THE WORKSHOP

Blameless Post-Mortems

Run a 90-minute structured meeting that converts an incident into two or three concrete, owned, dated structural fixes — without scapegoating the people involved.

DURATION

90

min

GROUP SIZE

—

people

WHAT YOU BRING

A whiteboard with sticky notes (or a Miro board), and a rough timeline drafted by the on-call engineer from logs and the incident channel.

WHAT YOU LEAVE WITH

- An agreed chronological timeline of the incident
- A structural root cause reached via 5 Whys
- Two or three actions, each with a named owner and date
- A one-page write-up plus a row in the incident log

WHO TO INVITE

- **On-call engineer.** Diagnosed the incident; leads the timeline reconstruction from logs, monitoring, and the incident channel.
- **Developer who shipped the change.** Provides first-hand context on what was deployed and what assumptions were in play at the time.
- **Affected-team representative.** Speaks for any other squad whose system or customers were impacted by the incident.
- **Manager or tech lead.** Brings authority to commit to action items and ensure they get prioritised against other work.
- **Facilitator.** Someone with enough distance from the incident to keep asking why and to redirect blame back to systemic factors.

USE WHEN

An incident reached customers, even briefly

A deployment caused unexpected downtime or behaviour

A near-miss would have been serious under different timing

The same kind of issue has appeared more than once

AVOID WHEN

For every minor bug fix — post-mortem fatigue is real

During the incident itself — use the incident channel

More than 48 hours after the event, when memory has faded

A status debrief is what's actually needed, not a root-cause review

How the session runs

Phase 1 — Set the room (5 min)

Read the Prime Directive aloud as a contract, not a ritual. State the three deliverables — timeline, root cause, two-or-three actions — and license everyone to call out blame, including the facilitator.

Phase 2 — Timeline (15-25 min)

Draw a horizontal line on the whiteboard and walk through events chronologically with the on-call engineer leading. Capture facts and signals on two colours of sticky; park interpretation questions for later.

Phase 3 — Root cause (20-30 min)

Run 5 Whys from the observable failure down to something structural. Stop only when the answer points to engineering work, not to a memo asking people to be more careful.

Phase 4 — Contributing factors (10 min)

List everything that made the incident worse, harder to detect, or harder to fix — missing alerts, stale runbooks, reasonable assumptions. Treat assumptions as evidence the system failed to inform, not as faults.

Phase 5 — Actions (15 min)

Brainstorm fixes on stickies, force-rank by impact, and pick two or three. Each gets a named person and a real date; close by reading them aloud while owners say yes.