



UNIF-HSE-PRO-102 Safe Systems of Work Incident Investigation and Reporting

**HSE Safe Systems of Work
Volume 1**

UNIF-HSE-PRO-102

Incident Investigation and Reporting

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APPENDIX A – MAJOR [INCIDENT NOTIFICATION PRO-FORMA](#)
 APPENDIX B – /HIGH POTENTIAL NOTIFICATION PRO-FORMA
 APPENDIX BC – [Tr@ction Severity Matrix](#)[INCIDENT REPORTING AND INVESTIGATION FORM](#)
 APPENDIX DC – MODEL TERMS OF REFERENCE TEMPLATE
 APPENDIX ED – [SYSTEM CAUSE ANALYSIS CHART](#)[CLC CHART](#)
 APPENDIX E – [INCIDENT INVESTIGATION REPORT](#)
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 APPENDIX G – [INJURY AND ILLNESS REPORTING DECISION TREE](#)
 APPENDIX H – [HSE ACCOUNTABILITY BOUNDARIES](#)

FIGURES

FIGURE 1 MAJOR / HIGH POTENTIAL INCIDENT NOTIFICATION CHART 8

Incident Investigation and Reporting

1 INTRODUCTION

1.1 PURPOSE

This document describes the procedures employed for investigating incidents related to BP activities in the Azerbaijan Business Unit (AzBU) and in the preparation of associated reports.

Note: The prime objectives of such an investigation are to analyze the causes and make recommendations to prevent recurrence of a similar incident. It is not to attribute blame.

1.2 SCOPE

This process is to be used for all types of incidents, including:

- fatalities
- workplace injuries and illness
- security breaches
- spills and leaks
- vehicle accidents,
- significant near misses, etc.

All events resulting in harm to people, industrial illness, damage to assets, and environmental harm (together with near miss events in these categories) are to be reported immediately to the supervisor and / or the BP representative.

1.3 CONTRACTOR INVESTIGATIONS

For serious incidents involving contractor employees, contractor management may wish to conduct a separate internal incident investigation. BP policy is to respect the wishes of contractors, but to encourage completion of a joint investigation in a cooperative manner with representatives of both BP and affected contractors.

The contractors' own incident investigation procedure may be used if it is at least as comprehensive as this procedure.

1.4 DEFINITIONS

Guidance and detailed explanations of definitions are provided in the Appendix F, Guidelines for Reporting and Recording Occupational Injuries and Illnesses.

Accident

Accident is an undesired event that results in harm to people, damage to property/assets, environmental harm and breach of security.

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Incident Investigation and Reporting

~~Incident~~

~~The term used to describe the undesired transfer of energy that may either result in an accident or has the potential to do so.~~

2 RESPONSIBILITIES

2.1 ALL PERSONNEL

Any person involved in or observing an accident or near miss must immediately report it to his / her supervisor or BP Representative.

2.2 PERFORMANCE UNIT LEADER

Performance Unit Leaders (PUL) ~~are~~ responsible and accountable for:

- ensuring that this procedure is implemented in their performance units
- reporting Major Incidents and High Potential Incidents to the Corporation.

2.3 SITE MANAGER

Site Managers are responsible for:

- making an initial assessment of the severity of an incident
- instigating the appropriate investigation process
- assuming ownership of minor incidents on his site
- accepting the Incident Report and allocating the resultant actions.

2.4 OWNER

The Owner is the individual who requested the Incident Investigation to be performed. This will be the Site Manager or PUL.

The Owner shall:

- appoint the Investigation Team
- draw up the terms of reference for the investigation
- provide a business overview on actions prior to entry into the tracking system and shall review each action item for confidentiality
- review the selection of the Responsible Party for handling the action items
- ensure that all new or reassigned action items are entered in to the Accident and Incident database under the appropriate category
- review progress reports to ensure that all outstanding action items are being completed within specified deadlines
- shall take appropriate action with the Responsible Party if action items are not being completed within the desired deadline.

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2.5 INVESTIGATOR / INVESTIGATION TEAM

The Investigator / Investigation Team are responsible for:

- investigating the circumstances leading to the event
- making recommendations to prevent recurrence
- ensuring that the written report is completed.

2.6 APPROVER

The Approver is responsible for assuring the quality of the investigation report and the data entered into the Accident and Incident Reporting database.

Note: ~~This role will normally be undertaken by the most senior HSE person in the Owner's organisation;~~ the most senior HSE person in the Owner's organisation will normally undertake this role.

The Approver shall:

- review the Incident Report to ensure an accurate document with proper root cause analysis
- ensure that:
 - ⇒ appropriate hazards have been identified
 - ⇒ action items will effectively mitigate the hazards
 - ⇒ action items are clear and provide the Responsible Party with adequate details to implement the action item
- review the selection of the Responsible Party for handling the action item in order to ensure that the action item has been assigned to an individual or job position with sufficient authority and expertise to complete the action
- approve the report in the Accident and Incident database.

2.7 INCIDENT REPORT ORIGINATOR

The Incident Report Originator is responsible for entering the Incident Report into the Accident and Incident database.

Note: This will normally be the Investigator, a member of the Investigating Team or a nominated Accident and Incident data base operator.

2.8 RESPONSIBLE PARTY

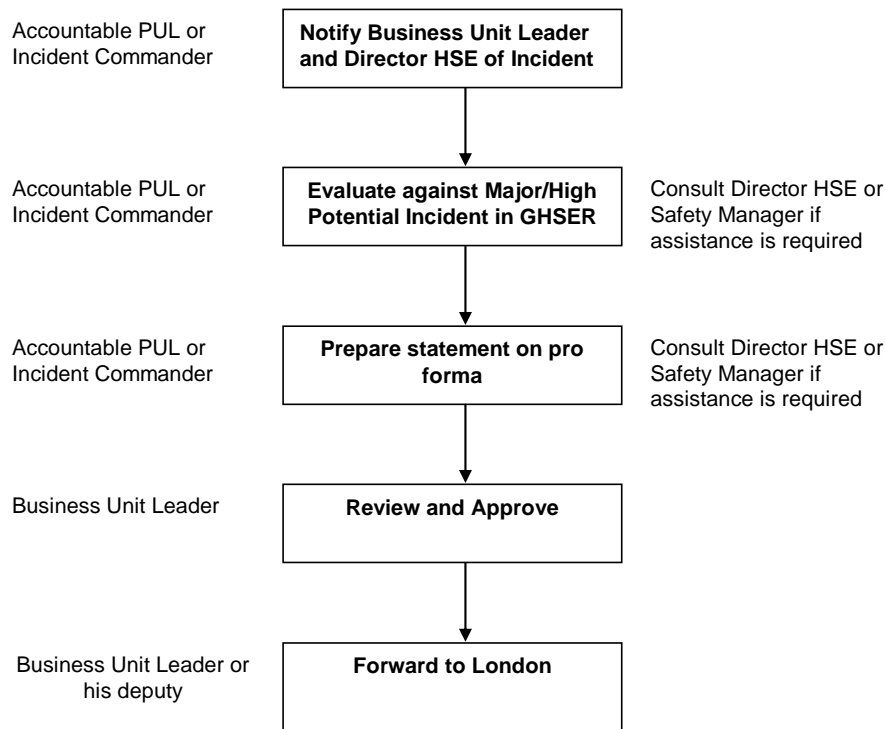
The Responsible Party is the individual who has been assigned an action item arising from an Owner's Incident Investigation. The Responsible Party must have sufficient authority and expertise to carry out the action.

