



HSSE WORLD EXAMPLE FORM

HSE Incident Reporting procedure

HEALTH, SAFETY and ENVIRONMENTAL INCIDENT REPORT

PART 1 – INITIAL INCIDENT REPORT FORM

To be used to complete an initial report of the incident. Complete Section 1 for all Incident Types and any other Section in Part 1 as appropriate. Part 2 of the Form is to be used for providing updated information and details of the investigation and Close Out Actions.

Section 1 – General Information

Note: Any incident may have more than one type. For instance a Vehicle Incident may result in an injury to the driver/passenger. For reporting purposes if a vehicle is involved then the PRIMARY incident type will be vehicle and the SECONDARY incident type will be injury.

Are you reporting a Near Miss? (Note: If reporting a Near Miss, only complete Section 1 of Part 1. Complete Part 2 as appropriate)

Primary Incident Type

- | | | | | |
|--|---|--|-----------------------------------|--|
| <input type="checkbox"/> Vehicle | <input type="checkbox"/> Environmental | <input type="checkbox"/> Injury | <input type="checkbox"/> Illness | <input type="checkbox"/> Property/Equipment Damage |
| <input type="checkbox"/> Fire | <input type="checkbox"/> External Assessment | <input type="checkbox"/> Theft | <input type="checkbox"/> Sabotage | <input type="checkbox"/> Security |
| <input type="checkbox"/> Radiation Involved? | <input type="checkbox"/> Explosives Involved? | <input type="checkbox"/> Other (describe): _____ | | |

Briefly Describe Incident: Describe what happened (DO NOT use people's names or any medical diagnosis):

Date and Time information	dd-Mmm-yyyy	24-hr clock	Form Completed by:	Name:
Occurrence Date and Time:				Phone:
Date and Time Reported:			Supervisor of Work Detail:	Name:
				Phone:

Location

Occurrence Site:
Detailed description of location (e.g. corner of 5th and 6th Avenue):

Location Type (refer to Guidance Note 6.3):

Secondary Incident Type: *Check all that apply*

- | | | | | |
|--|---|--|-----------------------------------|--|
| <input type="checkbox"/> Vehicle | <input type="checkbox"/> Environmental | <input type="checkbox"/> Injury | <input type="checkbox"/> Illness | <input type="checkbox"/> Property/Equipment Damage |
| <input type="checkbox"/> Fire | <input type="checkbox"/> External Assessment | <input type="checkbox"/> Theft | <input type="checkbox"/> Sabotage | <input type="checkbox"/> Security |
| <input type="checkbox"/> Radiation Involved? | <input type="checkbox"/> Explosives Involved? | <input type="checkbox"/> Other (describe): _____ | | |

Actual Severity refer to Note 6.5

Potential Severity refer to Note 6.5

<input type="checkbox"/> Category I	<input type="checkbox"/> Category IV	<input type="checkbox"/> Category I	<input type="checkbox"/> Category IV
<input type="checkbox"/> Category II	<input type="checkbox"/> Category V	<input type="checkbox"/> Category II	<input type="checkbox"/> Category V
<input type="checkbox"/> Category III		<input type="checkbox"/> Category III	

Organization responsible for work activity at time of incident:

- Client Contractor Subcontractor Other



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Section 2 - Injury / Illness Details

For Additional Injuries with this incident make copies of this page

Check the one that applies:

- Company Employee Casual / Temp / Contract Employee Client Employee Subcontractor Employee Public
 JV Employee

Injured Party Details:

Last Name: _____ First Name: _____ ID/Badge No. _____

Job Task/Activity at time of Incident: _____

	Body Part (s) (refer to Guidance Note 6.1):	Nature of Injury (refer to Guidance Note 6.2):
<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both		
<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both		

Cause of Injury (refer to Guidance Note 6.4): _____

Injury Classification:

- | | | | |
|-------------------------------------|--|---|--|
| <input type="checkbox"/> Fatality | <input type="checkbox"/> Medical Case | <input type="checkbox"/> Non Occupational Fatality | <input type="checkbox"/> Non Occupational Restricted |
| <input type="checkbox"/> Lost Time | <input type="checkbox"/> First Aid | <input type="checkbox"/> Non Occupational Lost Time | <input type="checkbox"/> Non Occupational Medical |
| <input type="checkbox"/> Restricted | <input type="checkbox"/> If First Aid, Was Treatment Administered by a Doctor? | <input type="checkbox"/> Non Occupational First Aid | |

