



ABU DHABI WATER AND ELECTRICITY AUTHORITY
(ADWEA)

ADWEA & GROUP COMPANIES

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INCIDENT REPORTING, INVESTIGATION AND ANALYSIS PROCEDURES

Approved By:

Planning & Development Director



ADWEA HSE PROCEDURE MANUAL

INCIDENT REPORTING, INVESTIGATION AND ANALYSIS PROCEDURES

Prepared by:

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PLANNING & DEVELOPMENT
DIRECTOR

Date:



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Definitions

- ACCIDENT:** This term is to be replaced by Incident as the preferred term.
- ACTIVITY AUTHORITY:** The party/section in charge of an activity/task/job/project and related personnel i.e. Performing Authority.
- ASSET LOSS/DAMAGE:** The true cost of assets destroyed by the incident. It is Property damage or loss of production/productivity.
- BASIC CAUSES:** Real causes/reasons why the unsafe/substandard acts and conditions occurred; the personal, job and organizational factors that, when identified, permit meaningful management control.
- CONTRACTORS:** All parties working for Company either as a direct Contractor or sub-contractor. It also includes Contracted Personnel who are sponsored by an agent.
- DANGEROUS OCCURRENCE:** Readily identifiable event with potential to cause an incident or disease to persons at work and the public or, of significant actual or potential material damage.
- ENVIRONMENT:** The biological and non-living systems within which we live.
- ENVIRONMENTAL INCIDENT:** An unplanned event or chain of events that has or could have a negative impact on the environment.
- EXPOSURE HOURS(HOURS WORKED):** The number of hours worked by all personnel of the Company, to include direct hire and contract staff, who are located on site or operate remotely of it. In the case of on-call contractors, and in the absence of a recording system, the estimated annual total should be applied.
- FATAL INCIDENT FREQ. RATE (FIFR):** The number of fatalities per 100 million man-hours worked i.e. $FIFR = \text{number of fatalities} \times 100,000,000 \text{ divide by man-hours worked}$.
- FATALITY:** Death due to work injury or illness.
- HAZARD:** Source ,situations or act with a potential for harm in terms of human injury or ill health ,or combination of these
- HSEMS:** Health, Safety & Environment Management System: The Company structure, responsibilities, practices, procedures and resources for implementing Health, Safety and Environment Management.



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HSED: Health, Safety & Environment Department within the concerned Company.

IMMEDIATE CAUSE: The immediate reason why an incident has occurred. It can encompass unsafe conditions (which are not under the control of the person in the workplace) and/or unsafe acts (which are under a person's control).

INCIDENT: Work-related event(s) in which an injury or ill health (regardless of severity) or fatality occurred, or could have occurred.

INJURY: Physical harm or damage to a person resulting from a single incident traumatic contact between the body of the person and an outside agency, or from exposure to environmental factors i.e. cut, fracture, sprain, amputation, burn by hot surface or caustic chemical etc.

INJURY SEVERITY RATE: The number of days lost per 1 million man-hours divided by the total man-hours worked.

LACK OF CONTROL: Deficiency/inadequacy in management functions such as programme(s) standards and compliance with standards.

LOST TIME INCIDENT (LTI): Any work related injury or illness, which prevents that person from doing work the day after the incident/injury.

LOST TIME INCIDENT FREQ. (LTIF): The number of lost time injuries (fatalities - lost time injury) per 1,000,000 (million) man-hours divided by the number of man-hours worked (exposure hours).

NEAR MISS: An incident where no injury, ill health or fatality occurs.

NUMBER OF FATALITIES: The total number of Company's employees and or contractors employees who died as result of an injury. Delayed deaths that occur after the incident are to be included if the deaths were a direct result of the incident.

OCCUPATIONAL ILLNESS: An abnormal condition (physical or mental) that is caused or aggravated by prolonged or repeated exposure to environmental factors associated with employment, including chemical, physical, biological and ergonomic factors i.e. sunburn, loss of hearing, chemical harms. Food poisoning is considered as occupational illness.

UNSAFE ACT: Any act (behavior) that deviates from a generally recognized safe way or specified method of doing a job and increases the potential for an incident.

UNSAFE CONDITIONS: Circumstances which deviate from a generally recognized condition that could permit the occurrence of an incident.

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Incident Classification

1) General

Incidents may affect people, property /assets, the environment or the reputation of the Company. Incidents are classified for reporting purposes according to the actual and potential degree of injury, loss/damage, harm (negative impact) to the environment or Company reputation as shown in the HSE Loss Matrix (Appendix 2). Once the potential degree (severity) of injury or harm is determined, the potential loss to the Company can be determined by assessing the probability of a similar incident happening again and using the HSE Loss Matrix.

2) Determination of the Consequence Type

There are four general types of incident consequences:

2.1 Personnel Injury or Occupational Illness

Refer to general definitions of injury and occupational illness. From these definitions we can deduce that the basic determinant separating an injury from an illness is the single-incident concept. If the case resulted from something that happened in one instant, it is classified as an injury. If the case resulted from something that was not instantaneous, such as prolonged/repetitive exposure to hazardous substances or other environmental factors, it is considered an occupational illness. Back disorders should be classified as injuries if they are triggered by an instantaneous event. On the other hand, loss of hearing as a result of repetitious/prolonged exposure to noise, it should be classified as occupational illness.

Typical examples of work injuries

Cut, fracture, sprain, amputation, deafness from explosion, insect bites, one-time chemical exposure, back disorder from a slip, trip or other instantaneous event.

Typical examples of occupational illness

Deafness from non-instantaneous exposure to noise, back disorder from repeated, continuous, or other non-instantaneous event. Note food poisoning is also considered an occupational illness.

2.2 Asset/Property Loss or damage

With respect to asset/property loss or damage, these procedures apply only to those incidents, which primarily have an impact on Company HSE performance. This includes all cases of asset/property damage (fire/explosion, crane, vehicle, etc) which are the result of unplanned or unexpected events where injury, environmental harm or reputation damage has or could have resulted. The classification of the severity is set in HSE Loss Matrix.



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2.3 Environmental Incidents

Reportable Environmental Incidents include damage to flora and fauna, oil spills, algae blooms, contamination of ground water, public interest, chemical spills, hazardous waste discharge, loss or discharge of radioactive material and accidental release of toxic, flammable or explosive liquids or gases. The classification of the severity follows the HSE Loss Matrix.

2.4 Company Reputation

Incidents which have actually damaged, or have the potential to damage Company reputation can only be classified in qualitative terms. A visible and serious commitment to all aspects of HSE performance is an essential part of the equation to maintain a sound reputation.

Incident - Types of Contact:

Fatalities, serious injuries, Assets/Property/product damages/loss and recorded near misses/dangerous occurrences may be the consequences of:

1) Personal Falls

Falling, tripping and/or slipping at the floor level or at different levels on working locations or access within the general environment of the plants/facilities controlled by the Company, whether or not in the performance of a specific task.

1) Falling objects

Free falling, flying objects causing injury to persons associated/unassociated with the task related to the incident.

2) Caught in/between

Entrapment in or between objects.

3) Fires and Explosions

All such events as a consequence of any activity including failure of machinery.

4) Machinery, Tools and Equipment

Including hand tools, breakdown, malfunction, repair, misuse, maintenance and operation (outside/inside a workshop).



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5) Electricity

Electrocution, burns, shock and resuscitation.

6) Handling

Lifting or moving goods and equipment, including the use of forklift trucks.

7) Cranes

Handling, breakdown, malfunction, misuse, maintenance and repairs, movement of goods or persons except in connection with operation as (9).

8) Wires, Ropes, Cables and Chains

Snapping, severing, falling, and dragging.

9) Vehicles and Transports

All concerned in the transport of persons and goods with any kind of vehicles excluding forklift trucks.

10) Dangerous Materials

Chemicals, corrosive, reactive and poisonous or radioactive materials.

11) Leaks/Spills

Fuel Oil/gas leaks due to human error such as lack of/or inadequate procedures/planning, maintenance, corrosion, ruptures and fugitive leaks (passing of valves and gasket leakage).

12) Environmental Impact

Emissions, discharges and waste materials.

13) Noise

Unsafe conditions where it exceeds acceptable limits/levels.

14) Stress

Environmental, psychological and physical stress.



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15) Loss to Process

Loss to process are those events that "resulted" from incidents" i.e. leak/spill, loss to production/productivity, quality deterioration or down time of an activity for which Company is losing money "due to an incident".

16) Others

Not directly or in association with any of the above (specify).

Incident Reportability

An incident requires the professional attention of HSE personnel which will endeavour to enforce an effective incident prevention technique.

Incidents have the potential to result in time loss or even loss of life or damage to property/asset, environment and/or Company reputation in addition to loss of production and employee(s) compensation.

The loss prevention technique needs a sharp scrutiny of any incident, however small.