The Responsible Party shall:

- review validity of assignments of an action item with the Owner, if and when they consider the assignment inappropriate

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- date and time of incident
- brief description of the event
- injury details
- damage
- oil or chemical spilled
- immediate corrective action taken to prevent further loss
- contact name (person supplying information) and telephone number.

Incident Investigation and Reporting**Figure 1 Major / High Potential Incident Notification Flowchart****4 THE INVESTIGATION PROCESS****4.1 DETERMINING INCIDENT SEVERITY**

The processes used to investigate an incident always follow the same principles. However, the make up of the Investigation Team, and the investigation process followed, is determined by the potential severity of the incident.

The first stage of the process is therefore to make an estimate of the worstmost serious probable outcome of the incident in order to determine the process to be followed. This will be done by the Site Manager.

Note: Potential Incident severity is based upon the worstmost serious probable outcome. For example:

If a man cuts his finger with a knife, the most likely outcome of the incident is a cut finger and the potential severity of the incident should be judged on that basis

but...

If a man cuts his finger on a power saw, the worstmost serious possible probable outcome could easily have been an amputation and the potential severity of the incident is therefore judged to be much greater.

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Major Incident (Definition)

A Major Incident is an incident, including a security incident, involving any one of the following:

- a fatality associated with BP operations
- multiple serious injuries
- significant adverse reaction from authorities, media, NGO's or the general public
- cost of accidental damage exceeding US\$ 500,000
- oil spill of more than 100 barrels, or less if it at a sensitive location (1 barrel=159 litres=42 US gallons)
- release of more than ten tonnes of a classified chemical.

Note: An incident must always be treated as a Major Incident for investigation purposes if personal injury resulting in a day away from work case or an oil or chemical release beyond company premises has occurred.

Tr@ction

Tr@ction is a software tool designed to provide a single data entry system for all [Health, Safety, Environmental, Property Damage, Reputation and Business Interruption/Unit Outage](#) ~~HSE, Security and Quality~~ incidents. Tr@ction also offers an actual and potential severity matrix that allows the user to assess the incident severity on a consistent basis. [A sample of Incident Reporting and Investigation form and severity matrix](#) ~~is~~ [are](#) provided in [Appendix BC](#).

4.2 ESTABLISH INVESTIGATION TEAM

The responsibility to establish the Investigation Team is with the initiating PUL, ~~Director HSE,~~ and Business Unit Leader. An Owner for the investigation will be designated.

The Business Unit Leader and Department Manager shall initiate the investigation by issuing "Terms of Reference" to the Investigation Team Leader.

Terms of Reference

Terms of Reference detail the requirements of the investigation and give official status to the investigation. In particular they will:

- identify references
- define the scope of work
- list the team members
- provide objectives/guidance
- indicate any requirements for intermediate reporting.

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Note: The investigation shall remain strictly within the Terms of Reference and deviate from them only after discussion with the Owner. A model Terms of Reference template is provided in *Appendix [CD](#)*.

Copies of the Terms of Reference shall be provided to the Investigation Team and the Site Manager.

The Team Leader of the Investigating Team shall discuss the Terms of Reference with the Owner to ensure that he is fully briefed.

Team Selection

Incident investigation teams are determined according to the type of incident. Generally, the team will consist of the following:

- a member designated as the Investigation Team Leader
- at least one person knowledgeable in the process involved
- a contract employee, contractor management representative, and / or HSE representative if the incident involved the work of a contractor
- a person knowledgeable in incident investigation techniques and system cause analysis
- other persons, as needed, with appropriate knowledge and experience to thoroughly investigate and analyze the incident, i.e., may include persons from other assets or within the industry as a third party representative in major investigations.

Note: For Major Incidents, the Investigation Team Leader and at least one other member shall be from a different Business Unit (GHSER requirement).

Team Mobilisation

All teams shall be mobilized within 48 hours of the incident.

4.3 CONDUCT INVESTIGATION

The Team Leader is responsible for completing the investigation.

Scope and Objectives

The investigation shall:

- establish the facts surrounding the incident
- review the application of management systems and management practices and their impact
- identify system causes and make recommendations to prevent recurrence.

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Fact Finding

Information on the incident can be obtained by collecting information from people, positions, parts and papers.

Interviews with witnesses shall be carried out as soon as possible after the incident; while the incident is fresh in their minds and before too much discussion has taken place with their colleagues.

Witnesses should be interviewed individually, so that they are not interrupted or questioned by others involved. One member of the team shall interview the witness and a second record the interview. ~~Interview transcripts must be signed by the interviewee~~[The interviewee must sign interview transcripts.](#)

Checklists are useful in the early stages to keep the full range of inquiry in mind, but they cannot cover all possible aspects of an investigation, nor can they follow all individual leads back to system causal factors. To ensure that all facts are uncovered, ask the broad “who, what, where, when, why and how” open-ended questions.

Establish the Sequence of Events

As the investigation progresses, the investigators should begin to identify the sequence of events and concentrate efforts on increasing their knowledge in areas of uncertainty.

As the extent of physical factors involved in an incident becomes clear, the investigators should shift the emphasis of their investigation and questioning to the system causes and the reasons for people's actions.

Establish a chronology of events by date, time and place. The construction of a diagram showing the connections between the various events and conditions leading up to the incident, called Sequence of Events, is a useful technique in the investigation process, especially for more complex incidents.

Establish Findings

The findings of the investigation should establish the system causes of the incident so that corrective measures can be taken to prevent future incidents.

4.4 ANALYSE FINDINGS

Identify Critical Factors and Causes and Make Recommendations

The investigation process shall identify actions to prevent recurrence. This is achieved by addressing the substandard acts and conditions and by identifying and correcting the latent failures.

Not all causes can be completely eliminated and some may be eliminated only at prohibitive cost. Some recommendations will, therefore, be focused on reducing the risk to a tolerable level, while others will be focused on improving protective systems (the defenses) to limit the consequences.

At least one recommendation should be made for each finding.

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Actions shall be ranked for order or priority as follows.

1. Requires immediate action before activity at the site resumes.
2. Must be completed to an agreed plan.
3. Should be considered but not a priority.

System Cause Analysis

All incident findings should be reviewed to determine the critical factors, immediate causes and system causes of the incident.

Identification of system causes of an incident may often reveal underlying management system failures that resulted in the incident occurring.

System causes should be correlated with *Getting HSE Right*, and other controlled documents to determine recommendations to prevent recurrence.

System Cause Analysis is a:

- process for analyzing incidents-
- means to provide consistent and repeatable results-
- means of providing objective and not punitive results-
- means of providing final results from which system causes can be identified. Once identified, actions can be taken to correct the cause and prevent a similar type incident-

After examining all the critical factors involved in an incident and arriving at the system causes, a good check to use is to ask, "If these system causes were corrected, would this prevent the incident from happening again?" If the answer is no, further evaluation is needed.

System Cause Analysis - Example

It is very easy to mistake an immediate cause for a system cause of an incident. As stated above, the system causes of an incident will often be a management system failure. The following example illustrates this point:

A spill occurred when an employee overflowed a fuel truck while loading it at the bulk fuel loading facility.

The initial investigation revealed that the operator of the truck overestimated the amount of fuel required to fill the truck. By the time he realized he was running out of tank capacity, he couldn't reach the shutoff switch before the truck overflowed.