Non Employee Details:

Name of Company / JV / Client / Member of Public: _____

Address of Company / JV / Client / Member of Public: _____

First Aid Classification Justification (This list indicates those treatments that constitute first aid treatment):

- Use of a non prescription medication at non prescription strength
 Administering tetanus immunisation
 Cleaning, flushing or soaking wounds on the surface of the skin
 Using wound coverings such as bandages, gauze pads or butterfly bandages
 Use of hot or cold therapy
 Using any non rigid means of support (i.e. elastic bandages)
 Use of a temporary immobilisation device for transportation
 Drilling of a fingernail or toenail to relieve pressure or draining fluid from a blister
 Using eye patches
 Removing foreign bodies from the eye using only irrigation or a cotton swab
 Removing splinters or foreign material from areas other than the eye by simple means
 Using finger guards
 Using massages
 Drinking fluids for the relief of heat stress
 No treatment given (Diagnostic only)

Other Details

- | | |
|--|---|
| <input type="checkbox"/> Lost Time, estimate number of days: _____ | <input type="checkbox"/> Injured Party lost consciousness |
| <input type="checkbox"/> Restricted Case, estimate number of days: _____ | <input type="checkbox"/> Injury resulted in transfer to another job |



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Section 3 - Vehicle Details

If more than one company / non company vehicle was involved, make additional copies of this page

Company Vehicle Involved Non Company vehicle Involved

Company Vehicle Information

Vehicle VIN Number:	Vehicle Make:	Vehicle Model:
Company Number:	Licence Plate Number:	Registration:
Vehicle Type:	<input type="checkbox"/> Light Duty Passenger	<input type="checkbox"/> Body Load Truck
	<input type="checkbox"/> Tractor	<input type="checkbox"/> Sports Utility
		<input type="checkbox"/> Other (specify)
Description of Damage to Vehicle:		

Company Vehicle Driver Information

Last Name:	First Name:	ID/Badge Number:
Address / Phone No. if Non Company Driver:		
Drivers Licence Number:	Country:	Expiry Date (dd Mmm yyyy):
City/Province nearest the place where the incident occurred:		Seat Belt Worn <input type="checkbox"/> Yes <input type="checkbox"/> No

Descriptors of Incident

<input type="checkbox"/> Yes <input type="checkbox"/> No	Vehicle was a rental vehicle (Rental company and agreement number):		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Company vehicle towed from scene?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vehicle weight more than 10,000 lbs (4550 kg)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Non Company vehicle towed from scene?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vehicle designed to carry 16 + passengers?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hazardous Chemicals Spilled (other than fuel from fuel tanks)? (if yes complete Section 5)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Were there any fatalities? (if yes complete Section 2)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any party receive medical treatment away from scene? (if yes complete Section 2)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Was Company Driver cited?

Vehicle Descriptors of Incident

Road Conditions	<input type="checkbox"/> Dry	<input type="checkbox"/> Wet	<input type="checkbox"/> Ice	<input type="checkbox"/> Snow	<input type="checkbox"/> Mud
Vehicle Motion	<input type="checkbox"/> Forward	<input type="checkbox"/> Reversing	<input type="checkbox"/> Stationary	<input type="checkbox"/> Turning Left	<input type="checkbox"/> Turning Right
Incident Type	<input type="checkbox"/> Multiple	<input type="checkbox"/> Ran off roadway	<input type="checkbox"/> Struck fixed object	<input type="checkbox"/> Struck other vehicle	<input type="checkbox"/> Other vehicle struck our vehicle
Road Surface	<input type="checkbox"/> Asphalt / Tarmac	<input type="checkbox"/> Concrete / Paved	<input type="checkbox"/> Loose Gravel	<input type="checkbox"/> Loose Sand	<input type="checkbox"/> Packed Gravel
				<input type="checkbox"/> Packed Sand	<input type="checkbox"/> Unimproved

Company / Non Company Passenger Details

Company Employee	Yes	No	Last Name	First Name	ID/Badge Number	Seat Belt Worn?
Passenger 1	<input type="checkbox"/> Y	<input type="checkbox"/> N				<input type="checkbox"/> Yes <input type="checkbox"/> No
Passenger 2	<input type="checkbox"/> Y	<input type="checkbox"/> N				<input type="checkbox"/> Yes <input type="checkbox"/> No
Passenger 3	<input type="checkbox"/> Y	<input type="checkbox"/> N				<input type="checkbox"/> Yes <input type="checkbox"/> No

