Process Safety Incident Root Cause Analysis Outline

1. Incident Description

- Date, Time, and Location of Incident
- Brief Summary of the Incident
- Immediate Consequences or Impacts

2. Initial Response

- Actions Taken Immediately After Incident
- Personnel Involved in Initial Response
- Emergency Measures Applied

3. Data Collection

- Gathering Available Evidence (Photos, Logs, Reports)
- Witness Statements
- Relevant Operating Data

4. Chronology of Events

- Timeline Leading Up to the Incident
- Key Actions and Decisions Noted in Sequence
- Identification of Abnormal Conditions

5. Root Cause Analysis

1. Problem Statement
2. Identification of Immediate Causes
3. Systematic Analysis (e.g., â€œ5 Whysâ€, Fishbone Diagram)
4. Identification of Underlying (Root) Causes

6. Contributing Factors

- Human Factors
- Equipment or Process Failures
- Organizational or Procedural Weaknesses

7. Corrective and Preventive Actions

- Immediate Corrective Actions Implemented
- Long-Term Preventive Measures Proposed
- Assignment of Responsibilities and Timelines

8. Lessons Learned

- Key Findings from the Investigation
- Recommendations for Organization-wide Improvement

9. Appendices

- Supporting Documents and Evidence
- Investigation Team Details
- Additional Notes