The initial finding was that the operator of the fuel truck was inattentive. However further questioning of the driver and a survey of the scene revealed that the truck was being loaded from the top and the emergency shutoff switch for top loading was not functioning properly. This required the operator

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to climb down off of the truck and to enter the pump room to shut off the flow of fuel. The malfunctioning switch had been reported several weeks prior to the incident but had not yet been repaired.

Note: One system cause of the incident was subsequently found to be a management system that allowed a critical component of an emergency shutdown system to remain in service while not functioning properly.

After arriving at one of the most obvious causes of the incident, it is important to ask, "Why?" In the case above, asking why the employee overflowed the tank resulted in the identification of the malfunctioning switch, and the need for a system to prioritize work requests so critical safety components are repaired as soon as possible.

The BP ~~System Cause Analysis~~ [Comprehensive List of Causes](#) Chart see *Appendix DE* shall be used to determine system causes for all incident investigations.

4.5 COMPILE REPORT

Note: Minor Incidents need only be reported on the Incident Investigation Report form ([Appendix C](#)) ~~(see Appendix E)~~. Major and High Potential Incident Reports must follow the layout described.

Records

A copy of all BP Major Investigation Reports shall be kept in the Business Unit files and in Corporate HSE files. The incident shall also be entered into the Accident and Incident Data Base. The original of the report will be kept in the files of the site or area in which the incident occurred [for the life of the facility](#).

Report Outline

The report contents should adhere to the following outline:

Title Page: Includes title, location and date of the incident and date of the report.

Executive Summary: "High-level" summarized description of the incident, highlighting significant findings/ conclusions and referencing the investigating team's recommendations. Should be restricted to one page.

Table of Contents: A listing of the report contents and page numbers.

Terms of Reference: An example is attached in the *Appendix GD*.

Core report: Critical factors identified during investigation should be addressed clearly and specifically. [Critical factors are those events which if eliminated would prevent the incident from occurring or significantly reduce the severity of the incident.](#)

Incident Description: Describe the situation before the incident, what happened during the incident and actions taken after the incident. The questions who, what, where and when must be answered.

Discussion of the Evidence & Losses: This section should take the Leader through the logical discussion of the ~~evidence which~~ [evidence that](#) leads to the conclusion of immediate causes.

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Immediate Causes: These are “symptoms” of the system causes and may be identified by utilizing the Incident Investigation Report (~~Appendix E~~) form ([Appendix C](#)) and the ~~System Cause Analysis~~CLC -Chart (~~Appendix DE~~).

System Causes: Categorized as “~~Basic Causes~~System Causes” on the Incident Investigation Report form ([Appendix C](#)) (~~Appendix E~~) and “~~System Causes~~” on the ~~System Cause Analysis~~[Comprehensive List of Causes](#) Chart (~~Appendix DE~~), they are the “whys” of the immediate causes.

Recommendations to Prevent Recurrence: Review each of the immediate and system causes to develop recommended actions to address all identified risks. If causes and recommendations are related to other Controlled Documents and/or regulations, i.e., Traffic Regulations of Azerbaijan / Georgia, those documents should be referenced.

Signatories: After the report has been reviewed and agreed by the Owner, the Investigation Team Leader will sign the report as representative of the Investigation Team and the Owner will sign the report to signify acceptance of the findings and recommended actions on behalf of the Business Unit.

Appendices: **Appendix A - Incident Investigation Report** - This initial report will be completed by the Incident Investigation Team. It is the primary information required to document the incident on Accident and Incident Reporting database.

Appendix B - Diagrams and Photographs - To correlated and illustrate locations and/or progressive locations of people, equipment, etc. that were influential in incident cause and/or prevention.

Appendix C - Documentation - This information is generally the most difficult to find, but the most objective. It is the primary reason why at least one team member must be knowledgeable of the process (operations / maintenance).

Supporting documentation of relevance to the overall report should be contained in this section. This should include statements from witnesses, photographs or drawings, copies of Work Permits, or other documents of importance. If equipment was damaged the details could be recorded in this section.

Appendix D - Interviews - Most information during investigation is obtained from people. They must be interviewed separately and as quickly as practical. The longer the interval between incident and interview, the more distorted the information becomes.

Interview statements should not be a verbatim record of each interview, but should summarize the information gained at each interview. The detailed interview notes may be appended to the report or archived as considered appropriate.

Note: At least one team member must be trained and competent in - interviewing.

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Non-Contributory Factors

The Team may find deficiencies when investigating an incident, which have no bearing on the incident or outcome. If recorded these must be clearly stated as such in the report.

4.6 REVIEW WITH MANAGEMENT

BP Management

The report will be reviewed with management to confirm that the technical aspects are correct and the Terms of Reference have been met. The recommendations should be reviewed and action items assigned to a responsible party with target completion dates and priorities before the report is submitted to the Owner.

Contractors

For investigations involving contractor owned / operated worksites or equipment, located on BP operated areas, efforts will be made to obtain agreement on the report context by BP and contractor management.

4.7 AGREE WITH OWNER

Each action in the recommendations must have been assigned to a person accountable for the action, a target date for completion and a risk rating (low / medium/ high).

The Owner is responsible for making the actions, required completion date, and risk rating, known to the person accountable for the action and assuring timely completion).

4.8 ACTIONS

For all Incident Reports, the basic causes and actions must be agreed with the Owner before the final 'approved' or signed off report is produced. Recommended actions must state explicitly what is to be done, when and by whom.

Owner

The Owner (Site Manager for Minor Incidents or PUL or Manager for Major Incidents) shall allocate actions to a Responsible Party. The Owner and Responsible Party shall reach an understanding on the scope of the action and the time by which it is to be completed.

Responsible Party

The Responsible Party shall ensure that the action is closed out in the Action and Incident Data Base. An action will not be considered finalised until the database has been updated.

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Close Out of Actions

Each Performance Unit shall establish a process for tracking the close out of actions. ~~This shall be done on a monthly basis by the Managers directly accountable to the Performance Unit Leader.~~ The Managers directly accountable to the Performance Unit Leader shall do this on a monthly basis. The Performance Unit Leader shall be notified of the number of overdue actions each month. Actions resulting from Major Incidents, High Potential Incidents, Day Away From Work Cases and significant audits will be tracked to resolution at the BU level in Tr@ction. Actions resulting from minor incidents will be tracked by means of action tracking system operated at PU level.

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Incident Report Originator

Each Performance Unit shall formally appoint Incident Report Originators who will be responsible for entering Incident Reports into the database and closing actions in the database when advised to do so by Responsible Parties.

Incident Investigation and Reporting

5 REPORT DISTRIBUTION

All incidents reports shall be copied to:

- the Owner
- the Site Manager (if he is not the Owner)
- Responsible Parties (i.e. those allocated remedial actions)
- the senior HSE person of the BU or service unit
- HSE Director (Major Incident [and HiPo](#) Reports as defined above only).

When the Incident Report is entered directly into the Accident and Incident Data Base, the report may be distributed by use of an e-mail referring the recipient to the report reference number and title in the database. Paper copies must be circulated to / from sites which do not have access to the database.

6 STORAGE OF RECORDS

6.1 MAJOR INCIDENTS

The master copy of the report must be retained on file by the ~~business-unit~~[Performance Unit](#) and the copy sent to the HSE Director must be retained in the ~~Corporate BU~~ HSE Department files.

