

# THE BLAMELESS CLOUD: BRINGING ACTIONABLE RETROSPECTIVES TO SALESFORCE

KEVINA FINN-BRAUN  
SALESFORCE

J. PAUL REED  
RELEASE ENGINEERING APPROACHES

DEVOPS ENTERPRISE SUMMIT, 2015



# KEVINA FINN-BRAUN

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- Director of Site Reliability Service Management at [Salesforce](#)
- Business Continuity at [Yahoo](#)
- Geeks out on [Group Dynamics](#) and [Behavior](#)
- [@kfinnbraun](#) on 
- Prepping for the [zombie apocalypse](#)



# J. PAUL REED

- [@jpaulreed](https://twitter.com/jpaulreed) on 
- Host of The Ship Show,  
[@shipshowpodcast](https://twitter.com/shipshowpodcast) on 
- Principal Consultant, Release Engineering Approaches
- Spend my days talking to organizations about “The DevOps™”



# “SITE RELIABILITY” AT SALESFORCE

- Primary operational team supporting availability
- Acceptance and validation activities
- Develop and implement operational improvements for SFDC
- “Game days”



# SERVICE RELIABILITY HURDLES AT SFDC

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- Inconsistent application of process, leading to inconsistent information collection
- Incident handling/remediation crossing silo boundaries
- Confusion over service ownership, due to restructured responsibilities
- Disjointed, “heavyweight” meetings
- Postmortems centered around “The Old View” of human error

# LANGUAGE OF THE “OLD VIEW”

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- “5 whys”
- “Root cause” analysis
- “Why didn’t you[r team]...”
- “You[r team] should have...”
- “Best practices”



# INCIDENTS LEAD TO POST MORTEMS

- Invoke the space: we are here to learn, not to blame
- Describe the incident
- Establish the timeline
- Identify contributing factors
- Describe customer impact
- Describe remediation tasks
- Describe improvement tasks for response process

# THE TIMELINE

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- October 2014: First Meeting
- January 2015: “Blow up” HA Forum
- April 2015: Status Check, including assessment shared with senior leaders
- May 2015: Service ownership roles shift