The normal steps to be taken after an incident are:

- ◆ Conduct the investigation.
- ◆ Prepare the report with conclusions and recommendations.
- ◆ Prepare the statistics and analysis and present the appropriate plan of corrective actions.

All incidents, regardless of their potential or magnitude, shall be reported as per established procedures and in accordance with Company rules and regulations and relevant Governmental Ministerial Decrees.

All incidents shall receive the proper attention by various disciplines depending on its loss potential:

a) Near Miss/Dangerous Occurrence

The type of occurrences that did not lead to any injuries, property/asset or environmental damages or loss of production / process should be treated like any injury or property/environmental damage. A Near Miss Card shall be filled by the observer. Near misses with high potential need further investigation.

b) Fatal and Major Incidents (Permanent Disability/Property Damage): Severity 5 - Catastrophic and 4 - Severe:



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A complete investigation shall be undertaken by the concerned Company. A complete report to be built-up and sent immediately to Company Management and copied to ADWEA HSE Advisor, in addition the Police is to be informed by the concerned company.

However, upon notification (Incident Preliminary Notification), Company Senior Management shall issue its directives to form a Task Force or Inquiry Team to investigate the incident in accordance with the attached **"Major Incidents Inquiry Team Terms of Reference"** (Appendix No. 1).

c) Serious Incidents : Severity 3 - Critical

The investigation should immediately be conducted by the injured person's Supervisor (for Lost Time Injuries) or Area/Activity Supervisor (for property/asset or environmental damage) and HSE staff. The report is to be forwarded immediately to Company Management.

d) Minor Incidents: Severity 2 - Marginal and 1 - Negligible

Minor property or environmental damage or injuries without lost time, are to be immediately investigated.

e) Reportability of Contractors Incidents

Incidents of all magnitudes and potentials sustained by Contractors personnel are to be treated like Company incidents and shall be reported to Company Management.

However, reporting of such incidents to the Ministry of Labour shall be made by the concerned contractor and not the Company unless Company personnel or property/asset is involved.

f) Reporting to Ministry of Labour

Any property / asset or environmental damage under the above two categories b & c (severity 3-5) and fatalities or injuries with three days or more lost time for company employees and contracted personnel under special Company contract must be reported immediately to HSED who in turn will prepare the necessary report and submit it to General Services/Public Relations to notify the Ministry of Labour as per Ministerial Decree No. 32 for 1982.

g) Reporting to ADWEA

All fatalities, injurious medical evacuations, fires/explosions and environmental incidents of categories b and c (Severity 3-5) shall be reported to ADWEA HSE Advisor.

An official Preliminary Report shall be prepared by the Company HSED and sent to ADWEA HSE Advisor as soon as practicable. Detailed Report shall be submitted upon completion.

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Incident Accountability (Ownership)

Incident accountability should normally lie with the party/section which has the most influence over the site or activity. Accordingly, defining clear criteria is essential in order to ensure that in every event, clear rules are set so that no time is lost in carrying out the investigation.

Therefore, the following criteria for Incident Accountability shall be followed:

- 1) **Area Authority is accountable for all incidents taking place within its area e.g.**
 - ◆ Operation Service in the plants/facility.
 - ◆ Administration or General Service in the office area, amenity centre, and accommodation area.
 - ◆ Maintenance Services in workshops.
 - ◆ General services or Logistics in warehouses.
 - ◆ Projects Department, during project construction or execution.
- 2) In certain areas where holdership was temporarily transferred to certain party/group, the area authority will not be accountable for the incidents that take place at that location. Relevant Job Officers (e.g. Projects Department) will be accountable for injuries sustained by these Contractors personnel e.g. fenced areas related to projects.
- 3) For all transport related incidents, accountability rests with the reporting line of the person in control of each vehicle at the time of the incident.
- 4) If none of the above criteria is definitive, then incident accountability rests with the reporting line responsible for supervising the activity during which the incident occurred.

Incident Audits

In order to enhance HSE performance and ensure progress to reach Company targets, HSED shall conduct incident audits such as:

- ◆ Relationship between HSE training and incidents.
- ◆ Follow-up of remedial actions.



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Follow-up & Reporting in Remedial Actions

- 1) Follow-up of Actions as set in the Incident Report shall be monitored by HSED for follow-up on timely actions and reviewed with Management. Upon completion of the recommended actions by concerned sections, HSED will close the report.

HSED will prepare a quarterly listing of the outstanding actions of all incident reports and submit it to concerned Services/Units for their comments/updates.

Section 1: INCIDENT REPORTING PROCEDURE

Objectives and Scope

- ◆ To define the proper reporting procedure of an incident regardless of its magnitude and potential loss.
- ◆ To define and utilize standardized HSE terminology, classification and systematic procedure.

Policy

- ◆ To ensure compliance with Company and ADWEA Policy.
- ◆ To comply with local and federal legislation with regard to reporting of incidents.

Reporting procedure

1. **Near Misses** : any person who sustains/witnesses this type of incident shall fill the "Near Miss Card" (Appendix No. 4) and submit/mail it to HSED who, in turn, shall determine whether further investigation is required or not. A copy of the card shall be dispatched to the concerned area/activity authority.
2. For other incidents (injury, property/asset damage, transport/vehicle, environmental) with severity 3 to 5, concerned HSED of the Group Company must complete the **Preliminary Incident Notification** (Appendix No. 5) and fax it to ADWEA HSE Advisor within 24 hrs. of the incident. On the other hand, the **Incident Report** (Appendix.3) shall be completed and sent to ADWEA HSE Advisor within one week.
3. In case of **injury or occupational illness**, the immediate supervisor of the injured person shall initiate the investigation and fill in the related section and submit it to the Medical Officer/clinic to complete the related section, i.e. details of the injury/illness treatment given, extent of injury, days lost and other information.



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4. In case of asset/**property loss/damage, environmental impact, radiation** the area authority/concerned section “the mostly involved in the activity” shall fill in the related section.
5. HSED at their end shall conduct their thorough investigation and complete their part of the Incident Report.
6. HSED shall then, submit the report to the Line Management for completing the related section of the report. Depending on the loss potential, Management may decide to conduct further investigation of the incident.
7. The original Incident Report shall be forwarded to HSED for monitoring and follow-up of actions, conducting audits and preparing the periodical Incident Statistics and Analysis Report. The Original Incident Report shall be kept in HSED custody. In the meantime, HSED shall monitor the implementation of item 39 in the incident report form. Upon completion of the recommended actions, HSED shall close the report.
8. On the directives of Company Senior Management, incidents of high loss potential may be investigated by a “Board of Inquiry” which shall be formed in accordance with established procedures (refer to Appendix No. 1: Terms of Reference).

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Near Miss Reporting Flowchart

Responsibilities

Observer of Near Miss

Fill up Near Miss Card

HSED

Review and forward copy of Card to Area / Activity Authority

HSED and Area / Activity Authority.

Further investigation?

Yes

Refer to Incident Report Flowchart

No

HSED

Send copy to concerned parties

HSED

Collate Info

HSED

Analyze and issue statistics

End

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Incident Reporting Flowchart