6.2 MINOR INCIDENTS

When a site has access to the ~~Accident and Incident Data Base~~ [Tr@ction](#), the report in the database is sufficient record of the incident. ~~(The approval process built into the data base means no signed copy needs to be retained).~~

When a site does not have access to the ~~Tr@ction Accident and Incident Data Base~~ a copy of the report signed by the Originator and Owner must be retained on the site ~~and forwarded to the BU HSE Department.~~

Field Code Changed

Field Code Changed

Appendix A – Major Incident /High Potential Notification Pro-Forma

BP Major Incident Announcement	URGENT
---------------------------------------	---------------

Send by E-mail to the relefant distribution list. Add other addressees as necessary to meet BU or Regional requirements e.g. local Management Team, Joint Venture partner

<u>Business Unit:</u>		<u>Issued by:</u>	
<u>Country:</u>		<u>Location of incident:</u>	
<u>Date of incident:</u>		<u>Time of incident:</u>	

Brief account of incident (Report as fact only what you are clear is fact. Specify the status of anything else which you report, e.g., a belief or an estimate):

.

<u>People:</u>	<u>No. of injuries</u>	<u>No. of fatalities</u>	<u>Description / details</u>
<u>Employee</u>			
<u>Contractor</u>			
<u>Third party</u>			

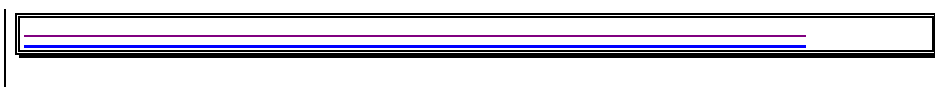
Business impact/damage/loss:

External agencies involved:

News media coverage seen:

What assistance has been requested:

<u>BP person in charge of response/ investigation</u>		<u>Business Unit Leader</u>	
<u>Office telephone:</u>		<u>Office telephone:</u>	
<u>Mobile telephone:</u>		<u>Mobile telephone:</u>	
<u>Home telephone:</u>		<u>Home telephone:</u>	



<u>INCIDENT ANNOUNCEMENT</u>		<u>BP MAJOR</u>	
		<u>URGENT</u>	
Business Unit:		Contact:	
Country:		Location of Incident:	
Date of Incident:		Time of Incident:	
Brief Account of Incident:			
People:		Number	Number
		Injuries	Fatalities
			Description
BP			
Contractor			
Third Party			
Business Impact/Damage/Loss:			
External agencies involved:			
News Media coverage:			
BP person in charge of Response/Investigation:			
What assistance has been requested?			

Appendix B – High Potential Incident Notification Pro-Forma

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BP HIGH POTENTIAL INCIDENT ANNOUNCEMENT
URGENT

Business Unit: _____ Contact: _____
Country: _____ Location of Incident: _____
Date of Incident: _____ Time of Incident: _____

Brief Account of Incident:

Potential Outcome:

Likely Causes:

Actions Taken:

BP person in charge of Response/Investigation:

		<u>BP HIGH</u>	
<u>POTENTIAL INCIDENT ANNOUNCEMENT</u>		<u>URGENT</u>	
Business Unit: _____		Contact: _____	
Country: _____		Location of Incident: _____	
Date of Incident: _____		Time of Incident: _____	
Brief Account of Incident: _____			
Potential Outcome: _____			
Likely Causes: _____			
Actions Taken: _____			
BP person in charge of Response/Investigation: _____			

Incident Report Form



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[Performance Unit]

REPORT TITLE
INCIDENT REPORT
NO

GENERAL INFORMATION

INCIDENT TYPE (Mark x)

Near Miss	
Injury / Illness	
Material Release	
Property Damage/Fire	
Business Interruption	
Security	
Not work related	
Reputation	

dd/mm/yy		Time	
Facility/Site			
Area/Module/Delivery Unit			
Companies involved			
Incident Function	Drilling & Wells / Construction / Production & Maintenance / Other / Fabrication Yards & Construction		
Responsible contact	[Name, Job Title]		

WORK PROCESS

Catering	Diving	Lifting/Loading	Storage
Commissioning	Drilling	Pipe laying	Testing
Construction	Inspection	Production/Injection	Transporting (Specify)
Demolition	Maintenance	Survey	Wire line / well service
Discharging Products	Normal Operation	Shutting down	Other (Specify)

INCIDENT DESCRIPTION, LESSONS LEARNED, COMMENTS

[Report as fact only what you are clear is fact. Specify status of anything else you report, e.g. estimate/belief]

[Lessons learned]

[Weather/Ground Comments]

OUTPUTS (use extra pages for multiple injuries)

PERSONAL INJURY (underline necessary item)

First Aid Treatments

1. Non-prescription medication at non-prescriptive strength
2. Tetanus immunizations
3. Cleaning, flushing or soaking wounds on the surface of the skin
4. Using wound coverings such as bandages, Band-Aids™, gauze pads, etc., or using butterfly bandages or Steri-Strips™
5. Hot or cold therapy
6. Any non-rigid means of support
7. Temporary immobilization devices
8. Drilling of a fingernail or toenail to relieve pressure, or draining fluid from a blister
9. Using eye patches
10. Removing foreign bodies from the eye using only irrigation of a cotton swab
11. Removing splinters or foreign material from areas other than the eye by irrigation, tweezers, cotton swabs or other simple means
12. Using finger guards
13. Using massages
14. Drinking fluids for relief of heat stress

Work-Related:

YES
NO

Classification:

Fatality
DAFWC
Restrictive
d-work Medical
Treatment
First aid
No
treatment

Overtime

Yes No

Age

Male/Female

Nature of injury/illness:

Abrasion; Amputation;
Avulsion; Bite; Blister; Blood Borne Pathogen; Burn-Chemical; Burn-Thermal; Carpal Tunnel Syndrome; Chemical Exposure; Concussion; Contusion/Bruise; Death; Dislocation; Dust Disease - Lung; Electric Shock; Fracture; Hernia; Impalement; Incision; Irritation; Laceration; Loss of Consciousness (asphyxiation); No apparent Injury; Occupational Skin Disease; Physical Agent Disorder (e.g., heat, cold); Poisoning; Puncture; Wound; Respiratory Condition - Toxic Agent; Sprain or Strain; Standard Threshold Shifts (STS); Trauma; Disorder (e.g., noise, vibrations); Other (Specify)

Occupation

Experience

Type of contact

Caught Between;
Chemical Substances; Cold Substances; Diving Related; Electricity; Eye flash; Fall from Height; Fall from Ladder/Steps; Fire or Explosion; Foreign Body in Eye; Fumes or Gas; Handling Goods or Materials; Lifting/Handling Equipment; Failed; Loss of Containment; Machinery; Radiation; Slip or Fall at same level; Struck Against; Struck by; Structural Failure; Transport; Use of Hand Tools; Other (Specify)

Bodily part injured:

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MATERIAL RELEASE

Release Type	Material Released	Total Volume	Not recovered	Released to:
Atmospheric/Leak/Spill/Waste Disposal				Water/Air/Ground/Containment Area

TRANSPORTATION

Type (Car, Truck, Aircraft, Maritime, etc.)	Driver	Road / Accident type / Load / Other comments
[Be specific]	Bp/Contractor/ 3 rd Party	

PROPERTY/EQUIPMENT DAMAGE/ FIRE

Description	Loss in \$	Comments

CLC – COMPREHENSIVE LIST OF CAUSES

(View pg. 3 for supplementary material and input the numbers for Immediate and Root Causes)

Critical Factors		
Immediate Causes		
Root Causes		

SEVERITY MATRIX (for explanations roll over the matrix or refer to pg.4)

Actual Loss (What was actual loss using matrix below?)