Non Company Vehicle Details

Vehicle VIN Number:	Vehicle Make:	Vehicle Model:
Licence Plate Number:	Registration:	
Vehicle Type:	<input type="checkbox"/> Light Duty Passenger	<input type="checkbox"/> Body Load Truck
	<input type="checkbox"/> Tractor	<input type="checkbox"/> Sports Utility
		<input type="checkbox"/> Other (specify)
Description of Damage to Vehicle:		

Non Company Vehicle – Driver / Passenger Details

	Last name	First name	Address	Tel No.	Drivers Licence No. & Country
Driver					
Passenger 1					
Passenger 2					
Insurance Company:					Policy No:



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Section 4 – Property & Equipment Damage

Who owns the Property / Equipment?

<input type="checkbox"/> Company	<input type="checkbox"/> Client	<input type="checkbox"/> Employee
<input type="checkbox"/> Third Party	<input type="checkbox"/> Subcontractor	<input type="checkbox"/> JV

Equipment Type (refer to Guidance Notes):

Examples: Tank, building, Trailer, Fork lift, Vessel etc

Type of Damage

<input type="checkbox"/> Structural	<input type="checkbox"/> Mechanical	<input type="checkbox"/> Theft	<input type="checkbox"/> Process Failure	<input type="checkbox"/> Natural Causes (Earthquake, Flood etc)
<input type="checkbox"/> Sabotage	<input type="checkbox"/> Fire			

Description of Damage:

Provide details of the Type of Property and Equipment (with serial numbers etc if available) and describe what happened and the extent of damage. If possible provide an estimate of the cost of the damage.

Section 5 – Environmental Details

Check all that apply

Agent	<input type="checkbox"/> Substance	<input type="checkbox"/> Explosion	<input type="checkbox"/> Light	<input type="checkbox"/> Noise	<input type="checkbox"/> Radiation	<input type="checkbox"/> Vibration
Medium	<input type="checkbox"/> Air	<input type="checkbox"/> Soil	<input type="checkbox"/> Surface Water	<input type="checkbox"/> Ground Water		
Effect	<input type="checkbox"/> People	<input type="checkbox"/> Animals	<input type="checkbox"/> Vegetation	<input type="checkbox"/> Structures	<input type="checkbox"/> Equipment	<input type="checkbox"/> Materials

Substance Information:

Name	Amount	Unit of Measure (i.e. LB)
1.		
2.		
3.		

Describe Response Details:

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Section 6 – External Assessment

Check all that apply

<input type="checkbox"/> Notice of Violation	<input type="checkbox"/> Audit	<input type="checkbox"/> Self Reported	<input type="checkbox"/> Other
<input type="checkbox"/> Regulatory Visit	<input type="checkbox"/> Inspection	<input type="checkbox"/> Regulatory Investigation	Describe:

Describe the Assessment (include Name and contact details of assessor)

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HEALTH, SAFETY and ENVIRONMENTAL INCIDENT REPORT

PART 2 – FOLLOW-UP, INVESTIGATION & CORRECTIVE ACTIONS To be used for providing Follow-up and Investigation details.

Section 1 – Incident Identification

Incident Number: Incident Date: Date format: dd-Mmm-yyyy

Detailed Description – Additional details not provided as part of the Initial Incident Report:

Updated Injury / Illness Details

Last Name: First Name: ID/Badge No.

Recordable Injury Class:

- Fatality Medical Case Non Occupational Fatality Non Occupational Restricted
- Lost Time First Aid Non Occupational Lost Time Non Occupational Medical
- Restricted If First Aid, Was Treatment Administered by a Doctor?

If Lost Time	Number of Lost Days	If Restricted Work Case	Number of Restricted Days
--------------	---------------------	-------------------------	---------------------------

Witness Details

	Name:	Address:	Phone:	Comments:
Witness 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Witness 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Witness 3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
External Investigator (if applicable) Organization/Company	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Incident Costs

 Where possible provide actual or estimated costs for the incident.