Responsibilities

HSE

HSE and Area Authority
Area/Activity Authority

Area/Activity Authority

Medical Officer

HSE

Line Management

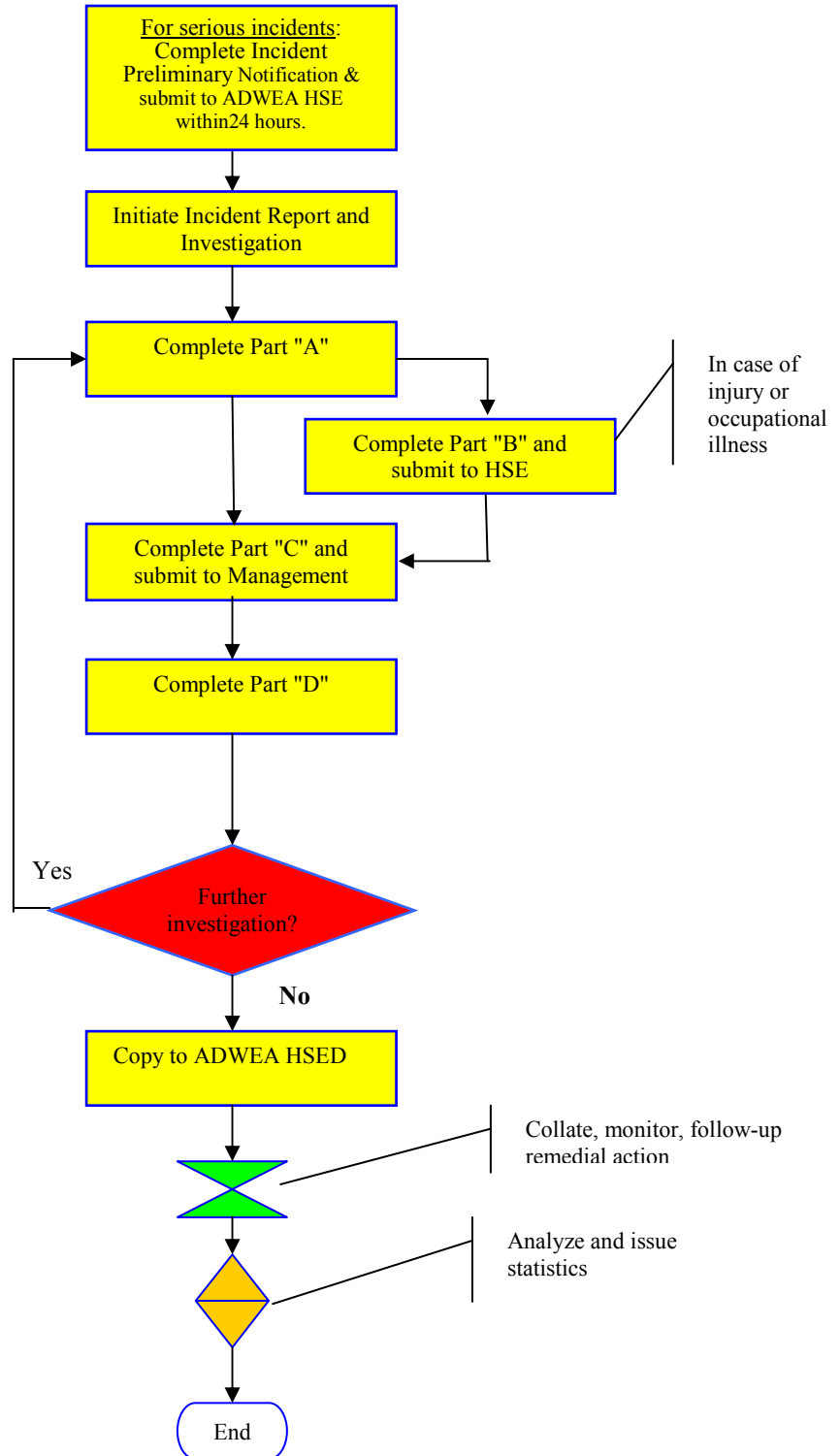
Plant/Facility Manager

HSED - if severity 3-5

HSED

HSED

Investigation Team



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Section 2: INCIDENT INVESTIGATION PROCEDURE

Objectives of Investigation

- ◆ **Describe what happened:** Through investigation, the Investigator can arrive at an accurate statement of what really happened.
- ◆ **Determine the underlying HSE deficiencies and other factors that might be causing or contributing to the occurrence of incident:** Reviewing the immediate cause(s) will eventually lead to the basic cause(s) of the incident.
- ◆ **Decide the risks:** The investigation can evaluate the loss potential of an incident. i.e. loss severity potential and probable recurrence rate.
- ◆ **Develop Controls (corrective actions):** Adequate controls (corrective actions) will minimize or eliminate the problems.
- ◆ **Identify opportunities for preventive action: adequate investigation will give a chance to identify the cause and adopt preventive actions for nonoccurrence.**
- ◆ **Identify opportunities for continual improvement.**
- ◆ **Demonstrate Management Concern:** Prompt and objective investigations along with action to reduce or eliminate the possibility of recurrence would help to encourage and aid employee relations.

Under no circumstances should an investigation undertaken by HSE representative, lead to indicate who is guilty or not. The only objective of the investigation is to establish the facts. To define the proper reporting procedure of an incident regardless of its magnitude and potential loss.

Investigation Procedure

1. Supervisor's Initial Actions

The success of an investigation is often accomplished in the first few moments after the incident. A lot of critical things happen in quick order. The Area Authority/Activity Supervisor should work on reducing the extent of loss and get the investigation started immediately and properly. The following steps are guidelines to apply as appropriate:

- ◆ Take control at the scene by directing personnel to act properly.
- ◆ Ensure first aid and call for emergency services.
- ◆ Control potential secondary incidents by taking the proper measures to control the situation and prevent aftermath mishaps.
- ◆ Identify sources of evidence at the scene.

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- ◆ Preserve evidence from alteration or removal.
- ◆ Investigate to determine the loss potential.
- ◆ Notify concerned Supervisor(s)/Head(s) of Service and HSED.

At the earliest possible moment, photographs should be taken and accurate notes and sketches of the salient points made.

It is particularly important that:

- ◆ **Nothing is altered or removed from the scene**, unless necessary for safety reasons as decided by HSE representative, until investigation is complete. Protecting devices, slings hoists, ladders, tools, etc. may be vital evidence as to the cause of the incident and must be impounded and labeled. In the event of legal proceedings following a fatal or major incident they may be required as evidence in Court.
- ◆ **The witnesses' statements to be collected** as soon as possible away from the scene of incident.

2. Gathering Information

The investigator should always look over the scene of the incident and surrounding environment in order to get a mental picture that will allow him to determine what elements are involved: i.e. people, equipment, materials and environment. Once this "big picture" is obtained then the job starts.

2.1 Interview Witnesses and Supervisors

◆ Speed of Investigation

One of the most important aspects of incident investigation is speed. It is important and even vital, to arrive at the scene of an incident before people have had time to change their minds, as sometimes happens to cover up by a concocted story of the injured colleague, and to see the scene before anything is moved/altered.

◆ Statements

Getting a statement of facts from witnesses is, generally, a difficult task and can be expected to become more and more difficult as time elapses.



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2.2 Examine Equipment

A good basic investigation requires a look at the tools, equipment and materials that people were using.

2.3 Check Records

In order to determine the basic causes of incidents, the investigator should check procedures, sketches, maps, photos, maintenance records, etc.

2.4 Incident Photography

Photos of the incident scenes are very useful. They can reveal much about the incident and save hours of note-taking and drawing.

3. Facts Analysis

Reaching conclusions and making recommendations need a strict analysis of the facts; the first target of an investigation is to gather the facts about what caused the incident.

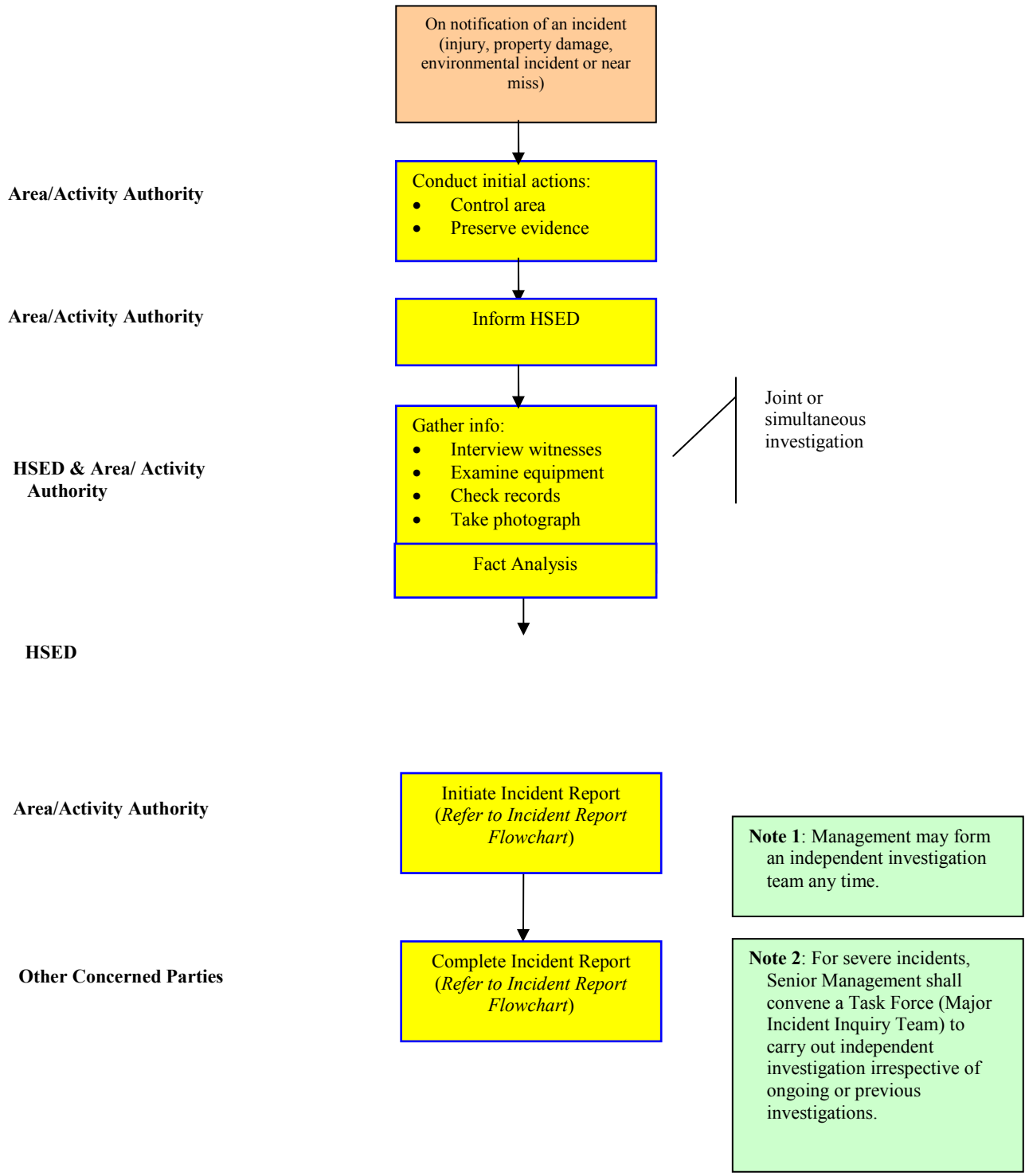
The gathering of facts is an operation to be conducted by the HSED, as per an established plan in the form of area checklists and forms (Incident Report) to support investigations.