Potential Loss (What might have been the most serious probable (not worst imaginable) outcome of this event?)

For Potential Loss choose probability of Reoccurrence:

H (high) – chance greater than 1 in 10 of outcome being realized
M (medium) – chance between 10 and 1000 of outcome being realized
L (low) – chance less than 1 in 1000 of outcome being realized

Severity level	Health			Safety			Environment			Property Damage			Reputation			Business Interruption/ Unit Outage			Security/ Criminal Act		
1	A1			B1			C1			D1			E1			F1			G1		
2	A2			B2			C2			D2			E2			F2			G2		
3	A3			B3			C3			D3			E3			F3			G3		
4	A4			B4			C4			D4			E4			F4			G4		
5	A5			B5			C5			D5			E5			F5			G5		
	L	M	H	L	M	H	L	M	H	L	M	H	L	M	H	L	M	H	L	M	H

GETTING HSE RIGHT

(mark X one)

A – inadequate requirements/guidelines
B – requirements/guidelines not appropriate
C – requirements/guidelines not complied

Does Incident relate to the one of the Golden Rules?
If Yes, mark appropriate Rule(s)

A	B	C
		1. Leadership and Accountability
		2. Risk Assessment and Management
		3. People, Training and Behaviors
		4. Working with Contractors and Others
		5. Facilities Design and Construction
		6. Operations and Maintenance
		7. Management of Change
		8. Information and Documentation
		9. Customers and Products
		10. Community and Stakeholder Awareness
		11. Crisis and Emergency Management
		12. Incident Analysis and Prevention
		13. Assessment, Assurance and Improvement

	Getting the Basics Right
	Permit to Work
	Energy Isolation
	Ground Disturbance
	Confined Space Entry
	Working at Heights
	Lifting Operations
	Vehicle Safety
	Management of Change (MOC)

Does Incident Relate to Dropped Objects?

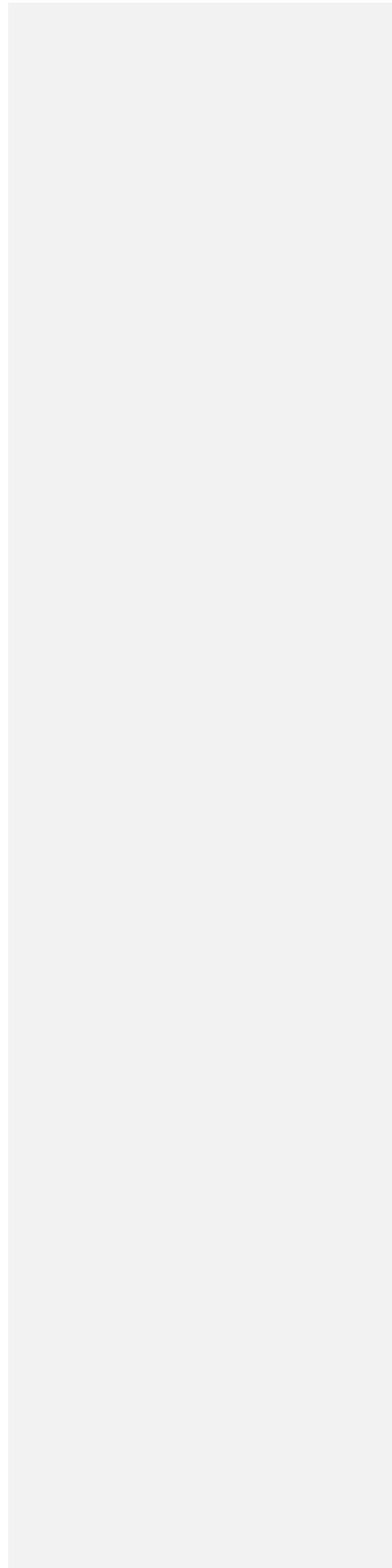
Yes	
No	

ACTIONS TO PREVENT RECCURRENCE

Action	Responsible person	Assignee	Priority (1, 2 or 3)	Due Date

SIGNATURE

Originator	Supervisor for activity	Site/facility manager
Name	Name	Name
Job Title	Job Title	Job Title



Appendix B — Tr@ction Severity Matrix

_____ Type (Car, Truck, Aircraft, Maritime, etc.)	_____ Driver	_____ Road / Accident type / Load / Other comments
_____ [Be specific]	_____ Bp /Contractor /3 rd Party	_____
<u>PROPERTY/EQUIPMENT DAMAGE/ FIRE</u>		
_____ Description	_____ Loss in \$	_____ Comments
_____	_____	_____

GLC – Comprehensive list of causes

(View pg. 3 for supplementary material)

Critical Factors

Immediate Causes

Root Causes

Severity matrix (for explanations roll over the matrix or refer to pg.4)

Actual Loss (What was actual loss using matrix below?)

Potential Loss (What might have been worst probable **not worst imaginable outcome** of this event?)

For Potential Loss choose probability of Reoccurrence:

H (high) – chance greater than 1 in 10 of outcome being realized

M (medium) – chance between 10 and 1000 of outcome being realized

L (low) – chance less than 1 in 1000 of outcome being realized

Severity level	Health	Safety	Environment	Property Damage	Reputation	Business Interruption/ Unit Outage	Security/ Criminal Act
1	A1	B1	C1	D1	E1	F1	G1
2	A2	B2	C2	D2	E2	F2	G2
3	A3	B3	C3	D3	E3	F3	G3
4	A4	B4	C4	D4	E4	F4	G4
5	A5	B5	C5	D5	E5	F5	G5

Actions to prevent recurrence

Action	Responsible person	Priority (1, 2 or 3)	Due date	Completion date

Appendix C - Incident Report Form



[Performance Unit]

REPORT TITLE
INCIDENT REPORT
NO

GENERAL INFORMATION

(Mark x only one)

Accident (fill out appropriate accident category)

Near Miss

ACCIDENT CATEGORY
(Mark x one or more)

Injury /Illness

Illness

Material Release

Property Damage/Fire

Transport accident

Security

dd/mm/yy	Time
Facility/Site	
Area/Module	
Companies involved	
Companies involved Incident Function	Drilling & Wells / Construction / Production & Maintenance / Other / Fabrication Yards & Construction

work process

Air Transport	Drilling	Office Work	Sea transport
Catering	Inspection	Oil transport	Storage
Commissioning	Lifting – Crane operations	Pipe laying	Survey
Construction	Lifting – Rigging operations	Production/Injection	Wire line / well service
Demolition	Maintenance	Process shutdown	Other (Specify)
Discharging Products	Material handling	Receipt of shipment/goods	

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Diving	Normal Operation	Road transport	
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INCIDENT DESCRIPTION, LESSONS LEARNED, COMMENTS

[Report as fact only what you are clear is fact. Specify status of anything else you report, e.g. estimate/belief]

[Lessons learned]