Cost Type (i.e. Medical, Investigation Time, Ops Down Time, Legal etc)	Amount	Unit of Measure (i.e. L.E, US\$)



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Section 2 – Causal Factors

Root Cause Information (refer to Guidance Note 6.6 and indicate codes) **NOTE:** Only ONE can be Primary

Causal Group	Causal Factors	Primary	Causal Group	Causal Factors	Primary
		<input type="checkbox"/> Yes			<input type="checkbox"/> Yes
		<input type="checkbox"/> Yes			<input type="checkbox"/> Yes
		<input type="checkbox"/> Yes			<input type="checkbox"/> Yes

Investigation Findings

Findings Details (if more than one finding make copies of this page)

What is the Status of the Finding? <input type="checkbox"/> Complete <input type="checkbox"/> In Progress <input type="checkbox"/> Under Review	Scheduled Close Date (dd-Mmm-yyyy) Actual Close Date (dd-Mmm-yyyy)	
Finding Description (e.g. No HSE training provided on project):		
Recommendation (e.g. Provide HSE training):		

Risk Assessment of Finding (refer to Halliburton Risk Matrix):

Severity	<input type="checkbox"/> Catastrophic	<input type="checkbox"/> Critical	<input type="checkbox"/> Marginal	<input type="checkbox"/> Negligible	
Likelihood	<input type="checkbox"/> Improbable	<input type="checkbox"/> Remote	<input type="checkbox"/> Occasional	<input type="checkbox"/> Reasonably Probable	<input type="checkbox"/> Frequent

Action(s) (describe actions taken):

	Scheduled Close Date	Actual Close Date															
1.																	
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">Person Responsible for Action:</td> <td style="width: 15%;">Last Name</td> <td style="width: 20%;"></td> <td rowspan="3" style="width: 15%;"><input type="checkbox"/> Ops Personnel</td> <td rowspan="3" style="width: 15%;"><input type="checkbox"/> Site Management</td> <td rowspan="3" style="width: 15%;"><input type="checkbox"/> Site Supervision</td> <td rowspan="3" style="width: 15%;"><input type="checkbox"/> HSE Manager</td> <td rowspan="3" style="width: 15%;"><input type="checkbox"/> Project Manager</td> <td rowspan="3" style="width: 15%;"><input type="checkbox"/> PL Manager</td> </tr> <tr> <td></td> <td>First Name</td> <td></td> </tr> <tr> <td></td> <td>Employee No.</td> <td></td> </tr> </table>	Person Responsible for Action:	Last Name		<input type="checkbox"/> Ops Personnel	<input type="checkbox"/> Site Management	<input type="checkbox"/> Site Supervision	<input type="checkbox"/> HSE Manager	<input type="checkbox"/> Project Manager	<input type="checkbox"/> PL Manager		First Name			Employee No.			
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Person Responsible for Action:	Last Name		<input type="checkbox"/> Ops Personnel							<input type="checkbox"/> Site Management	<input type="checkbox"/> Site Supervision	<input type="checkbox"/> HSE Manager	<input type="checkbox"/> Project Manager	<input type="checkbox"/> PL Manager			
	First Name																
	Employee No.																
3.																	
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Person Responsible for Action:	Last Name		<input type="checkbox"/> Ops Personnel							<input type="checkbox"/> Site Management	<input type="checkbox"/> Site Supervision	<input type="checkbox"/> HSE Manager	<input type="checkbox"/> Project Manager	<input type="checkbox"/> PL Manager			
	First Name																
	Employee No.																

CLOSE OUT SIGNATURES

To be completed when all Findings and Actions resulting from the incident have been closed to the satisfaction of Site / Local Management and Responsible Officer.

Last Name:	First Name:	Position:	Date (dd Mmm yyyy)	Signature:
			
			
			



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HSE Incident Reporting procedure

ROOT CAUSE ANALYSIS QUESTIONNAIRE

Interviewee's Name:

Date:

Interviewed By:

Answer the following questions as factually as possible. Use "n/a" if the question is not Applicable. Please write on the back of the paper if you need more room.