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Incident Investigation Flowchart





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Purpose of Investigation

The main purpose of an investigation is to collect the maximum amount of information to discover the immediate and basic causes, so corrective action(s) can be taken and prevent recurrence.

The information to collect and present, in a report, is as follows:

1. About the Injured Person(s)

- a) **WHO** is (are) the injured person(s)?
- b) **WHERE** was (were) the person(s) at the time of the incident?
- c) **WHEN** was (were) the person(s) injured?
- d) **WHAT** are the injuries?
- e) **HOW** did these injuries occur?
- f) **WHAT was** the medical care given?

2. About the Incident

- a) **WHO** was involved?
- b) **WHERE** did the incident occur?
- c) **WHEN** did the incident occur?
- d) **WHAT** were the associated damages/losses?
- e) **HOW** did it happen?
- f) **WHY** did it happen?
- g) **WHAT** should be done to avoid recurrence?
- h) **WHAT** has been done already?

Some facts are very important to state:

- a) The exact nature of the injured person's job and what in fact he was doing at the moment of the incident, whether it was his actual job or something he should not have been doing.
- b) What instructions the injured person had received before commencing his job and from whom.
- c) In case of a property damage/near miss, describe the equipment, status at time of the incident, (potential) damages/losses.



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- d) In case of oil spill, state all relevant details/causation of the incident and actions to combat the spill.
- e) Other facts such as: exact location of the incident, names of witnesses, equipment used with exact description, any available details.

What to Investigate

In order to evaluate/determine the loss potential, all incidents (including near misses) should be investigated. Further in-depth investigation to be conducted to those of higher potential.

The Investigators

The investigator as a person or a committee of 2 or more persons must be efficient, tactful, patient and preserving and **completely unbiased**. It would be advisable to request persons from another sister Company for the investigation, but always keeping in mind the absolute necessity of fast action.

Investigation of some incidents with high loss potential should be conducted by an Investigation/Inquiry Team and may require the involvement of an outside expert.

The Investigator is usually the **person who is directly responsible for the area or the injured person and has the most interest in solving the problem**. Selection of the Investigator or Investigation/Inquiry Team depends on various factors such as type of incident and its loss potential.

With regard to a personal injury it's the immediate Supervisor of the injured person (whether he is a Company or Contractor's employee) who shall conduct the investigation and submit the report to his Sr. Supervisor. On the other hand, investigation of a property damage is conducted by either the area or task/job Supervisor who is "the person who has the most interest in solving the problem" e.g. Operation Supervisor, Maintenance Supervisor for on-plant incidents, Catering Supervisor for amenity centre/accommodation and Lifting Supervisor (if available) for lifting incidents.

It is always very important that the Investigator reaches the scene of the incident as quickly as possible. A near miss or minor incident must be investigated by a HSE Engineer. Lost time/fatal and major incidents, to be investigated by a suitably selected committee from within the Company. However, in depth investigation shall be conducted by a committee/team in accordance with "Major Incident Inquiry Team: Terms of Reference" - Appendix No. 1.

INCIDENT REPORTING, INVESTIGATION AND ANALYSIS PROCEDURES

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SECTION 3: INCIDENT ANALYSIS REVIEW PROCEDURE

Objectives

Incident statistics and analysis are one measure of HSE Performance and are used in the incident prevention programme.

The statistics are collated from incident reports & investigations and analyzed to indicate frequencies & trends with regard to the kind of injury, cause, occupation, types of incident, tools and equipment used, etc. With careful appraisal of the analysis suitable corrective measures can be taken.

Categories of Incident Analysis:

Some of the common or most useful categories are:

- Incident Frequency and Severity Rates by Site or category of employees (Company or Contractors).
- Incident trends by cause factor.
- Injury and damage by the Agency (materials/tools) inflicting the harm on people or property.
- Occupation of injured personnel.

Measurement of Incident Rate:

The most common measurement of incident rate is known as the Lost Time Incident Frequency (LTIF) Rate.

The Lost Time Incident Frequency (LTIF) Rate relates the number of lost time injuries to the hours worked during the period and expresses them in terms of a million hour unit.

This is calculated from the following formula:

$$\text{LTIF} = \frac{\text{Number of lost time injuries} \times 1,000,000}{\text{Man-hours worked}}$$

Another measurement is the **Severity Rate (SR)** or Duration Rate which relates the lost days to the hours worked during the period and expresses them in terms of a million hour unit.

This is calculated from the following formula:

$$\text{SR} = \frac{\text{Number of lost days} \times 1,000,000}{\text{Man-hours worked}}$$



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Incident Analysis Review Procedure:

A Review Team, formed by HSED, shall review and analyse the incidents on a quarterly basis to identify root causes, trends and make recommendations as appropriate.

The analysis shall be reviewed and endorsed by HSED who shall submit the recommended actions that minimize potential future incidents to Senior Management to assess the impact of these recommendations on operations and develop an implementation strategy.

The strategy shall be reviewed by Line Management who shall develop action plan as appropriate where HSED shall monitor and report progress of implementation.

Line Management shall ensure that all actions are completed in accordance with the action plan and provide closeout report to Senior Management for review and endorsement.

APPENDIX 1: MAJOR INCIDENTS INQUIRY TEAM TERMS OF REFERENCE (TOR)

In order to achieve the objectives of an incident investigation as set in this Chapter (For major incidents: Severity 4 & 5), the Major Incidents Inquiry Team shall be formed and assume its duties in accordance with the following Terms of Reference (TOR):

1) Formation of the Inquiry Team:

- 1.1 Regardless of the location of the major incident, upon the directives of Senior Management, HSED acting as Inquiry Team Secretary, shall liaise the formation of the Inquiry Team.
- 1.2 The team shall consist of specialized personnel from various disciplines with one Senior Officer as the Chairman, nominated by Senior Management, who will direct the work of the team as deemed necessary and report the team's findings to Company Senior Management.

2) Preparatory Work:

The Chairman, without any delay, shall summon his team, discuss the objectives of the investigation, review the information already in hand and set the action plan

3) Investigation of the Scene/Equipment:

In liaison with Line Management, the inquiry team shall carry out, as early as possible, a visit to the scene of the incident and inspect all relevant equipment/machinery to collect all necessary information that will reveal the causes of the incident.

The inquiry team may, if necessary, request to take photographs that may assist them in their investigation.

The Chairman may seek the presence of an outside expert to clarify a point in the investigation.

4) Personnel Interview:

4.1 The concerned area/location shall facilitate personnel interview process by providing list of names of the witnesses and provide the team with all required facilities to conduct such interviews.

4.2 In their attempt to collect all necessary information, the inquiry team may also elect to interview other personnel (not witnesses) if necessary.

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4.3 The team may also request further meetings with interviewed personnel for verification purposes if necessary.

5) Documentation Review:

In order to gather maximum information related to the incident, the inquiry team shall review all relevant documentation that will shed light in revealing the basic causes of the incident:

- ◆ The preliminary incident reports and interviews.
- ◆ Company HSE policy, procedures, standards, instructions, manuals, etc.
- ◆ Company operational/maintenance policy, procedures, instructions, manuals, etc.
- ◆ Area drawings (original, as-built, modified), P & I.D's, sketches, isometrics, etc.
- ◆ Equipment certification, manuals and maintenance log books, etc.
- ◆ Company HSE Management Systems and standards accreditations etc.
- ◆ All auditors reports/studies and Hazop/Hazan studies conducted at an earlier stage and monitored at all times.
- ◆ If Contractor and/or his equipment are involved, all relevant documentation may be checked/examined and personnel interviewed.
- ◆ Any other relevant documentation.