WEATHER CONDITIONS

Clear/Fair	Sleet	Bituminous based	Muddy
Foggy	Snow	Concrete	Rocky
Freezing Temperature	Sunny	Dry	Sandy
Hail	Thunderstorm	Gravel	Slippery
Mist	Windy	Ice	Wet
Overcast	Dark	Inclined	Not relevant
Rain	Not relevant	Level	Other (Specify)

OUTPUTS (USE EXTRA PAGES FOR MULTIPLE INJURIES)

PERSONAL INJURY (underline necessary item)

Work Related:	First Aid Treatments		Nature of injury:		Type of contact	Body part injured:
YES NO	<u>1. Non-prescription medication at non-prescriptive strength</u> <u>2. Tetanus immunizations</u> <u>3. Cleaning, flushing or soaking wounds on the surface of the skin</u> <u>4. Using wound coverings such as bandages, Band-Aids™, gauze pads, est., or using butterfly bandages or Steri-Strips™</u> <u>5. Hot or cold therapy</u> <u>6. Any non-rigid means of support</u> <u>7. Temporary immobilization devices</u> <u>8. Drilling of a fingernail or toenail to relieve pressure, or draining fluid from a blister</u> <u>9. Using eye patches</u> <u>10. Removing foreign bodies from the eye using only irrigation of a cotton swab</u> <u>11. Removing splinters or foreign material from areas other than the eye by irrigation, tweezers, cotton swabs or other simple means</u> <u>12. Using finger guards</u> <u>13. Using massages</u> <u>14. Drinking fluids for relief of heat stress</u>		<u>Abrasion; Amputation; Avulsion;</u> <u>Bite; Blister; Blood Borne</u> <u>Pathogen; Burn-Chemical; Burn-</u> <u>Thermal; Carpal Tunnel</u> <u>Syndrome; Chemical Exposure;</u> <u>Concussion; Contusion/Brui-</u> <u>Death; Dislocation; Dust Disease -</u> <u>lung; Electric Shock; Fracture;</u> <u>Hernia; Impalement; Incision;</u> <u>Irritation; Laceration; Loss of</u> <u>Consciousness (asphyxiation); No</u> <u>apparent injury; Occupational Skin</u> <u>Disease; Physical Agent Disorder</u> <u>(e.g., heat, cold); Poisoning;</u> <u>Puncture Wound; Respiratory</u> <u>Condition - Toxic Agent; Sprain or</u> <u>Strain; Standard Threshold Shifts</u> <u>(STS); Trauma Disorder (e.g.,</u> <u>noise, vibrations); Other (Specify/</u>		<u>Caught Between; Chemical</u> <u>Substances; Cold</u> <u>Substances; Diving Related;</u> <u>Electricity; Eye flash; Fall from</u> <u>Height; Fall from</u> <u>Ladder/Steps; Fire or</u> <u>Explosion; Foreign Body in</u> <u>Eye; Fumes or Gas; Handling</u> <u>Goods or Materials;</u> <u>Lifting/Handling Equipment</u> <u>Failed; Loss of Containment;</u> <u>Machinery; Radiation; Slip or</u> <u>Fall at same level; Struck</u> <u>Against; Struck by; Structural</u> <u>Failure; Transport; Use of</u> <u>Hand Tools; Other (Specify/</u>	<u>1. Ankle</u> <u>2. Arm/Shoulder</u> <u>3. Back</u> <u>4. Chest</u> <u>5. Ear</u> <u>6. Eye</u> <u>7. Extensive</u> <u>In Finger</u> <u>9. Foot</u> <u>10. Hand</u> <u>11. Head</u> <u>12. Internal lesions</u> <u>13. Knee</u> <u>14. Mouth</u> <u>15. Skin</u> <u>16. Throat</u> <u>17. Tooth</u> <u>18. Toe</u> <u>19. Thigh/leg</u> <u>20. Wrist</u> <u>21. Other (specify)</u>
Shift	Overtime	Age	Male/ Female	Occupation	Experience	Person Affected
<div><div></div><div>Normal</div><div>Changeover</div><div>Extended</div></div>	Yes No					BP / Contractor / 3 rd Party

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MATERIAL RELEASE

Release Type	Material Released	Total Volume	Not recovered	Released to
Atmospheric /Leak /Spill / Waste Disposal				Water /Air /Ground /Containment Area

TRANSPORTATION

Type (Car, Truck, Aircraft, Maritime, etc.)	Driver	Road / Accident type / Load / Other comments
[Be specific]	Bp /Contractor /3 rd Party	

PROPERTY/EQUIPMENT DAMAGE/ FIRE

Description	Loss in \$	Comments

CLC – COMPREHENSIVE LIST OF CAUSES

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[View pg. 4 for supplementary material and input the numbers for Immediate and Root Causes]

Critical Factor(s) (major contributors to the incident which, if eliminated, could prevent the occurrence or reduce the incident's severity):

√	Immediate Causes	1.1, 1.2, etc DEFINE
	1. Following Procedures	
	2. Use of Tools & Equipment	
	3. Use of Protective Methods	
	4. Inattention/ Lack of Awareness	
	5. Protective Systems	
	6. Tools, Equipment & Vehicles	
	7. Work Exposure to	
	8. Work Place Environment/ Layout	

√	Root Causes	1.1, 1.2, etc DEFINE
	1. Physical Capability	
	2. Physical Condition	
	3. Mental State	
	4. Mental Stress	
	5. Behavior	
	6. Skill Level	
	7. Training/ Knowledge Transfer	
	8. Management/ Supervision/ Employee Leadership	
	9. Contractor Selection & Oversight	

	10. Engineering/ Design	
	11. Work Planning	
	12. Purchasing, Material Handling & Material Control	
	13. Tools & Equipment	
	14. Work Rules/Policies/Standards/Procedures (PSP)	
	15. Communication	

Severity matrix (for explanations roll over the matrix or refer to pg.5)

Actual Loss (What was actual loss using matrix below?) Mark all appropriate categories.

Potential Loss (What might have been worst probable **not worst imaginable outcome** of this event?) Mark all appropriate

Potential Loss choose probability of Reoccurrence:

H (high) – chance greater than 1 in 10 of outcome being realized

M (medium) – chance between 10 and 1000 of outcome being realized

L (low) – chance less than 1 in 1000 of outcome being realized

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Severity level	Health	Safety	Environment	Property Damage	Reputation	Business Interruption/ Unit Outage	Security/ Criminal Act
-	A	B	C	D	E	F	G
1	A1	B1	C1	D1	E1	F1	G1
2	A2	B2	C2	D2	E2	F2	G2
3	A3	B3	C3	D3	E3	F3	G3
4	A4	B4	C4	D4	E4	F4	G4
5	A5	B5	C5	D5	E5	F5	G5
	L M H L M H L M H L M H L M H L M H L M H						

GETTING HSE RIGHT (refer to pg.6)

GOLDEN RULES

(mark **X** one)

A - inadequate requirements/guidelines

B - requirements/guidelines not appropriate

C - requirements/guidelines not complied

Does Incident relate to the one of the Golden Rules?

If Yes, mark appropriate Rule(s)

A	B	C	Specify (1.1, 1.2 etc)
			1. Leadership and Accountability
			2. Risk Assessment and Management
			3. People, Training and Behaviors
			4. Working with Contractors and Others
			5. Facilities Design and Construction
			6. Operations and Maintenance
			7. Management of Change
			8. Information and Documentation
			9. Customers and Products
			10. Community and Stakeholder Awareness
			11. Crisis and Emergency Management
			12. Incident Analysis and Prevention
			13. Assessment, Assurance and Improvement

	Getting the Basics Right
	Permit to Work
	Energy Isolation
	Ground Disturbance
	Confined Space Entry
	Working at Heights
	Lifting Operations
	Vehicle Safety
	Management of Change (MOC)

Does Incident Relate to Dropped Objects?

