

TRAINING TITLE

INCIDENT INVESTIGATION AND ROOT CAUSE ANALYSIS

Training Duration

5 days

Training Venue and Dates

HS017	Incident Investigation and Root Cause Analysis	5	26 Feb- 1 Mar 2024	\$6,500	Madrid, Spain.
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In any of the 5-star hotels. The exact venue will be intimated once finalized.

Training Fees

\$6,500 per participant including Very useful Materials/ Handouts, Tea/Coffee, Breakfast, Snacks, Refreshments, and International Buffet Lunch.

Training Certificate

Define Management Consultancy & Training Certificate of course completion will be issued to all attendees.

TRAINING OVERVEIW

This Root Cause Analysis training course will enable delegates to remain abreast of the latest researched trends, techniques and strategies to improve the condition and performance of their operational process. This hands-on intervention will equip you with the necessary basic knowledge and skills to optimize the function, daily running, and maintenance of the five main aspects of the process.

Delegates will be exposed to and learn the core competencies required for successful problem solving and solution implementation of an effective operations process against the background of the current global economic downturn. They will complete several in-course assignments, which will enhance their problem-solving skills and which will serve as an action plan for improvement. Setting the correct priorities and doing the right thing, makes all the difference to your performance.

in this course, you will apply a process for root cause analysis, establish a culture of continuous improvement, and create a proactive environment. Learn to ask the right questions, establish triggers that drive you to the RCA process, and perform cost-benefit analysis. When you learn to practice true root cause analysis you are able to eliminate the latent roots and stop recurring failures once and for all. After this three-day course, you will be able to develop and implement an RCA program, thus leading your organization to reduced downtime, increased production and a more proactive culture

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TRAINING OBJECTIVES

By the end of this training course, participants will:

- Gain a broad understanding and appreciation of the core functional aspects of how to perform an effective Root Cause and Failure Analysis.
- Be able to review the six standard maintenance improvement tactics and their selection technique to ensure reliable process plant & equipment.
- Learn how to develop a comprehensive operational process resource and support system analysis.
- Understand the principles of an operational audit, develop your own process standard.
- Gain insight and understanding into the unique leadership and motivation principles required for technical process operation and management.

The objective of this course is to provide learners with knowledge and skill to manage incidents, with specific emphasis on the identification of the root causes and applying the RCAM (root cause analysis method), taking corrective action and implementing control measures to prevent the reoccurrence of incidents.

WHO SHOULD ATTEND

- ✓ All employees.
- ✓ Managers – Operations, Safety, and Executive
- ✓ Production Supervisors
- ✓ Training Managers
- ✓ Engineers – Process, Safety, and Mechanical
- ✓ Coordinators and Managers
- ✓ (Hazard review) Leaders and Incident Investigators

TRAINING METHODOLOGY

Delegates will learn by active participation through inspiring presentation tools and interactive program and role-playing activities, presented in a lively, enthusiastic and interesting style. Delegates will take part in topic exercises, case studies during this inclusive training program.

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A highly interactive combination of lectures and discussion sessions will be managed to maximize the amount and quality of information and knowledge transfer. The sessions will start by raising the most relevant questions and motivate everybody to find the right answers. You will also be encouraged to raise your own questions and to share in the development of the right answers using your own analysis and experiences. Tests of the multiple-choice type will be made available on a daily basis to examine the effectiveness of delivering the course.

Very useful Course Materials will be given.

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- 30% Lectures
- 30% Workshops and work presentation
- 20% Group Work & Practical Exercises
- 20% Videos & General Discussions

COURSE OUTLINE

Day 1

MODULE 1: FUNDAMENTAL CONCEPTS

- Incidents, Accidents and Near Misses
- Occupational Injury and Illness
- Incident Pyramid
- On-work and off-work incidents
- Observer, Local Area Supervisor, Witness
- Company HSE professional
- Company medical practitioner
- How small incidents turn into major incidents?
- Some major incidents in the industry
- Difference between Incident reporting and Incident Investigation report
- Other miscellaneous common refreshing discussions and Q&A to kick off.