# THE TIMELINE

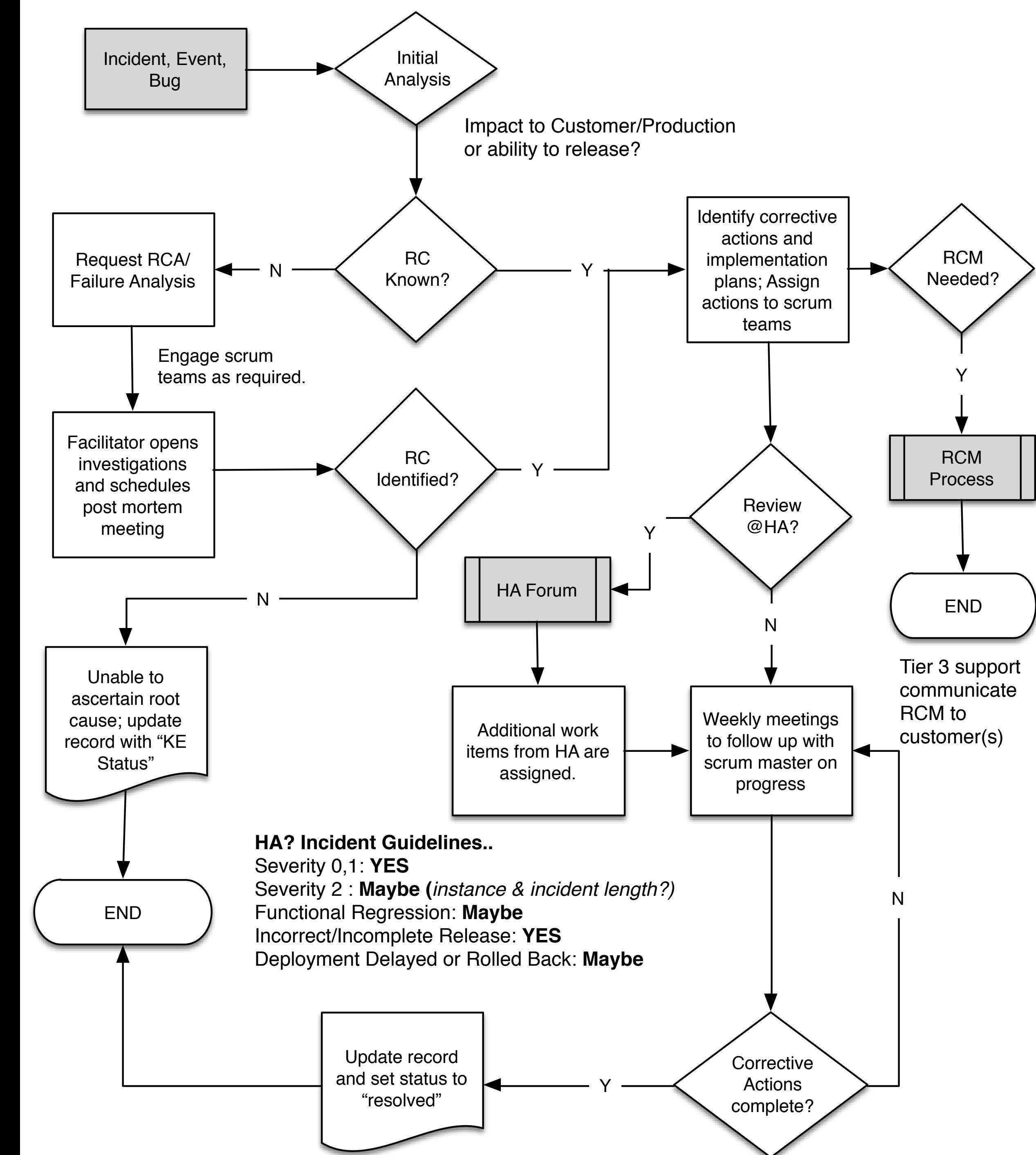
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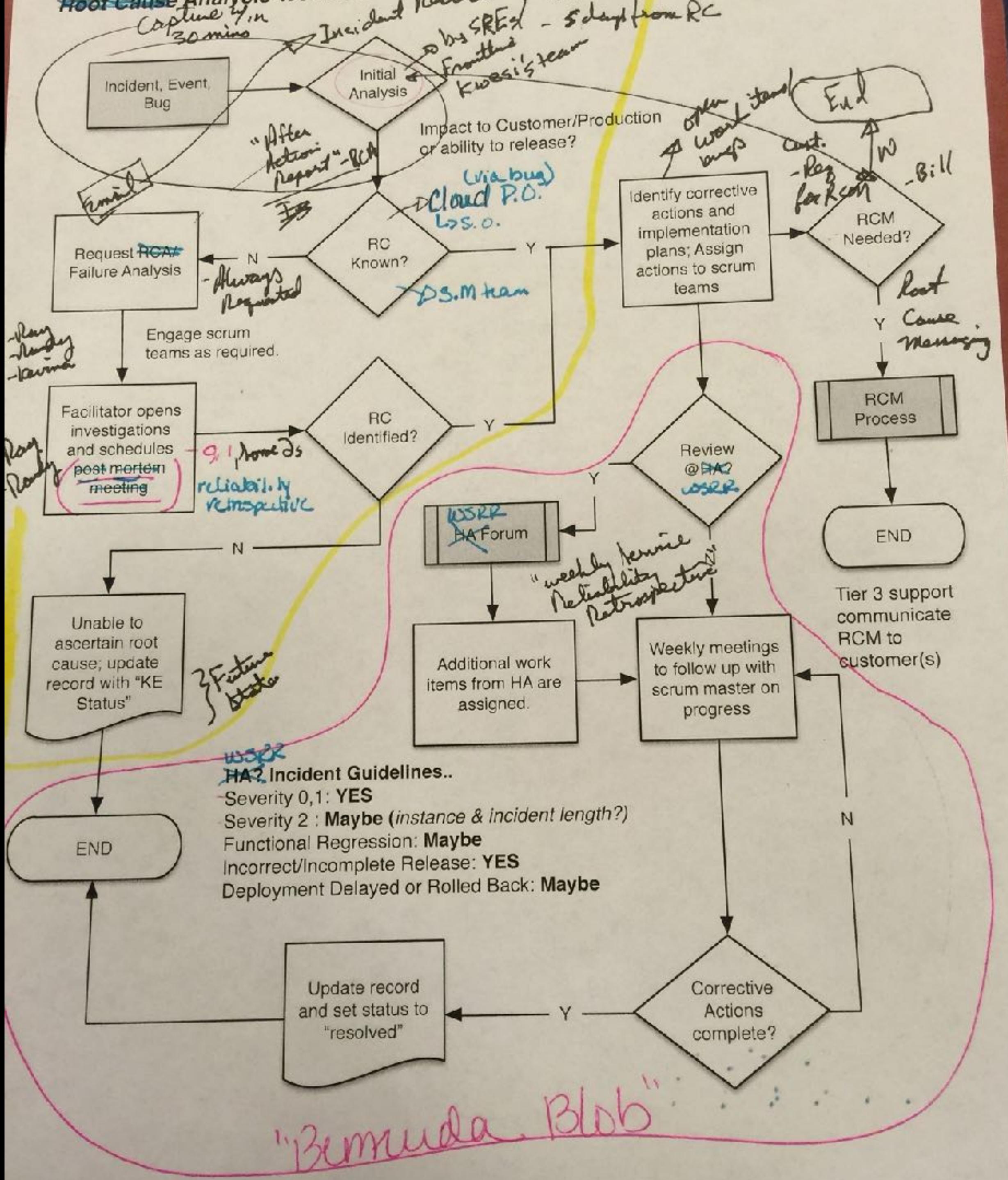
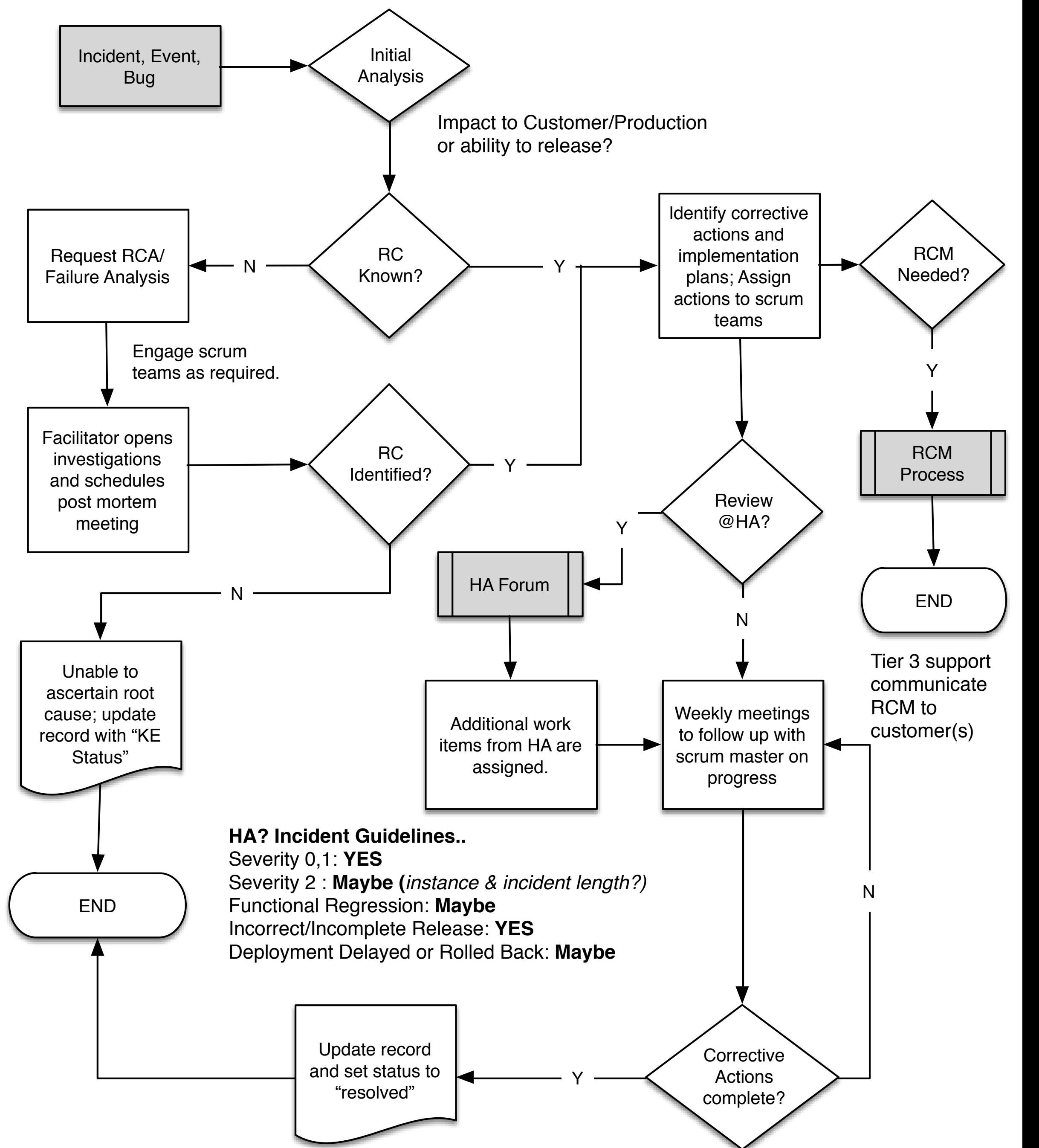
- October 2014: First Meeting
- January 2015: “Blow up” HA Forum
- April 2015: Status Check, including assessment shared with senior leaders
- May 2015: Service ownership roles shift
- July 2015: Initial Workshop on “The New View”
- August 2015: Identified first group for coaching
- August 2015 — today: Continued focus and deep-dive on WSRR
- August 2015 — today: Weekly sessions with the initial group