6) However, under certain circumstances, the inquiry team may request any of the following:

- ◆ The advice of an outside expertise.
- ◆ Carry out certain tests/examinations of equipment in professional laboratories.
- ◆ Carry out specific study/audit that may deem necessary.

7) Investigation Report:

The team shall prepare and issue a comprehensive investigation report determining the following items:

- ◆ Description/risk potential and costs implications.
- ◆ Causation factors of the incident.
- ◆ Recommendations to prevent recurrence.

However, if the investigation is prolonged for any reason, the team shall submit preliminary and follow-up reports to update Management with all developments.



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APPENDIX 2
USE OF THE HSE LOSS MATRIX

The HSE Loss Matrix is divided into two main sections. The left half provides a means to classify the severity or consequence of an incident. This can be used to classify both the actual and the potential consequences.

The right half provides a means to classify the probability/frequency or the chance of a similar incident (not the activity) happening again if nothing is done to prevent it.

By combining this probability with an estimated realistic potential consequence or severity, one can define the overall loss presented to the Company associated with this type of incident.

One of the main objectives of this document is to help the user to accurately assess the loss and subsequently to apply the appropriate resources to the investigation and reporting of an incident such that valuable actions can be taken to prevent recurrence and therefore reduce the risk facing the Company to a practical level. Only three levels of response are defined in this document - High, Medium and Low Potential.

The actual and potential consequence of all incidents shall be classified using the HSE Loss Matrix. This matrix allows assessment of an incident both in terms of its actual and potential, injury to people, damage to property/assets, negative impact on the environment or damage to Company reputation and its likelihood of happening again. This matrix also promotes awareness of the Health, Safety and Environmental implications of any incidents and provides a means for consistent historical trend analysis.

HSE LOSS MATRIX:

| CONSEQUENCES | | | | | Probability | | | | | |
|--------------------------|---|---------------------|------------------|----------------------|--|---|-------------------------|---|---|---------------|
| | | | | | 1(V.Low) | 2 (Low) | 3(Medium) | 4 (High) | 5 (V.High) | |
| Severity | People | Assets/ Property | Env. | Reputation | Has occurred in world-wide industry but not in ADWEA Group | Has occurred in other ADWEA Group Company | Has occurred in Company | Happens several times per year in Company | Happens several times per year in same location / operation | |
| 5 catastrophic | Multiple fatalities or permanent total disabilities | Extensive damage | Massive effect | International impact | | | HIGH | | | |
| 4 Severe | Single fatality or permanent total disability | Major damage | Major effect | National impact | | | | | | |
| 3 Critical | Major injury or health effects | Local damage | Localized effect | Considerable impact | | | | | | MEDIUM |
| 2 Marginal | Minor injury or health effects | Minor damage | Minor effect | Minor impact | | | | | | |
| 1 Negligible | Slight injury or health effects | Slight damage | Slight effect | Slight impact | | | | | | |



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A. Severity or Consequences Assessment

The vertical axis of the matrix classifies the severity or consequence of the incident. These classifications of consequence are consistent whether referring to actual or potential incident outcomes. They address harm to people, damage to property/assets, negative impact to the environment and damage to the Company reputation.

Classification of the severity of incidents involving people and assets/property is relatively straightforward and can normally be determined directly by using HSE Loss Matrix. However, the actual severity of a near miss is zero, but the potential severity in case of a similar situation, if led to injury/loss, will vary. Accordingly, we shall use the same matrix to identify the potential severity & probability for all Near Misses.

Expanded definitions for the severity classifications are:

A.1 Harm to people:

1. **Slight injury or health effects:** not affecting work performance, or causing disability. Included injuries requiring First Aid treatment. Severity rating '1' (Negligible).
2. **Minor injury or health effects:** affecting work performance, such as a restriction of activities or requiring medical treatment with possibly a need to take a few days to fully recover, whilst still at work. Severity rating '2' (marginal).
3. **Major injury or health effects:** affecting work performance, such as an absence from work the following day or affecting performance in the longer term, such as potential to cause a permanent partial disability. Severity rating '3' (critical).
4. **Single Fatality or Permanent Total Disability:** The response of the Company shall be at the maximum level. Severity rating '4' (severe).
5. **Multiple Fatalities or Permanent Total Disabilities:** The response of the Company shall be at the maximum level. Severity rating '5' (catastrophic).

A.2 Damages to a Property/Asset or Loss of Production.

These procedures apply only to Property/Asset Loss Incidents which occur in conjunction with actual or potential harm to personnel, the environment or Company reputation. The determination of the actual and potential impacts of an



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HSE Incident which affects Company assets shall consider both the primary and secondary losses (e.g. a production shut-down due to a damaged generator).

1. **Slight damage:** no disruption of the production and negligible repair cost (i.e. less than US \$ 1,000). Severity rating '1' (negligible)
2. **Minor damage:** some remedial work required which may include ordering parts. Production may be disrupted briefly and the repair cost is between US \$ 1,000 and \$ 9,999). Severity rating '2' (marginal).
3. **Local damage:** partial shut down of facilities, production can continue with little deferment, estimated repair cost between US \$ 10,000 and \$ 99,999. Severity rating '3' (critical).
4. **Major damage:** substantial shutdown of facilities, the production will be deferred for some time, estimated repair cost between US \$ 100,000 and \$ 999,999. Severity rating '4' (severe).
5. **Extensive damage:** major shutdown or total loss of facilities, the production will be deferred for some time, estimated repair cost US \$ 1,000,000 or more. Severity rating '5' (catastrophic).

A.3 Impact on the Environment

The severity classification of Environmental Incidents is less straightforward. Environmental Incidents can be divided into two main types:

1. Incidental releases of solid or liquid to either soil or water. The severity of these incidents can be classified quantitatively, using three elements – Quantity, Toxicity and Sensitivity.
2. All other incidents such as exceeding statutory limits, releases of gases, harm to flora and fauna, complaints, nuisance due to odours or noise, etc., which cannot be classified according to quantity, toxicity and sensitivity. The Potential Consequence of these incidents must be classified in a more qualitative manner.

Severity of the impact on the environment is therefore determined either quantitatively or qualitatively by comparing attributes affected by the incident with those described below. Main attributes of the environment which may be affected by an incident are visual quality: chemical quality (air, soil, water, living resources); biological quality (diversity); noise level or smell.



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1. **Slight effect:** An adverse effect on any attribute of the environment is measurable above normal background levels, is of short duration, confined to the Company site and with no complaints from third parties or governmental concern. Remedial action cost less than US \$ 1,000. Severity rating '1' (negligible).
2. **Minor effect:** Adverse effect is likely to be detected by third parties but does not exceed a recognised standard of environmental quality. Effect does not impair the use of the environment for other users. Single case of exceeding any permit requirement or internally prescribed standard. Investigation, monitoring or clean-up costs between US \$ 1,000 and \$ 9,999. Severity rating '2' (marginal).
3. **Localized effect:** Environmental quality in the vicinity of operations becomes substandard over a limited area for one or more purposes including supporting normal wildlife population; interference with other users causes loss of earnings, complaints or claims. Remedial action costs between US \$ 10,000 and \$ 99,999. Severity rating '3' (critical).
4. **Major effect:** Environmental damage is widespread and detectable for some distance beyond operational area. Large scale effort is required to restore the environment to a satisfactory condition. Clean-up and site restoration costs between US \$ 100,000 - 999,999. Severity rating '4' (severe).
5. **Massive effect:** Extensive damage to attribute(s) of the natural environment thereby affecting its ability to support human population or wildlife. Prolonged recovery period (several years) or site cannot be restored to satisfaction of interested parties.

A.4 Impact on the company's Reputation

The impact of an incident on Company's Reputation can only be defined in qualitative terms. For classification, refer to HSE Loss Matrix.

B. Probability of Happening Again (Frequency)

The horizontal axis of the HSE Loss Matrix measures the likelihood of a similar incident, not the activity, happening again, with a reasonable potential severity, in case nothing is done to prevent it. This measure is implicitly intended to account for the frequency of the activity underway at the time of the incident plus, the number of people or things exposed to a given hazard during the activity, and the likelihood of an incident being triggered in respect of the hazard controls and safeguards in place, in addition any other aspect which has relevance in respect of the specific circumstances of the incident.



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The user is constrained to use only one of five distinct probability classes. Either the incident:

- '1' has occurred in world-wide industry but not in ADWEA Group Company - i.e. Very low chance of recurring.
- '2' has occurred in other ADWEA Group Company - i.e. Low chance of recurring.
- '3' has occurred in Company - i.e. Medium chance of recurring.
- '4' happens several times per year in Company - i.e. High chance of recurring.
- '5' happens several times per year in same location or operation - i.e. Very high chance of recurring.

