WAC 296-67-363 Incident investigation—Root cause analysis. (1) The employer must develop, implement and maintain effective written procedures for promptly investigating and reporting any incident that results in, or could reasonably have resulted in, a process safety incident.

(2) The written procedures must include an effective method for performing a thorough root cause analysis.

(3) The employer must initiate the incident investigation as promptly as possible, but no later than 48 hours following the incident. As part of the incident investigation, the employer must perform a root cause analysis.

(4) The employer must establish an incident investigation team, which at a minimum must consist of a person with expertise and experience in the process involved, a person with expertise in the employer's root cause analysis method, and a person with expertise in overseeing the investigation and analysis. If the incident involved the work of a contractor, a representative of the contractor's employees must be included on the investigation team.

(5) The incident investigation team must implement the employer's root cause analysis method to determine the initiating and underlying causes of the incident. The analysis must include identification of management system failures, including organizational and safety culture deficiencies.

(6) The incident investigation team must develop recommendations to address the findings of the root cause analysis. The recommendations must include interim measures that will prevent a recurrence or similar incident until final corrective actions can be implemented.

(7) The team must prepare a written investigation report within 90 calendar days of the incident. If the team demonstrates in writing that additional time is needed due to the complexity of the investigation, the team must prepare a status report within 90 calendar days of the incident, and every 30 calendar days thereafter until the investigation is complete. The team must prepare a final investigation report within five months of the incident.

(8) Investigation reports must include:

(a) The date and time of the incident;

(b) The date and time the investigation began;

(c) A detailed description of the incident;

(d) The factors that caused or contributed to the incident, including direct causes, indirect causes and root causes, determined through the root cause analysis;

(e) A list of any DMR(s), PHA(s), SPA(s), and HCA(s) that were reviewed as part of the investigation;

(f) Documentation of relevant findings from the review of DMR(s), PHA(s), SPA(s), and HCA(s);

(g) The incident investigation team's recommendations; and

(h) Interim measures implemented by the employer.

(9) The employer must implement all recommendations pursuant to WAC 296-67-383 Corrective action program.

(10) The employer must complete an HCA in a timely manner for all recommendations that result from the investigation of a process safety incident. The employer must append the HCA report to the investigation report.

(11) Investigation reports must be provided to and upon request, reviewed with employees whose job tasks are affected by the incident. Investigation reports must also be made available to all operating,

maintenance and other personnel, including employees of contractors where applicable, whose work assignments are within the facility where the incident occurred or whose job tasks are relevant to the incident findings. Investigation reports must be provided on request to employee representatives and, where applicable, contractor employee representatives.

(12) Any draft or finalized investigation report must be provided immediately to the labor and industries' division of occupational safety and health (DOSH) upon written request.

(13) Incident investigation reports must be retained for the life of the process.

[Statutory Authority: RCW 49.17.010, 49.17.040, 49.17.050, 49.17.060, and chapter 49.17 RCW. WSR 24-02-037, § 296-67-363, filed 12/27/23, effective 12/27/24.]