1. What was the job assignment?
2. What happened?
3. Did the task/area receive a walk through or review (Safe Working Plan) by the Supervisor and task performer(s)?
4. What questions were asked?
5. What training is required for the task?
6. What hazards were associated with the task?
7. Were there any unusual hazards?
8. Is this a first time activity or does it involve work?
9. What information was available to perform the task?
10. Was the engineering data available, clear and adequate?
11. What permits are required for this job?
12. What training, qualifications and needed skills was provided (is needed) for this task?
13. What was the surrounding conditions/weather?
14. What was the allotted time frame to perform the task?
15. Were the proper tools/equipment selected or readily available (describe them)?
16. Was this activity in your normal work schedule?
17. What are your qualifications to perform the job?
18. How could this incident have been avoided?
19. Does a written or accepted procedure exist for this task/activity? If so, describe.
20. Was there an unrecognized hazard involved?
21. Was this activity or violation a frequent occurrence or an accepted practice as long as no? Incidents occurred?
22. Have similar near misses/hits, other incidents been recorded prior to this accident?
23. Had this behavior been observed by a supervisor previously and no corrective action Taken?
24. Are there any company, or other standards and procedures that prohibit this activity or Behavior/condition?
25. Was it well known or training provided?

HEALTH, SAFETY and ENVIRONMENTAL INCIDENT REPORT

Guidance Notes

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- | | |
|--|--|
| <p>1. The Incident Report is divided into two Parts. Part 1 must be completed and submitted by shift end on the day of occurrence or Contractor 1st becoming aware of incident and deals with the initial report of the Incident. Part 2 should be completed as soon as possible after the incident has occurred, but normally not more than 24 hrs.</p> <p>2. Section 1 of Part 1 of the Form <u>must</u> be completed for all incidents / near miss. Other than for very complex incidents it will not be necessary to complete all sections for every incident (e.g. for an injury incident it will only be necessary to complete Sections 1 and 2 of Part 1 of the Form)</p> <p>3. Indicate whether the report is applicable to an "incident" or a "near miss". An incident is defined as an event resulting in damage or loss. A near miss is an event where there was the potential for damage or loss but none actually occurred.</p> <p>4. Choose one of the values from the following lists as appropriate when completing the incident report form.</p> | <p>5. <u>Definitions:</u></p> <p>5.a <u>Lost Time Injury</u> – A work related injury / illness that results in days away from work (does not include the day of the injury or onset of illness).</p> <p>5.b <u>Restricted Work Activity Case</u> - A work related injury / illness that results in workdays on which the employee was assigned to another job on a temporary basis, worked a permanent job less than full time or worked at a permanently assigned job but could not perform all duties connected with it.</p> <p>5.c <u>Medical Treatment Case</u> – A work related injury involving treatment other than first aid (refer to Part 1; Section 2 "First Aid Case Justification" for definition of treatment that constitutes first aid). Any other treatment regardless of who provides the treatment not included on this list is considered to be Medical Treatment.</p> |
|--|--|

6.1 BODY PARTS:

Head - Multiple Head Injury	Neck - Vertebrae	Finger(s)	Trunk - Internal Organs
Head - Skull	Neck - Disc	Thumb	Trunk - Abdomen
Head - Brain	Neck - Spinal Cord	Trunk - Multiple Trunk	Trunk - Heart
Head - Ear(s)	Neck - Larynx	Trunk - Upper Back Area	Multiple Lower Extremities
Head - Eye(s)	Neck - Soft Tissue	Trunk - Chest (Ribs, Sternum, Soft Tissue)	Hip
Head - Nose	Neck - Trachea	Trunk - Sacrum & Coccyx	Thigh
Head - Teeth	Multiple Upper Extremities	Trunk - Buttocks	Knee
Head - Mouth	Upper Arm	Trunk - Pelvis	Lower Leg
Head - Other Facial Soft Tissue	Elbow	Trunk - Groin	Ankle
Head - Facial Bones	Lower Arm	Trunk - Spinal Cord	Foot
Neck - Multiple Injury	Wrist	Trunk - Lower Back Area	Toe(s)
	Hand	Trunk - Disc	Multiple Body Parts

6.2 NATURE OF INJURY:

Abrasion	Decomp Sickness Type 1	Enucleation (To Remove Tumor, Eye etc.)	Rupture
Amputation	Decomp Sickness Type 2	Hearing Loss (Traumatic Only)	Severance
Angina Pectoris (Heart Disease)	Dislocation	Heat Prostration	Sprain
Asphyxiation	Electric Shock	Inflammation	Strain
Burn	Foreign Body	Irritation	Vascular Loss
Concussion	Fracture	Laceration	Vision Loss
Contusion	Freezing	Myocardial Infarction (Heart Attack)	All Other Specific Injuries
Crushing	Hernia	Puncture	