Obviously, most of our incidents will fall into the '3' or '4' classes with the occasional '5' class potential. '1' and '2' classes will be very rare; however, they are included here.



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APPENDIX 3: THE INCIDENT REPORT

The report, to begin with, is a short summary giving the main information about the facts. The forms already completed by the investigator can be referenced and used at this stage.

At the end, the report gives the conclusions of the investigation, the cause(s) of the incident and the remedial action(s) proposed.

The main part of the report must remain clear and easily legible but complete in narrative form following the chronological sequence of events. It should contain information to identify clearly the plan concerned and commence with a statement of the conditions preceding the incident including the action taken to deal with the situation. Careful reading of the narrative can suggest if any further explanation is necessary which can be done as an addendum to the report.

Attachments and Enclosures

Statements of witnesses need not be attached to the report, but the writer should be prepared to support any fact by reference to a statement.

Copies of all photographs, notes, drawings, diagrams and sketches, as far as they are able to clarify a point of the report must be attached. The originals of these documents to be kept with the writer or investigator and produced, if necessary, in Court.

Conclusions

The Conclusions of a report will be:

- a) As far as they are known: the causes of the incident.
- b) The remedial actions recommended to prevent recurrence.

Whenever a cause (or believed causes) is given, the reasons should be clearly stated, even at the risk of being refuted.

There may be several contributory factors and these should all be indicated.

Any breach of Company or statutory regulations should be stated, but in circumstances where the report may be disclosed to outside parties, breach of regulations and remedial actions will be dealt with separately.

The action(s) to prevent recurrence include those that can be (or have been) taken immediately and long term actions.

The proposed actions will not only be concerned with such matters as Plant Modification but will embrace training (or re-training/refreshing), re-assessment of operational procedures and enhancing of HSE Guidelines.

The conclusion will indicate what follow-up measures are to be taken to ensure that the recommended remedial actions are given full effect.

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GUIDELINES FOR FILLING THE INCIDENT REPORT FORM

- 1) This comprehensive report form is intended to record all types of incidents whether it's minor, lost-time or fatal injury, asset/property loss/damage, vehicle/traffic related, occupational illness, radiation, leaks/spills or Near miss/dangerous occurrence. This report shall be duly filled/completed, as soon as possible.
- 2) In general, the report form shall be completed as follows:
 Section 'A': By the Area/Activity Authority
 Section 'B': By the Medical Officer
 Section 'C': By HSED
 Section 'D': By the Line Management./Service Head
- 3) The report form shall be filled as appropriate depending on the type of the incident i.e. injury, asset/property loss/damage, environment related or Near miss/dangerous occurrence.
- 4) For injuries or occupational illnesses, items 1-9 to be completed by the injured person's supervisor while items 10-12 (Section B) shall be completed by the Medical Officer. Should the Medical Officer need extra space to insert additional important information, he may use item 42 or attach any information or report as necessary.
- 5) For asset/property loss/damage or Environmental incident (spills/leaks/radiation) items 13-23 to be completed. Loss to process (production/downtime of an activity) due to an incident is included under asset/property loss/damage.
 Item 15 is related to environmental incidents.
 Items 16-23 are related only to vehicle/traffic incidents.
- 6) For Near Misses/dangerous occurrences, items 24-26 shall be completed.
- 7) Items 27 - 42, shall be filled by concerned parties for all types of incidents.
- 8) Item 28 for the evaluation of loss potential: Personnel completing the form shall check "tick" the exact box that defines the loss potential (frequency and severity) of the incident. The lower the number, the lower the frequency/severity and vice versa. If the severity is one and frequency is one, then the box at the left bottom corner shall be ticked and so on. For completion of this item, please refer to Appendix 5: Use of HSE Loss Matrix.



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9) Item 29 (comments/recommendations) shall identify all the required actions and specify the person (or section) who is responsible for executing the action(s) on/before a specific target date.

10) Items 32-40, Section 'C' shall be completed by HSED.

Item 36 of the report is intended for analyzing programme deficiencies (organizational factors). It reveals any failure to meet performance standards i.e. inadequate programmes/standards or inadequate compliance.

Item 39 of the report "Follow-up of Action(s)" lists all actions that have implications on the HSE Management System i.e. standards, procedures, training, campaigns, etc.

The report shall be forwarded to HSED for retention.

| | | | |
|---|-------------------------------------|--|---|
| | (COMPANY NAME) | INCIDENT REPORT | Report No.: _____ |
| | | | Date: _____ |
| A. Area/Activity Authority | | | |
| 1. Date and time of occurrence: _____ / _____ hrs. | | 2. Location: _____ | |
| TYPE OF INCIDENT | | | |
| Injury | | Occupational illness | Asset Loss/ Damage |
| Lost Time <input type="checkbox"/> | Minor <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | Fire/ Explosion | Environ- Mental* |
| | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | Radiation | Other |
| | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | Near Miss <input type="checkbox"/> | Dangerous occurrence <input type="checkbox"/> |
| 3. Name: _____ | | 13. Asset loss/damage/affected: _____ | |
| 4. Age: yrs _____ 5. I.D. No.: _____ | | 24. Near Miss Card No.: (Copy attached) | |
| 6. Position: _____ | | 25. Potential Loss: | |
| 7. Company: _____ | | - Injury <input type="checkbox"/> | |
| 8. Dept./Section: _____ | | - Asset/Property Damage <input type="checkbox"/> | |
| 9. Industrial: Yes <input type="checkbox"/> No <input type="checkbox"/> | | - Environmental Impact <input type="checkbox"/> | |
| | | - Loss of Production <input type="checkbox"/> | |
| | | - Loss of Manpower <input type="checkbox"/> | |
| | | - Others, specify <input type="checkbox"/> | |
| B. To be completed by Medical Officer | | | |
| 10. Part of Body Affected: _____ | | | |
| 11. Nature/Extent of Injury/Illness | | | |
| - Fatal <input type="checkbox"/> | | | |
| - Non-Disabling (minor) <input type="checkbox"/> | | | |
| - Disabling (Lost Time) <input type="checkbox"/> | | | |
| - No. of Lost Days: _____ | | | |
| 12. Treatment: _____ | | | |
| 15*. Samples Taken: Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| FOR VEHICLE INCIDENT | | | |
| PARTY NO. 1 (Vehicle) | | PARTY NO. 2 (Vehicle, Property, Equip.) | |
| 16. Type of Vehicle: _____ | | | |
| 17. Registration No.: _____ | | | |
| 18. Owner: _____ | | | |
| 19. Concerned Dept./Service: _____ | | | |
| 20. Driver's Name: _____ | | | |
| 21. Position/Dept./Serv.: _____ | | | |
| 22. Driving License No.: _____ | | | |
| 23. Date of Issue: _____ | | | |
| Additional remarks: _____ | | | |
| 27. Brief Description of Incident: (Complete - 43: Sketch / attach photos as necessary) | | | 28. Evaluation of Loss Potential: |
| | | | Frequency |
| | | | 1 2 3 4 5 |
| | | | SEVERITY |
| | | | 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> HIG |
| | | | 4 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| | | | 3 <input type="checkbox"/> <input type="checkbox"/> MED <input type="checkbox"/> <input type="checkbox"/> |
| | | | 2 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| | | | 1 LOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 29. Comments/Recommendations: | | | |
| No. | Action | Action by | Target Date |
| | | | |
| 30. Witnesses: (Attach written statements) | | | |
| - Name: _____ | Position: _____ | Company: _____ | Dept/Section: _____ |
| - Name: _____ | Position: _____ | Company: _____ | Dept/Section: _____ |
| 31. External Factors: (only tick if any factor contributed to the incident) | | | |
| Ground | | Illumination | |
| Wet <input type="checkbox"/> | Too Low <input type="checkbox"/> | Sea State: _____ | |
| Dry <input type="checkbox"/> | Too Bright <input type="checkbox"/> | High <input type="checkbox"/> | Fog <input type="checkbox"/> |
| | | Swell (ft.) <input type="checkbox"/> | Rain <input type="checkbox"/> |
| | | | Hot <input type="checkbox"/> |
| | | | Cold <input type="checkbox"/> |
| | | | Air Condition <input type="checkbox"/> |
| Supervisor's Name: _____ | | Signature: _____ | Date: _____ |
| Sr. Supv./Head Name: _____ | | Signature: _____ | Date: _____ |

