

# Blameless Incident Post-Mortem Template

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**Incident ID:** \_\_\_\_\_

**Date of Incident:** \_\_\_\_\_

**Post-Mortem Date:** \_\_\_\_\_

**Facilitator:** \_\_\_\_\_

**Attendees:** \_\_\_\_\_

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## Incident Summary

*In 1-2 sentences, what happened?*

Example: "On 2026-01-15 at 14:32 UTC, the API gateway became unresponsive causing a 27-minute outage affecting 45% of users."

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## Severity & Impact

**Severity Level:** P0 (Critical) | P1 (High) | P2 (Medium) | P3 (Low)

### Impact:

- **Users Affected:** [number or percentage]
- **Duration:** [start time - end time, total minutes]
- **Business Impact:** [revenue, reputation, SLA breach]
- **Systems Affected:** [list of services]

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## Timeline

Time (UTC)	Event	Actions Taken
14:32	Alert fired: API gateway CPU at 100%	On-call engineer paged
14:35	Confirmed widespread user reports	Incident declared, war room started
14:40	Identified memory leak in v2.3.1 deployment	Began rollback procedure
14:52	Rollback to v2.3.0 completed	Monitoring recovery
14:59	Service fully restored	Incident resolved
15:15	Post-incident monitoring complete	All systems normal

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## Root Cause

**Technical Root Cause:**

*What was the immediate technical cause?*

Example: "A memory leak introduced in release v2.3.1 caused the API gateway to exhaust available memory, leading to process crashes and service unavailability."

**Contributing Factors:**

*What systemic issues made this possible?*

1. Load testing didn't include 24-hour soak tests to detect memory leaks
2. Memory usage alerts set too high (90% threshold)
3. Gradual rollout skipped due to release pressure
4. Memory profiling not part of standard review process

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## Detection

**How was the incident detected?**

- Automated monitoring alert
- Customer report
- Internal team member
- Other: \_\_\_\_\_

**Time to detection:** \_\_\_\_\_ (from incident start to first awareness)

**Could detection be improved?** [Yes/No] - If yes, how?

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## Response

**What Went Well** 

1. On-call engineer responded within 3 minutes of page
2. War room assembled quickly with right stakeholders
3. Rollback procedure executed smoothly
4. Communication to customers timely and transparent
5. Team remained calm and followed runbooks

**What Went Wrong** 

1. Root cause took 20 minutes to identify (memory leak not immediately obvious)
2. Monitoring dashboards didn't show memory trends clearly
3. Rollback took longer than target (12 min vs 5 min SLA)
4. Some customer-facing teams weren't notified promptly
5. No immediate way to failover to backup region

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## Action Items

**Format:** [Priority] Action - Owner - Due Date - Status

## Immediate (This Week)

- [P0] Add memory trend monitoring to primary dashboard - DevOps Team - 2026-01-18 - Open
- [P0] Implement 24-hour soak tests in CI/CD - QA Lead - 2026-01-20 - Open
- [P1] Lower memory alert threshold to 75% - SRE Team - 2026-01-17 - Open

## Short-term (This Month)

- [P1] Improve runbook with memory leak troubleshooting steps - Tech Lead - 2026-02-01 - Open
- [P1] Optimize rollback automation to hit 5-min SLA - Platform Team - 2026-02-15 - Open
- [P2] Add customer success team to incident notification workflow - Operations - 2026-01-30 - Open

## Long-term (This Quarter)

- [P2] Implement multi-region failover capability - Architecture Team - 2026-03-31 - Open
- [P2] Adopt memory profiling in code review process - Engineering - 2026-02-28 - Open
- [P3] Conduct chaos engineering exercise - SRE Team - 2026-03-15 - Open

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## Lessons Learned

### Technical

- Memory leaks in long-running services require soak testing, not just load testing
- Memory monitoring needs better visualization of trends over time
- Automated rollbacks need optimization to meet SLA targets

### Process

- Release pressure shouldn't skip gradual rollout procedures
- War room communication worked well, extend to all stakeholder teams
- Runbooks need regular testing and updates

### Cultural

- Team handled pressure well with blameless mindset
- Cross-functional collaboration was strong
- Post-mortems are learning opportunities, not blame sessions

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## Follow-up

**Action Item Review Date:** \_\_\_\_\_

**Post-Mortem Published:**  Internal Wiki  Public Status Page  Team Retrospective

**Responsible for Follow-up:** \_\_\_\_\_

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## Blameless Culture Reminders

**☒ Do:**

- Focus on systems and processes, not people
- Ask "what" and "how", not "who" and "why"
- Assume everyone acted with best intentions given their information
- Celebrate what went well
- Learn and improve

**✗ Don't:**

- Assign blame to individuals
- Focus on punishment
- Assume malice or incompetence
- Skip follow-up on action items
- Hide incidents from the team

**Remember:** The goal is learning and improvement, not finger-pointing. Every incident is an opportunity to make our systems more resilient.