6.3 INCIDENT LOCATION TYPE:

Airport / Heliport	Manufacturing Area	Private Road / Haul Road	Vessel
Construction Site	Office	Public Highway / Road	Warehouse
Dock / Quayside	Offshore Platform	Shop	Waste Storage / Disposal Area
Fabrication Area	On-Shore Well Site	Vehicle Parking Area	Yard
Laboratory	Operating Area		

Guidance Notes

6.4 CAUSE OF INJURY:

Burn - Acid Chemicals	Fall from different level	Strain - Pushing or pulling	Struck by - Injured by moving parts of machine
Burn - Contact with hot objects	Fall from ladder scaffolding	Strain - Reaching	Struck by - Injured by object being lifted
Burn - From ambient temperature extremes	Fall / Slip from liquid / grease spill	Strain - Using tool or machine	Struck by - injured by object handled by others
Burn - Fire or Flame	Fall / slip on same level	Strain - Misc	Struck by - Misc
Burn - Steam or Hot fluids	Fall / Slipped did not fall	Strain - Climbing	Misc - Contact with electric current
Burn - Welding operations	Fall - Misc (fall or slip injury)	Strike - step on moving parts of machine	Misc - Animal or insect
Burn - Misc (burn, scald, heat, cold exposure)	MV - Collision with another vehicle	Strike by object being handled	Misc - Explosion or flare back
Caught in machine or machinery	MV - Collision with a fixed object	Strike - Sanding / scraping / cleaning operations	Misc - Foreign body in eye
Caught in object handled	MV - Crash of airplane	Strike / Step on stationary object	Misc - Robbery or criminal assault
Caught - Misc (caught in or between)	MV - Vehicle upset	Strike - Stepping on sharp object	Misc - Cumulative (all other)
Cut, Puncture - Broken glass	MV - Misc (Motor vehicle)	Strike - Misc	Misc - Other
Cut, Puncture - Hand tool / utensil - not powered	Strain - Jumping	Struck by - Falling or flying object	Personal (Non Job Related)
Cut, Puncture - Powered hand tool / appliance	Strain - Holding or carrying	Struck by - Injured by hand tool / machine in use	Non - Burn Chemical / Gas Exposure
Cut, Puncture - Misc (cut puncture, scrape)	Strain - Lifting	Struck by - motor vehicle	

6.5 INCIDENT SEVERITY CATEGORIES

INCIDENT EVALUATION										
Severity (Consequence) Category	Severity (Consequence) – Actual or Potential				Probability					
	Injury / Illness	Loss or Penalty (Vehicle / Equipment)	Reputation Impact	Environmental	A	B	C	D	E	F
I	Death	>\$1M	Global Impact	Massive Effect						
II	Disabling Injury	>\$200,000	Regional Impact	Major Effect			H			
III	Serious Injury / Illness	>\$50,000	National Impact	Local Effect				M		
IV	Moderate Injury / Illness	>\$5,000	Local Impact	Minor Effect					L	
V	Minor or No Injury /Illness	<\$5,000	No Impact	No or Slight Effect						

Probability Rating	Severity / Risk
A: FREQUENT – Likely to occur repeatedly during operations	D: REMOTE – Not Likely but Possible
B: REASONABLY PROBABLE – Likely to occur several times	E: EXTREMELY IMPROBABLE – Probability of Occurrence can not be distinguished from zero
C: OCCASIONAL – Likely to occur sometimes	
Disabling Injury / Illness: Is an incident that results in or has the potential to result in a permanent injury (disability / disfigurement) that the injured party will never recover completely from – loss of sight / loss of hearing / loss of limb / paralysis etc.	
Serious Injury / Illness: Is an incident that results in or has the potential to result in an injury that given time the injured person is likely to recover completely from – temporary hearing or vision impairment / certain classes of biological exposure / fractures etc. The injury may result in days away from work or on restricted duty.	
Moderate Injury / Illness: Is an incident that results in or has the potential to result in an injury requiring medical treatment (not affecting work performance or causing disability).	
Minor or No Injury / Illness: Is an incident that results in or has the potential to result in first aid treatment or no injury.	
Loss or Penalty: Is to be used for incidents where there are or potentially are no injuries. In particular use the Loss or Penalty Consequence for vehicle incidents if there are no injuries.	
Massive Environmental Effects: Any incident that potential harms or adversely affects the general public, causing widespread public concern. Can result in major economic loss or liability to the Company. Constant breaches of statutory or prescribed limits.	
Major Environmental Effect: Severe environmental damage, requiring extensive measures to restore contaminated environment to original state. Requires specialised expertise and resource for correction. Extended breaches of statutory or prescribed limits.	
Local Environmental Effect: Incident that presents limited environmental harm to the local area and neighbourhood. Requires general expertise and resources for correction. May involve repeated breaches in statutory or prescribed limits.	
Minor Environmental Effect: Damage sufficiently large to harm environment of localised area. May involve a single breach of statutory or prescribed limits.	
No or Slight Environmental Effect: Any incident that presents limited harm to the environment but may require minor corrective actions.	
In circumstances where an incident results in or potentially results in more than one consequence then assign the higher Severity Category as appropriate. This is more likely when dealing with vehicle incidents involving a injury and / or environmental issue.	