| C. | CAUSE ANALYSIS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|---|---|--------------------------------------|---|---|---|--|--|---|---|--------------------------------------|---|--|--|---|------------------------------------|--|--|--|--|---------------------------------|---|--|-------------------------------|---|--|-------------------------------------|------------------------------|--------------------------------|--|--|--|---|--|
| HSE | IMMEDIATE CAUSES | 32. Substandard actions: <table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">1. None</td> <td style="width: 33%;">10. Wrong or worn out equipment used</td> <td style="width: 33%;">19. Improper loading</td> </tr> <tr> <td>2. Defective equipment used</td> <td>11. Substandard conditions not reported</td> <td>20. Improper lifting</td> </tr> <tr> <td>3. Inattention to known hazards</td> <td>12. Work/move too slowly/too quickly</td> <td>21. Equipment moved to wrong place</td> </tr> <tr> <td>4. Procedures/Instruction not followed</td> <td>13. Equipment, tools used wrongly</td> <td>22. Equipment use without training/permission</td> </tr> <tr> <td>5. PPE not worn/worn but defective</td> <td>14. Horseplay</td> <td>23. Take short cuts, avoid discomfort</td> </tr> <tr> <td>6. Help not asked for</td> <td>15. Lack of communication</td> <td>24. Tired</td> </tr> <tr> <td>7. Safety rule not followed /did not warn</td> <td>16. Safety devices bypassed, not working</td> <td>25. Unwell</td> </tr> <tr> <td>8. Gas tester not used</td> <td>17. Working, riding on operating equipment</td> <td>26. Medication/Intoxicant influence</td> </tr> <tr> <td>9. Improper working position</td> <td>18. Using equipment improperly</td> <td>27. Other</td> </tr> </table> | | | 1. None | 10. Wrong or worn out equipment used | 19. Improper loading | 2. Defective equipment used | 11. Substandard conditions not reported | 20. Improper lifting | 3. Inattention to known hazards | 12. Work/move too slowly/too quickly | 21. Equipment moved to wrong place | 4. Procedures/Instruction not followed | 13. Equipment, tools used wrongly | 22. Equipment use without training/permission | 5. PPE not worn/worn but defective | 14. Horseplay | 23. Take short cuts, avoid discomfort | 6. Help not asked for | 15. Lack of communication | 24. Tired | 7. Safety rule not followed /did not warn | 16. Safety devices bypassed, not working | 25. Unwell | 8. Gas tester not used | 17. Working, riding on operating equipment | 26. Medication/Intoxicant influence | 9. Improper working position | 18. Using equipment improperly | 27. Other | | | | |
| | | 1. None | 10. Wrong or worn out equipment used | 19. Improper loading | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. Defective equipment used | 11. Substandard conditions not reported | 20. Improper lifting | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. Inattention to known hazards | 12. Work/move too slowly/too quickly | 21. Equipment moved to wrong place | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. Procedures/Instruction not followed | 13. Equipment, tools used wrongly | 22. Equipment use without training/permission | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. PPE not worn/worn but defective | 14. Horseplay | 23. Take short cuts, avoid discomfort | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. Help not asked for | 15. Lack of communication | 24. Tired | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. Safety rule not followed /did not warn | 16. Safety devices bypassed, not working | 25. Unwell | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. Gas tester not used | 17. Working, riding on operating equipment | 26. Medication/Intoxicant influence | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9. Improper working position | 18. Using equipment improperly | 27. Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 33. Substandard conditions: <table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">1. None</td> <td style="width: 33%;">11. Ventilation inadequate</td> <td style="width: 33%;">22. Personal Protective Equipment defective</td> </tr> <tr> <td>2. Substandard act by another person</td> <td>12. Work area congestion, restricted access</td> <td>23. Lockout of equipment not possible</td> </tr> <tr> <td>3. Hazard previously unrecognised</td> <td>13. Chemicals, fume, dust exposure hazard</td> <td>24. Insect, animal bite</td> </tr> <tr> <td>4. Housekeeping, PM standard poor</td> <td>14. Floor uneven, slippery</td> <td>25. Weather (rain/wind)</td> </tr> <tr> <td>5. Safety equip. unsuitable not there, not working</td> <td>15. Supervision inadequate</td> <td>26. Sharp edge, protrusion</td> </tr> <tr> <td>6. Heat or cold exposure hazard</td> <td>16. Noise exposure</td> <td>27. Process operation conditions changed</td> </tr> <tr> <td>7. Tools, equipment, materials defective</td> <td>17. Radiation exposure</td> <td>28. Equipment used for different process</td> </tr> <tr> <td>8. Guards, barriers inadequate</td> <td>18. Inadequate warning system</td> <td>29. Procedure/work instruction inadequate</td> </tr> <tr> <td>9. Equipment location unsuitable</td> <td>19. Abnormal operating conditions</td> <td>30. Other</td> </tr> <tr> <td>10. Lighting inadequate</td> <td>20. Fire, explosion, spill exposure hazard</td> <td></td> </tr> <tr> <td></td> <td>21. Personal Protective Equipment defective</td> <td></td> </tr> </table> | | | 1. None | 11. Ventilation inadequate | 22. Personal Protective Equipment defective | 2. Substandard act by another person | 12. Work area congestion, restricted access | 23. Lockout of equipment not possible | 3. Hazard previously unrecognised | 13. Chemicals, fume, dust exposure hazard | 24. Insect, animal bite | 4. Housekeeping, PM standard poor | 14. Floor uneven, slippery | 25. Weather (rain/wind) | 5. Safety equip. unsuitable not there, not working | 15. Supervision inadequate | 26. Sharp edge, protrusion | 6. Heat or cold exposure hazard | 16. Noise exposure | 27. Process operation conditions changed | 7. Tools, equipment, materials defective | 17. Radiation exposure | 28. Equipment used for different process | 8. Guards, barriers inadequate | 18. Inadequate warning system | 29. Procedure/work instruction inadequate | 9. Equipment location unsuitable | 19. Abnormal operating conditions | 30. Other | 10. Lighting inadequate | 20. Fire, explosion, spill exposure hazard | | | 21. Personal Protective Equipment defective | |
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| HSE | BASIC CAUSES | 34. Personal factors: <table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">1. None</td> <td style="width: 33%;">4. Over stressed (physically or mentally)</td> <td style="width: 33%;">6. Unsafe work permit</td> </tr> <tr> <td>2. Not able to do job (physically or mentally)</td> <td>5. Not motivated</td> <td>7. Other</td> </tr> <tr> <td>3. Not trained (lack of knowledge or skill)</td> <td></td> <td></td> </tr> </table> | | | 1. None | 4. Over stressed (physically or mentally) | 6. Unsafe work permit | 2. Not able to do job (physically or mentally) | 5. Not motivated | 7. Other | 3. Not trained (lack of knowledge or skill) | | | | | | | | | | | | | | | | | | | | | | | | |
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| 35. Job factors: <table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">1. None</td> <td style="width: 33%;">6. Maintenance deficiency</td> <td style="width: 33%;">10. Wear & tear</td> </tr> <tr> <td>2. Leadership/supervision deficiency</td> <td>7. Inspection deficiency</td> <td>11. Inadequate work standards</td> </tr> <tr> <td>3. Work instruction/procedure inaccurate</td> <td>8. Unsafe working conditions</td> <td>12. Abuse or misuse</td> </tr> <tr> <td>4. Engineering deficiency</td> <td>9. Tools, equipment, materials deficiency</td> <td>13. Other</td> </tr> <tr> <td>5. Purchasing inefficiency</td> <td></td> <td></td> </tr> </table> | | | 1. None | 6. Maintenance deficiency | 10. Wear & tear | 2. Leadership/supervision deficiency | 7. Inspection deficiency | 11. Inadequate work standards | 3. Work instruction/procedure inaccurate | 8. Unsafe working conditions | 12. Abuse or misuse | 4. Engineering deficiency | 9. Tools, equipment, materials deficiency | 13. Other | 5. Purchasing inefficiency | | | | | | | | | | | | | | | | | | | | |
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| 36. Organisational factors: <table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">1. None</td> <td style="width: 33%;">9. Safety audit schedule & follow-up</td> <td style="width: 33%;">16. Purchasing requirements</td> </tr> <tr> <td>2. Management and supervisory training</td> <td>10. Incident investigation procedures</td> <td>17. Engineering controls</td> </tr> <tr> <td>3. Personnel selection or assignment</td> <td>11. Incident analysis</td> <td>18. Planned inspection programme</td> </tr> <tr> <td>4. Personnel training</td> <td>12. Personal Protective Equipment</td> <td>19. Safety communications</td> </tr> <tr> <td>5. Responsibilities, accountability undefined</td> <td>13. Occupational safety/health programme</td> <td>20. Routine communications</td> </tr> <tr> <td>6. Company rules and standards unclear</td> <td>14. Safety procedures preparation/update</td> <td>21. Emergency preparedness</td> </tr> <tr> <td>7. Job safety analysis programme</td> <td>15. Normal/emergency procedures</td> <td>22. Other</td> </tr> <tr> <td>8. Task observation</td> <td></td> <td></td> </tr> </table> | | | 1. None | 9. Safety audit schedule & follow-up | 16. Purchasing requirements | 2. Management and supervisory training | 10. Incident investigation procedures | 17. Engineering controls | 3. Personnel selection or assignment | 11. Incident analysis | 18. Planned inspection programme | 4. Personnel training | 12. Personal Protective Equipment | 19. Safety communications | 5. Responsibilities, accountability undefined | 13. Occupational safety/health programme | 20. Routine communications | 6. Company rules and standards unclear | 14. Safety procedures preparation/update | 21. Emergency preparedness | 7. Job safety analysis programme | 15. Normal/emergency procedures | 22. Other | 8. Task observation | | | | | | | | | | | |
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| 37. Type of contact: <table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">1. Personal Falls</td> <td style="width: 33%;">8. Marine Vessels</td> <td style="width: 33%;">15. Rigs Ops.</td> </tr> <tr> <td>2. Falling Objects</td> <td>9. Cranes</td> <td>16. Oil/Gas leak/spill</td> </tr> <tr> <td>3. Caught in/between</td> <td>10. Wires, Ropes, Cables & Chains</td> <td>17. Environmental Impact</td> </tr> <tr> <td>4. Fires and Explosion</td> <td>11. Diving</td> <td>18. Noise</td> </tr> <tr> <td>5. Machinery, Tools & Equipment</td> <td>12. Vehicles and Transports</td> <td>19. Stress</td> </tr> <tr> <td>6. Electricity</td> <td>13. Helicopters</td> <td>20. Loss to Process</td> </tr> <tr> <td>7. Handling</td> <td>14. Dangerous Materials</td> <td>21. Others</td> </tr> </table> | | | 1. Personal Falls | 8. Marine Vessels | 15. Rigs Ops. | 2. Falling Objects | 9. Cranes | 16. Oil/Gas leak/spill | 3. Caught in/between | 10. Wires, Ropes, Cables & Chains | 17. Environmental Impact | 4. Fires and Explosion | 11. Diving | 18. Noise | 5. Machinery, Tools & Equipment | 12. Vehicles and Transports | 19. Stress | 6. Electricity | 13. Helicopters | 20. Loss to Process | 7. Handling | 14. Dangerous Materials | 21. Others | | | | | | | | | | | | |
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| 7. Handling | 14. Dangerous Materials | 21. Others | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