# ROOT CAUSE ANALYSIS WORKFLOW

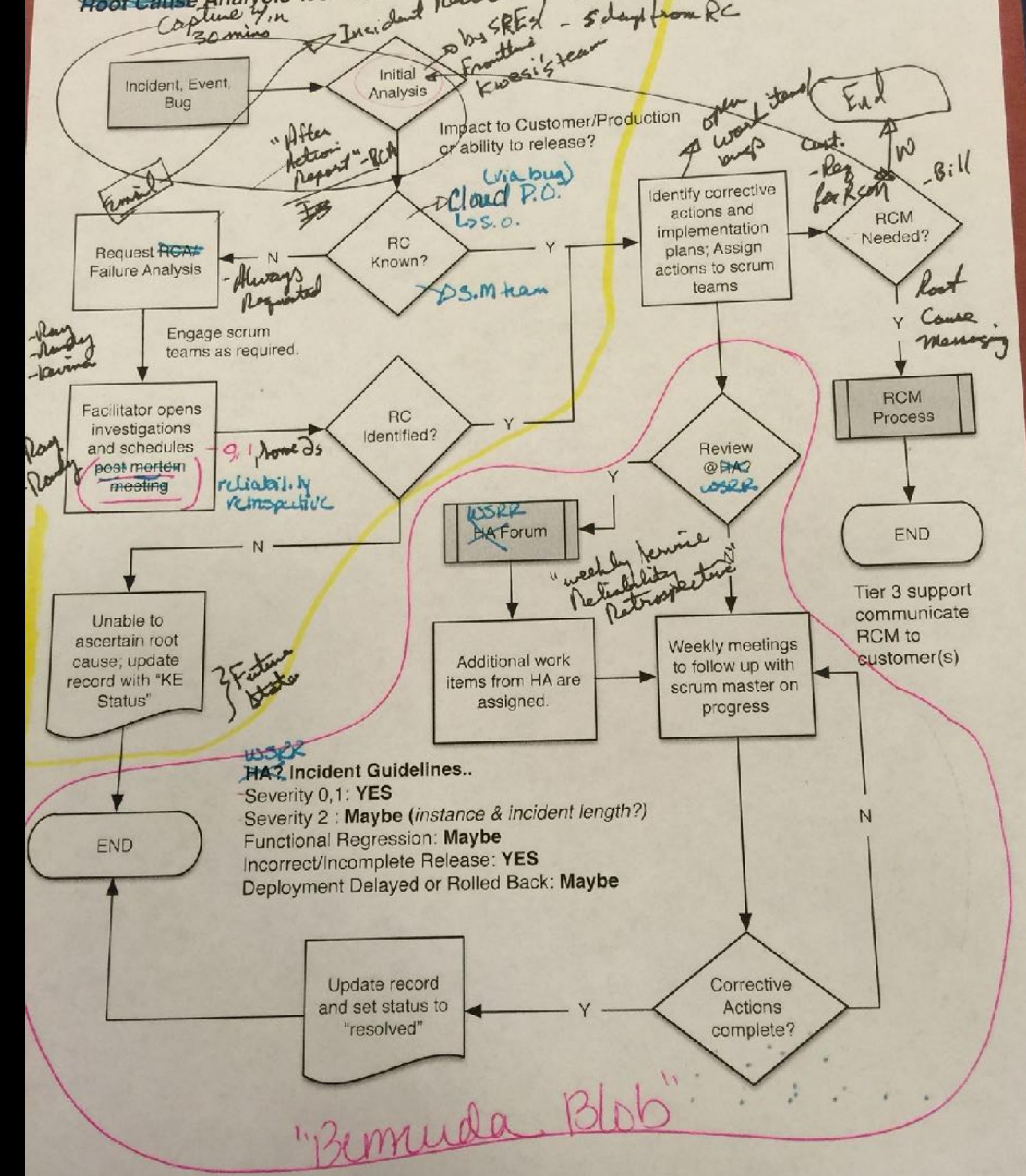
- Designed & implemented two years ago
- Anchored the process around the weekly “HA Forum”
- Intended to apply to all incidents...
- In practice, focused on high profile incidents





# ROOT CAUSE ANALYSIS WORKFLOW IN REALITY

- Silo transition boundaries **evident** in the workflow
- Some had little/no contact, via the process, with other teams **required** to perform their job
- Sampling of incident reports uncovered **consistent** inconsistencies
- The “Bermuda Blob”



