in the same situation, likely have made the same choice?

LIKELY SYSTEMIC

If yes

Look hard at the system. Discipline alone won't prevent the next one.

LIKELY INDIVIDUAL

If no

Look at individual accountability, and still fix any system gaps you found.

CORRECTIVE ACTION

Stronger fixes change the system, not just the memo

Weaker

Reminder emails, one-time retraining, new warning language.

Moderate

Checklists, standard templates, added review steps, closer supervision.

Stronger

Redesigned workflows, system controls that block the error, removed conflicting incentives.

Every action gets an owner, a deadline, and a way to test whether it worked.

TAKEAWAYS

What to take back to your team

- 1 Ask why at least as hard as you ask who.
- 2 Sort the behavior before you choose the response.
- 3 Map causes across people, process, policy, technology, culture, and oversight.
- 4 Choose fixes that change the system, then check that they worked.

Thank you

Questions, stories, and conversation welcome.

Jaime McNair-Benn