MODULE 2: INCIDENT REPORTING

- What is Incident reporting? (i.e., notification of occurrence of an incident)
- Incident Reporting procedure (informal and formal)
- Incident Reporting formats
- Categorization of HSE incidents and assessment of risk categories
- Reportable and Recordable Occupational Injury/ Illness
- Fatality (FAT), Permanent Total Disability (PTD), Permanent Partial Disability (PPD), Lost Time Injury/Illness (LTI) Lost Time Incident (LTI)/ Lost Workday Case (LWC)/Lost Time Case (LTC)
- Medical Treatment Case (MTC) and Restricted Work Case (RWC)
- Incident Frequency and Severity Rates
- Preparation of Incident Statistics. Presentation in the Management Information System (MIS)
- Internal and External Incident Reports (notifications)

Day 2

MODULE 3: CONCEPTS OF INCIDENT INVESTIGATION

- Types of Investigations (Mini, Formal)
- Criteria to decide types of investigation
- Composition of investigation teams
- Ethics, code of conduct, qualities and responsibilities of investigation members

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- Preparation for investigation
- Investigation tools (manual, software-based) and methodologies (RCA, fault tree, failure analysis etc)
- Investigation Plan

MODULE 4: EXECUTION OF INVESTIGATION (DATA COLLECTION)

- Briefing by Investigation team leader on scope, limitations and logistics
- Meeting with the affected area supervisor and stakeholders where incident took place
- Site Evidence Collection (photographs, documents etc)
- Witness Interviews
- Consolidation of evidence and statements
- Site discussion/feedback with the affected parties on conclusion of data collection.

MODULE 5: EXECUTION OF ROOT CAUSE ANALYSIS (RCA)

- Preparation of the snap-chart /storyline of the whole incident chronologically
- Use of the data collected to brainstorm within team using RCA methodology
- Identification of those items which require further confirmations/data collection from site
- Review of documents, evidence, interview statements etc as RCA progresses
- Roles of Procedures, Training, Quality Control, Communications, Management systems, Human engineering, Work direction
- Carrying out the RCA and saving the work daily/regularly with different file names
- Conclusion of RCA

Day 3

MODULE 6: PREPARATION OF DRAFT INVESTIGATION REPORT

- Shortlisting/finalizing the information from the site data collection and the RCA
- Importance of a comprehensive Investigation Report
- Finalization of structure of the Investigation Report
- Allocation of responsibilities among team members as to who covers which section
- Generation of Draft Investigation Report within the timeline planned
- Review and approval of Draft Investigation Report by Investigation Team Leader
- Generation of a mini draft investigation report in parallel if client management requires it.

MODULE 7: CIRCULATION OF DRAFT INVESTIGATION REPORT

- Decision on whom to circulate the Draft Investigation Report within the organization
- Circulation with a request to send comments within the stipulated time
- Receipt of comments and initial screening

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- Seeking clarification on comments, if any
- Emphasis on no-suppression of information by interested stakeholders
- Escalation to area management if someone is interfering to hide sensitive disclosures.

Day 4

MODULE 8: FINALIZATION OF INVESTIGATION REPORT

- Decision on finalization of received comments
- No compromise with integrity of investigation report
- Incorporation of comments
- Recommendation Section must focus on clarification of actions with regards to CAP & PAP
- The final report must bear names and signatures of Team leader and members
- Production of soft and hard copies of final investigation report as per agreement
- Presentation of the report to the client to highlight summary and CAP & PAP
- Answering questions during the presentation.

MODULE 9: IMPLEMENTATION OF RECOMMENDATIONS OF INVESTIGATION REPORT

- Review of the report by client area supervisor and management in detail
- Cost benefit analysis for implementation of recommendations
- Development of the plan for implementation of recommendations
- Allocation of resources to implement recommended actions as per HSE risks associated for not implementing them.

MODULE 10: FOLLOW UP AND CLOSE-OUT

- Ways to verify effectiveness of implementation of recommendations
- Observations, Interviews, and reviews of subsequent HSE reports of the affected area
- Insurance, Legal and Statutory Implications
- Archive and close-out of the incidents

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Day 5

MODULE 11: CASE STUDIES AND EXERCISES TO DO INCIDENT INVESTIGATION USING RCA

- Course Facilitator runs the above investigation methodology with respect to one incident case study to refresh understanding of the participants
- Course Facilitator presents a few other case studies and asks course participants to work them out with RCA and Investigation Reports
- Course Facilitator observes progress and provides support.

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MODULE 12: VARIATIONS TO THE ABOVE INVESTIGATION METHODOLOGY AND EXTRAS

- Small organizations
- Low risk organizations
- Any other constraints/assumptions
- Discussions on exceptions/ clarifications on special Injury/Illness cases
- Question and answers

NOTE:

Pre & Post Tests will be conducted.

Case Studies, Group Exercises, Group Discussions, Last Day Review & Assessments will be carried out.



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