# GETTING A FEEL FOR THE WEATHER

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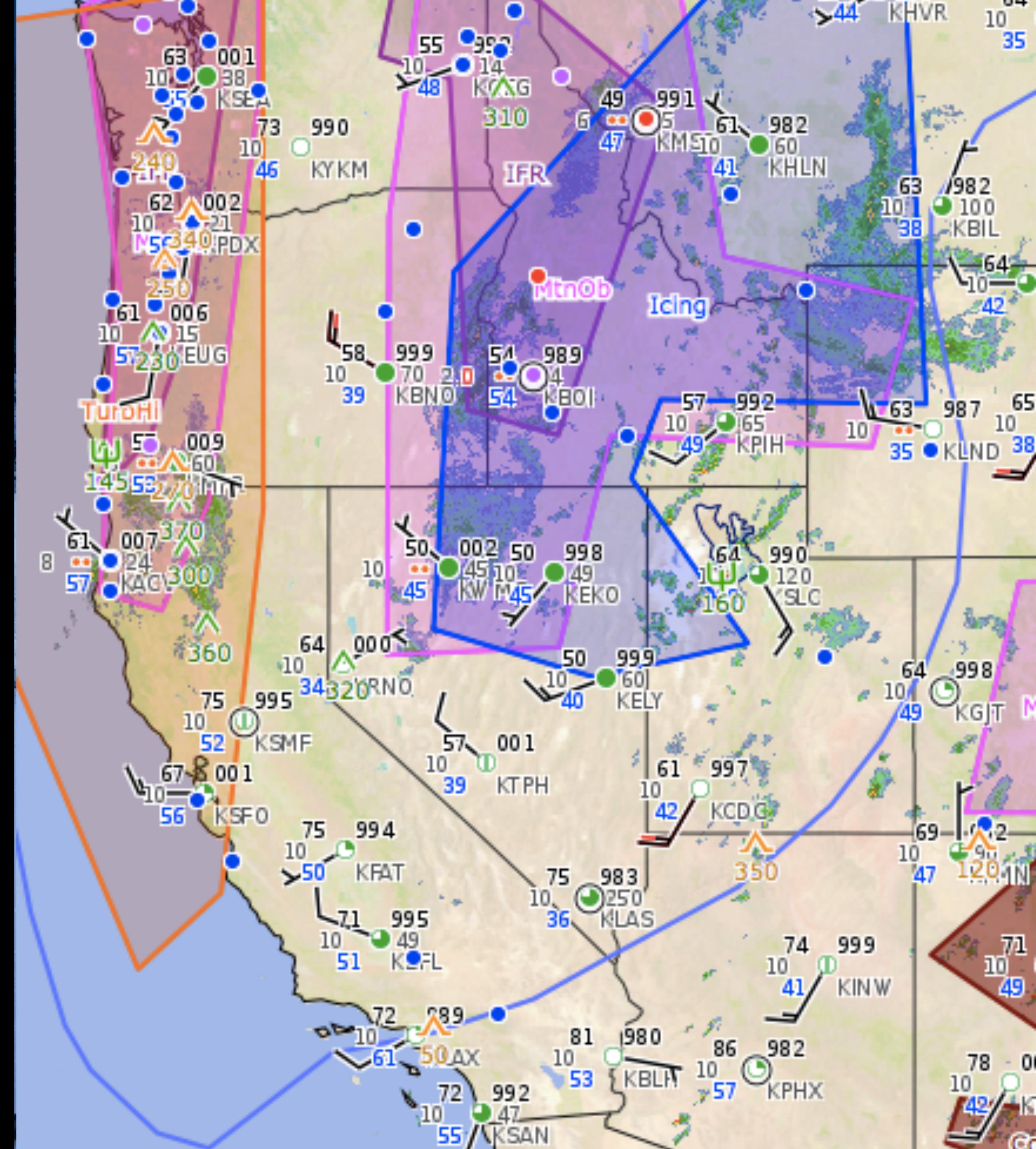


# HEADFIRST INTO THE STORM

A wide-angle photograph of a massive, dark, and turbulent storm system. The base of the clouds is a deep, saturated teal or turquoise color, transitioning upwards through various shades of grey and brown. The clouds are thick and billowing, filling most of the upper two-thirds of the frame. In the foreground, there's a flat, open landscape with a mix of green and yellow grass. A single, thin, paved road edge is visible on the far left. The horizon line is relatively flat, emphasizing the scale of the storm.

# LANGUAGE: MATTERS

- “HA Forum” → “WSRR”
  - “WAR” (What is it good for?)
  - Postmortem versus Retrospective
  - Problem Team versus Solution Team
  - Root Cause versus Proximate Cause



# BEHAVIOR: MATTERS

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- Intra-team behavior
- Inter-team behavior
- This is *not* “#NAFB”
- “People in complex systems create safety. ... The occasional human contribution to failure occurs because complex systems **need** an **overwhelming human contribution** for safety.” — Sydney Dekker



# STRUCTURE: MATTERS

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# STRUCTURE: MATTERS

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# “BLAMELESS” “POSTMORTEMS”?