Yes	
No	

FOR ACTIONS CHOOSE THE PRIORITY:

1 (High) – needs to be completed in less than 1 week

2 (Medium) – needs to be completed in less than 1 month

3 (Low) – needs to be completed in less than 6 months

ACTIONS TO PREVENT RECURRENCE

N	Action	Accountable person	Actionee	Priority (1,2 or 3)	Target Completion Date
1					
2					
3					

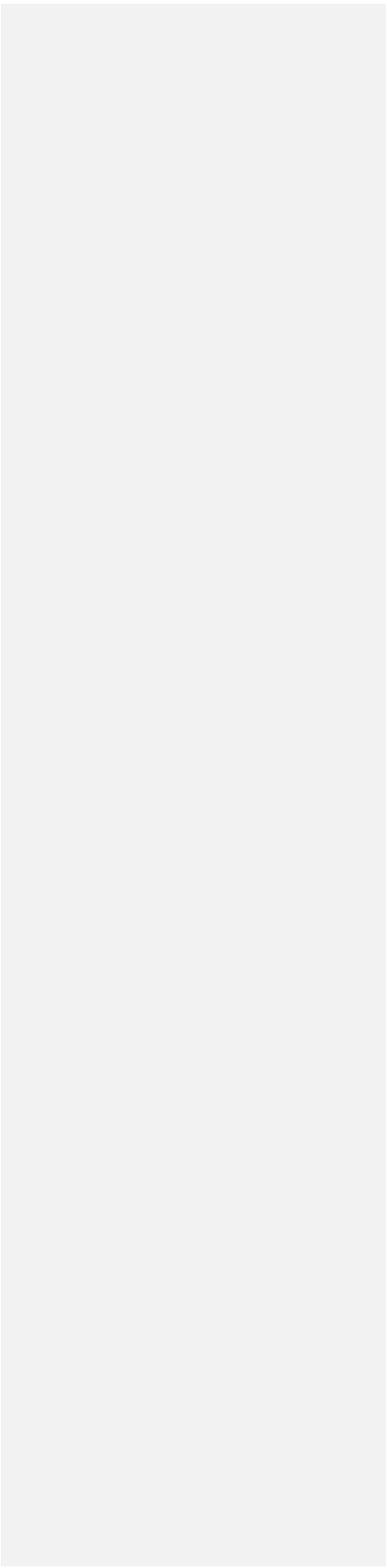
MANAGEMENT COMMENTS

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SIGNATURE

Originator Supervisor for activity Site/facility manager

Name		Name		Name	
Job Title		Job Title		Job Title	
Date		Date		Date	



CLC – COMPREHENSIVE LIST OF CAUSES

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Immediate Causes

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1	Following Procedures	1-1 Violation by individual; 1-2 Violation by group; 1-3 Violation by Supervisor; 1-4 Operation of equipment without authority; 1-5 Improper position/posture for work; 1-6 Overexertion of physical capability; 1-7 Work or motion at improper speed; 1-8 Improper lifting; 1-9 Improper Loading; 1-10 Shortcuts; 1-11 Others
2	Use of Tools & Equipment	2-1 Improper use of equipment; 2-2 Improper use of tools; 2-3 Use of defective equipment (aware); 2-4 Use of defective tools (aware); 2-5 Improper placement of tools, equipment or materials; 2-6 Operation of equipment at improper speed; 2-7 Servicing of equipment in operation; 2-8 Other
3	Use of Protective Methods	3-1 Lack of knowledge of hazards present; 3-2 Personal protective equipment not used; 3-3 Improper use of personal protective equipment; 3-4 Servicing of energized equipment; 3-5 Equipment or materials not secured; 3-6 Disabled guards, warning systems or safety devices; 3-7 Removal of guards, warning systems or safety devices; 3-8 Personal protection equipment not available; 3-9 Others
4	Inattention/Lack of Awareness	4-1 Improper decision making or lack of judgment; 4-2 Distracted by other concerns; 4-3 Inattention for footing and surroundings; 4-4 Horseplay; 4-5 Act of violence; 4-6 Failure to warn; 4-7 Use of drugs or alcohol; 4-8 Routine activity without thought; 4-9 Other
5	Protective Systems	5-1 Inadequate guards or protective devices; 5-2 Defective guards or protective devices; 5-3 Inadequate personal protective equipment; 5-4 Defective personal protective equipment; 5-5 Inadequate warning systems; 5-6 Defective warning systems; 5-7 Inadequate isolation of process or equipment; 5-8 Inadequate safety devices; 5-9 Defective safety devices; 5-10 Other
6	Tools, Equipment & Vehicles	6-1 Defective equipment; 6-2 Inadequate equipment; 6-3 Improperly prepared equipment; 6-4 Defective tools; 6-5 Inadequate tools; 6-6 Improperly prepared tools; 6-7 Defective vehicle; 6-8 Inadequate vehicle for the purpose; 6-9 Improperly prepared vehicle; 6-10 Other
7	Work Exposure to	7-1 Fire or explosion; 7-2 Noise; 7-3 Energized electrical Systems; 7-4 Energized systems, other than electrical; 7-5 Radiation; 7-6 Temperature extremes; 7-7 Hazardous chemicals; 7-8 Mechanical hazards; 7-9 Clutter or debris; 7-10 Storms or acts of nature; 7-11 Slippery floors on walkways; 7-12 Other
8	Work Place Environment/ Layout	8-1 Congestion or restricted motion; 8-2 Inadequate or excessive illumination; 8-3 Inadequate ventilation; 8-4 Unprotected height; 8-5 Inadequate work place layout; 8-6 Other
Back to CLC		