HSSE WORLD EXAMPLE FORM

HSE Incident Reporting procedure

Guidance Notes

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3P. Procedures	<u>3P.02 Not Used / Followed</u>	<u>3P.065 Procedure Wrong</u>	<u>3P.125 Procedure Followed Incorrectly</u>
	3P.03 No Procedure 3P.04 Not available or inconvenient 3P.05 Difficult to use 3P.06 Use not required but should be	3P.07 Typo Error 3P.08 Sequence Wrong 3P.09 Facts Wrong 3P.10 Situation not covered 3P.11 Wrong Revision Used 3P.12 Second Checker Needed	3P.13 Format Confusing 3P.14 >1 Action Step 3P.15 Excess References 3P.16 Multiunit References 3P.17 Limits NI 3P.18 Details NI 3P.19 Data/Computation Wrong/Incomplete 3P.20 Graphics 3P.21 No Check Off 3P.22 Check Off Miss Used 3P.23 Miss Used Second Checker 3P.24 Ambiguous Instructions 3P.25 Equipment ID NI
3Q. Quality Control	<u>3Q.02 No Inspection</u>	<u>3Q.06 Quality Control NI</u>	
	3Q.03 Inspection Not Required 3Q.04 No Hold Point 3Q.05 Hold Point Not Performed	3Q.07 Inspection Instructions NI 3Q.08 Inspection Techniques NI 3Q.09 Foreign Material Exclusion During Work NI	
3T. Training	<u>3T.02 No Training</u>	<u>3T.06 Understanding NI</u>	
	3T.03 Task not analysed 3T.04 Decided not to train 3T.05 No Training Objective	3T.07 Learning objectives NI 3T.08 Lesson plan NI 3T.09 Instruction NI 3T.10 Practice / Repetition NI 3T.11 Testing NI 3T.12 Continuing training NI	
3W. Work Direction	<u>3W.02 Preparation</u>	<u>3W.10 Worker Selection</u>	<u>3W.16 Supervision</u>
	3W.03 No preparation 3W.04 Work package / Permit NI 3W.05 Pre-Job briefing NI 3W.06 Walk-thru NI 3W.07 Scheduling NI 3W.08 Lock Out / Tag Out 3W.09 Fall Protection NI	3W.11 Not Qualified 3W.12 Fatigued 3W.13 Upset 3W.15 Team Selection NI	3W.17 No Supervision 3W.18 Crew Teamwork NI
3Z. Other	<u>3Z.01 Other</u>		
	Specify		
3M. Management Systems	<u>3M.02 Standards, Procedures & Admin Controls (SPAC)</u>	<u>3M.08 Not Used SPAC</u>	<u>3M.14 Oversight / Employee Relations</u>
	3M.03 No SPAC 3M.04 SPAC not Strict Enough 3M.05 Confusing or Incomplete 3M.06 Technical Error 3M.07 Drawings / Prints NI	3M.09 Communication NI 3M.10 Recently Changed 3M.11 No Way to Implement 3M.12 Accountability NI	3M.15 Infrequent A&E 3M.16 A&E Lack Depth 3M.17 A&E Not Independent 3M.18 Employee Communications NI 3M.19 No Employee Feedback
	<u>3M.20 Corrective Actions</u>		
	3M.21 Corrective Actions NI 3M.22 Corrective Actions Not Yet Implemented 3M.23 Trending NI		