- Brené Brown, research sociologist, on vulnerability
- “Blame is a way to discharge pain and discomfort”
- Postmortem has a heavy connotation
- “Awesome postmortems?” Really?!



*Behaviors*

*Language*

Novice

Beginner

Competent

Proficient

Expert



## Language

"Incidents are bad;  
my job is on the line"

"I'm getting sent to **the principal's office** because of this outage"

## Behaviors

Novice

Beginner

Competent

Proficient

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Completes  
the  
post-incident  
"paperwork"

No formal retrospective/  
**hallway retrospectives**

# Language

"Incidents are bad;  
my job is on the line"

"Let's fix this as  
**fast as possible**"

"I'm getting sent to **the principal's office** because of this outage"

"What's the correct fix to **avoid this specific issue** in the future?"

## Novice

Completes the post-incident "paperwork"

No formal retrospective/  
**hallway retrospectives**

## Beginner

Jump to a **focus on why**

Some **information** (**inconsistently**) **recorded**

## Competent

## Proficient

## Expert

# Behaviors



No formal retrospective/  
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## Language

"Incidents are bad;  
my job is on the line"

"I'm getting sent to **the principal's office** because of this outage"

"We need to find the **root cause** of this incident"

"Let's fix this as **fast as possible**"

"What's the correct fix to **avoid this specific issue** in the future?"

"Let's review the **timeline/incident report** to answer that"

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Jump to a **focus on why**

Have and incorporate **complete dataset** for the incident into the retrospective

## Competent

Follows the **prescribed format** for retrospectives

## Proficient

## Expert

## Behaviors

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"Let's review the **timeline/incident report** to answer that"

"How did these **multiple factors** influence our complex system?"

## Competent

Follows the **prescribed format** for retrospectives

Have and incorporate a **complete dataset** for the incident into the retrospective

Perspectives solicited from **all involved team members**/functional groups

"Now that we've established what happened,  
**how did it happen?**"

## Proficient

Identifies **inherent bias** in self and others

## Expert



## Behaviors

## Language

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### Competent

Identifies **inherent bias** in self and others

"Let's review the **timeline/incident report** to answer that"

"How did these **multiple factors** influence our complex system?

### Proficient

Retrospective outcomes are **fed back into the system** and prioritized

Able to facilitate retrospectives by **healthily helping others address**

**tendency to blame/ personal & systemic bias**

"We need to find the **root cause** of this incident"

"Now that we've established what happened, **how did it happen?**"

"What can we incorporate from this incident to **better respond next time?**"

"How does our team/system contribute to our **successes?**"

### Expert

RETROSPECTIVES FACILITATE THE  
SERVICE (AND DEVELOPMENT!)  
IMPROVEMENT PROCESS

BEING "TOO BUSY" TO LEARN  
OR IMPROVE MEANS YOU ARE IN  
A DOWNWARD SPIRAL,  
*BY DEFINITION*

IT'S NOT ABOUT THE OUTCOME.  
IT'S ABOUT THE RESPONSE.

WHY + HOW  
IS MORE IMPORTANT THAN  
WHAT

YOU ARE NEVER DONE.

YOU. ARE. NEVER. DONE.

# OUR FORECAST FOR THE FUTURE

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- Evolving the concept of Service Ownership
- Salesforce-specific Retrospective Guides
- Global “live-site” coaching
- Refocus on getting the business what it wants



## AVENUES FOR COLLABORATION

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- How does the described Dreyfus model apply in other organizations?
- Would love to hear stories from other enterprises about their retrospective process, who does them, and where they live within the organization



**Kevina Finn-Braun**

[kevina.finnbraun@salesforce.com](mailto:kevina.finnbraun@salesforce.com)

<http://lnkdin.me/kevinafinnbraun>

**J. Paul Reed**

[preed@release-approaches.com](mailto:preed@release-approaches.com)

<http://jpaulreed.com>