38. Comments/Recommendations:

HSE Engineer, Name:

Signature:

39. Taken/Follow-up of Action(s):

| No. | Action | Action By | Target Date | Comments |
|-----|--------|-----------|-------------|----------|
| | | | | |

40. Comments/Recommendations:

HSE Advisor / Head of HSE, Name:

Signature:

D.

41. Comments:

Further investigation is required: Yes No

Line Management/Head of Dept., Name:

Signature:

42. Sketches/Continuation of explanation. List number of report item being continued.

APPENDIX 4
NEAR MISS CARD

| |
|---|
| <p>(Company Name) HEALTH, SAFETY & ENVIRONMENT NEAR MISS CARD</p> <p><i>Date Observed:</i> _____ <i>Location</i> : _____</p> |
| <p>HAZARD DESCRIPTION (Please write what you saw and where it took place):</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> |
| <p>WERE YOU ABLE TO CORRECT THE PROBLEM? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>WHAT ACTION WAS <input type="checkbox"/> TAKEN <input type="checkbox"/> SUGGESTED <input type="checkbox"/></p> <hr/> <hr/> <hr/> |
| <p>OBSERVER NAME/I. D. NO.: _____ (optional)</p> |
| <p>Please complete reverse side.</p> |
| <p>This portion to be completed by HSED</p> <p>IS DETAILED INVESTIGATION REQUIRED?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> |

| TICK WHERE APPROPRIATE: | |
|---|---|
| What hazardous act/condition did you see? | ENGINEERING |
| PPE | II) Moving parts not guarded <input type="checkbox"/> |
| A) Head Protection not worn <input type="checkbox"/> | JJ) Electrical substandard <input type="checkbox"/> |
| B) Eye protection not worn <input type="checkbox"/> | KK) Chemical substandard <input type="checkbox"/> |
| C) Face protection not worn <input type="checkbox"/> | LL) Pressure substandard <input type="checkbox"/> |
| D) Ear protection not worn <input type="checkbox"/> | MM) Maintenance substandard <input type="checkbox"/> |
| E) Protective clothing not worn <input type="checkbox"/> | ENVIRONMENT |
| F) Safety shoes not worn <input type="checkbox"/> | NN) Water is being polluted <input type="checkbox"/> |
| G) Hand protection not worn <input type="checkbox"/> | OO) Air being polluted <input type="checkbox"/> |
| H) PPE in bad condition <input type="checkbox"/> | PP) Too much noise <input type="checkbox"/> |
| I) Wrong PPE for the job <input type="checkbox"/> | OCCUPATIONAL HEALTH |
| J) Substandard PPE <input type="checkbox"/> | QQ) High noise area <input type="checkbox"/> |
| TOOLS/EQUIPMENT | RR) Exposure to hazardous substances <input type="checkbox"/> |
| k) Wrong tool for the job <input type="checkbox"/> | SS) Heat Stress <input type="checkbox"/> |
| L) Tools in bad condition <input type="checkbox"/> | TT) Radiation exposure <input type="checkbox"/> |
| M) Tools not inspected <input type="checkbox"/> | Why did the hazardous act/condition occur? |
| N) Misuse <input type="checkbox"/> | |
| MATERIAL HANDLING | NOT AWARE |
| O) Too heavy for manual lifting <input type="checkbox"/> | 1) Not informed <input type="checkbox"/> |
| p) Wrong mechanical manual lifting <input type="checkbox"/> | 2) Language problem <input type="checkbox"/> |
| Q) Lifting tool not inspected <input type="checkbox"/> | 3) Not reading permit <input type="checkbox"/> |
| R) Chemicals not properly handled <input type="checkbox"/> | 4) Wrong interpretation of risk <input type="checkbox"/> |
| POSITIONS OF PEOPLE | 5) Wrong instruction <input type="checkbox"/> |
| S) In danger of struck by... <input type="checkbox"/> | 6) No procedure <input type="checkbox"/> |
| T) In danger of striking against <input type="checkbox"/> | 7) Forgotten <input type="checkbox"/> |
| U) In danger of caught by <input type="checkbox"/> | AWARE |
| V) In danger of fall/slip/trip <input type="checkbox"/> | 8) Negligence <input type="checkbox"/> |
| W) In danger of burnt <input type="checkbox"/> | 9) Working condition (including Weather) <input type="checkbox"/> |
| X) Wrong position <input type="checkbox"/> | 10) Worksite layout <input type="checkbox"/> |
| Y) In danger of electricity <input type="checkbox"/> | 11) The design of equip./tools <input type="checkbox"/> |
| HOUSEKEEPING | 12) Work habits <input type="checkbox"/> |
| Z) Access block by obstruction <input type="checkbox"/> | 13) Lack of skill <input type="checkbox"/> |
| AA) Tools/materials disorganized <input type="checkbox"/> | 14) Time pressure <input type="checkbox"/> |
| BB) Poor/improper roping off <input type="checkbox"/> | 15) Not requested <input type="checkbox"/> |
| CC) Accumulation of rubbish <input type="checkbox"/> | 16) Physical limitations <input type="checkbox"/> |
| PERMIT/PROCEDURES | 17) Not supplied/available <input type="checkbox"/> |
| DD) Work without permission <input type="checkbox"/> | 18) Lack of ownership <input type="checkbox"/> |
| EE) Wrong permit <input type="checkbox"/> | |
| FF) Procedure not followed <input type="checkbox"/> | |
| GG) Wrong instruction on permit <input type="checkbox"/> | |
| HH) Permit procedure not followed <input type="checkbox"/> | |

APPENDIX 5
INCIDENT PRELIMINARY REPORTING

| | | |
|--|--|--------------------------------|
| (COMPANY NAME) | INCIDENT PRELIMINARY NOTIFICATION FACSIMILE MESSAGE | DATE: _____ TIME: _____ |
| LOCATION: | | |
| THIS REPORT SHALL BE COMPLETED AND FAXED TO ADWEA HSE WITHIN 24 HRS. OF THE EVENT | | |
| TYPE OF INCIDENT | | |
| TICK AS APPLICABLE: | | |
| <input type="checkbox"/> Fatality | <input type="checkbox"/> Transport/Vehicle | |
| <input type="checkbox"/> Injury | <input type="checkbox"/> Marine Collision | |
| <input type="checkbox"/> Occupational Illness | <input type="checkbox"/> Leaks/Spills | |
| <input type="checkbox"/> Property Damage | <input type="checkbox"/> Chemical Spill | |
| <input type="checkbox"/> Fire/Explosion | <input type="checkbox"/> Radiation | |
| <input type="checkbox"/> Other, specify: | | |
| BRIEF DESCRIPTION: | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| Line Manager, NAME: | SIGNATURE: | |