Why process safety incidents still occur

Contributions are invited from practitioners across the process industries. Submissions should be experience-based, practical, and thought-provoking, rather than purely theoretical.

Length: ~500–1,000 words. Named incidents or anonymised examples are both welcomed.

1. Title (your "reason")
A very short statement of the issue. E.g. "Overconfidence in 'Proven' Systems"

2. Your core insight
Provide 2-3 sentences on what you believe to be the underlying reason and what are people missing?

3. What this looks like in practice, with example if possible
Give a short description of how this shows up in real operations. Include a short case, anecdote or observation (300 words maximum). This could be a near miss; an incident (named or anonymised) or something you have often seen. This is strongly encouraged – as this experience is what makes the insight memorable.

4. Why does it go unnoticed or unaddressed?
Explain why this issue persists.

5. What needs to change (the practical takeaway)
Give a couple of concise suggestions what practitioners or leaders could do differently, or what can be done to verify or improve

6. A final challenge
End with something thought-provoking for readers to consider, "Where might this already be happening on your site?" "What information are you relying on but not checking?"

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