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Root Causes

1	Physical Capability	1-1 Vision deficiency; 1-2 Hearing deficiency; 1-3 Other sensory deficiency; 1-4 Reduced respiratory capacity; 1-5 Other permanent physical disabilities; 1-6 Temporary disabilities; 1-7 Inability to sustain body positions; 1-8 Restricted range of body movement; 1-9 Substance sensitivities or allergies; 1-10 Inadequate size or strength; 1-11 Diminished capacity due to medication; 1-12 Other
2	Physical Condition	2-1 Previous injury or illness; 2-2 Fatigue; 2-3 Diminished performance; 2-4 Blood sugar insufficiency; 2-5 Impairment due to drug or alcohol use; 2-6 Other
3	Mental State	3-1 Poor judgment; 3-2 Memory failure; 3-3 Poor coordination or reaction time; 3-4 Emotional disturbance; 3-5 Fears or phobias; 3-6 Low mechanical aptitude; 3-7 Low learning aptitude; 3-8 Influenced by medication; 3-9 Other
4	Mental Stress	4-1 Preoccupation with problems; 4-2 Frustration; 4-3 Confusing directions/demands; 4-4 Conflicting directions/demands; 4-5 Meaningless or degrading activities; 4-6 Emotional overload; 4-7 Extreme judgment/decision demands; 4-8 Extreme concentration or perception demands; 4-9 extreme boredom; 4-10 Other
5	Behavior	5-1 Improper performance is rewarded; 5-2 Improper Supervisory example; 5-3 Inadequate identification of critical safe behaviors; 5-4 Inadequate reinforcement of critical behaviors; 5-5 Inappropriate of aggression; 5-6 Improper use of production incentives; 5-7 Supervisor implied haste; 5-8 Employee perceived haste; 5-9 Other
6	Skill Level	6-1 Inadequate assessment of required skills; 6-2 Inadequate practice of skills; 6-3 Lack of coaching on skill; 6-4 Insufficient review of instruction to establish skill; 6-5 Other
7	Training/Knowledge Transfer	7-1 Inadequate knowledge transfer; 7-2 Inadequate recall of training materials; 7-3 Inadequate training effort; 7-4 No training provided; 7-5 Other
8	Management/ Supervision/ Employee leadership	8-1 Conflicting roles/responsibilities; 8-2 Inadequate leadership; 8-3 Inadequate correction of prior hazards/incident; 8-4 Inadequate identification of worksite/job hazards; 8-5 Inadequate management of change system; 8-6 Inadequate incident reporting/investigation system; 8-7 Inadequate/lack of safety meetings; 8-8 Inadequate performance measurement and assessment; 8-9 Other
9	Contractor Selection & Oversight	9-1 Lack of contractor pre-qualifications; 9-2 Inadequate contractor pre-qualifications; 9-3 Inadequate contractor selection; 9-4 Use of a non-approved contractor; 9-5 Lack of job oversight; 9-6 Inadequate oversight; 9-7 Other
10	Engineering/Design	10-1 Inadequate technical design; 10-2 Inadequate standards, specifications and/or design criteria; 10-3 Inadequate assessment of potential failure; 10-4 Inadequate ergonomic design; 10-5 Inadequate monitoring and construction; 10-6 Inadequate assessment of operational readiness; 10-7 Inadequate monitoring of initial operation; 10-8 Inadequate evaluation and/or documentation of change; 10-9 Other
11	Work Planning	11-1 Inadequate work planning; 11-2 Inadequate preventive maintenance; 11-3 Inadequate repair; 11-4 Excessive wear & tear; 11-5 Inadequate reference materials and publications; 11-6 Inadequate audit/inspection/monitoring; 11-7 Inadequate job placement; 11-8 Other
12	Purchasing, Material Handling and Material Control	12-1 Incorrect item received; 12-2 Inadequate research on materials/equipment; 12-3 Inadequate mode or route of shopping; 12-4 Improper handling of materials; 12-5 Improper storage of materials or spare parts; 12-6 Inadequate material packaging; 12-7 Material shelf life exceeded; 12-8 Improper identification of hazardous materials; 12-9 Improper salvage and/or waste disposal; 12-10 Inadequate use of safety and health data; 12-11 Other
13	Tools & Equipment	13-1 Inadequate assessment of needs and risks; 13-2 Inadequate human factors/ergonomic considerations; 13-3 Inadequate standards or specifications; 13-4 Inadequate availability; 13-5 Inadequate adjustment/repair/maintenance; 13-6 Inadequate salvage and reclamation; 13-7 Inadequate removal/replacement of unsuitable items; 13-8 No equipment record history; 13-9 Inadequate equipment record history; 13-10 Other
14	Work Rules/ Policies/Standards/ Procedures (PSP)	14-1 Lack of PSP for the task; 14-2 Inadequate development of PSP; 14-3 Inadequate implementation of PSPs, due to deficiencies; 14-4 Inadequate enforcement of PSP; 14-5 Inadequate communication of PSP; 14-6 Other
15	Communication	15-1 Inadequate horizontal communication between peers; 15-2 Inadequate vertical communication between supervisor and person; 15-3 Inadequate communication between different organizations; 15-4 Inadequate between work groups; 15-5 Inadequate communication between shifts; 15-6 Inadequate communication methods; 15-7 No communications method available; 15-8 Incorrect instructions; 15-9 Inadequate communication due to job turnover; 15-10 Inadequate communication of safety and health data, regulations or guidelines; 15-11 Standard terminology not used; 15-12 Verification/repeat back techniques not used; 15-13 Messages too long; 15-14 Speech interference; 15-15 Other
Back to CLC table		

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SEVERITY MATRIX EXPLANATION

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A1	Multiple person on-site with over-exposure to harmful effects with onset of severe or life-threatening irreversible health effects e.g. occupationally induced cancer, kidney damage, asbestosis and mesothelioma, genetic or harm to the unborn. Single persons off-site with over-exposure to harmful effects with onset of severe or life-threatening irreversible health effects e.g. cancer, kidney damage, asbestosis and mesothelioma, genetic or harm to the unborn. Multiple persons off-site with over-exposure to harmful effects with resultant moderate or worse irreversible health effects e. g. asthma, noise induced hearing loss
A2	Multiple persons on-site with over-exposure to harmful effects with resultant moderate irreversible health effects e.g. asthma, occupational noise induced hearing loss. Single person on-site with over-exposure to harmful effects with onset of severe or life-threatening irreversible health effects e.g. cancer, kidney damage, asbestosis and mesothelioma, genetic or harm to the unborn. Single person off-site with over-exposure to harmful effects with resultant moderate irreversible health effects e.g. asthma, occupational noise induced hearing loss. Multiple persons off-site with over-exposure to harmful effects with mild to moderate reversible health effects e. g. irritation, nausea
A3	Multiple persons on-site with over-exposure to harmful effects with reported and confirmed mild to moderate reversible health effects, e.g. irritation, nausea. Single person on-site with over-exposure to harmful effects with resultant moderate irreversible health effects e.g. asthma, occupational noise induced hearing loss. Single person off-site with over-exposure to harmful effects with mild to moderate reversible health effects e. g. irritation, nausea
A4	Potential for on-site over-exposure but no reported ill-health effects. Single person on-site with reported symptoms of mild to moderate reversible health effect, e.g. irritation, nausea-confirmed by medical authority. Potential for off-site exposure but no effects identified
A5	Single person on-site with over-exposure to harmful effects, but no reported ill-health effect e.g. monitoring result shows occupational exposure limit has been exceeded, or one-off event such as failure of local controls or PPE. No impact off-site or detectable off-site exposure
B1	Multiple fatalities amongst persons on site. Fatality to single person off site. Multiple permanent injuries to person off site
B2	Fatality to single person on site. Multiple permanent injuries amongst persons on site. Permanent injury to single person off site. Multiple non permanent injuries to persons off site
B3	Permanent injury to single person on site. Multiple non-permanent injuries (DAFWC) amongst persons on site. Non permanent injury to single person off site
	Back to Matrix
B4	Single or Multiple minor (recordable) injuries amongst persons on site. Recordable injury (medical treatment) to single person off site
B5	First Aid or less. No impact to persons off site
C1	Large uncontrolled release of hazardous material, e.g. > 10,000 barrels, 1,000 barrels in sensitive area, > 100 Te of classified material Impact for beyond the facility boundary. Long term damage affecting extensive area off site and prolonged clean-up
C2	Uncontained release of reportable quantity, e.g. >100 barrels, 10 Te classified material. Impact on immediate neighborhood beyond facility boundary. Long term damage affecting limited area off site and prolonged clean-up
C3	Uncontained release of minimum reportable quantity. No long-term impact beyond facility boundary. Prolonged damage on site
C4	Release contained site. No prolonged damage
C5	Contained releases of hazardous material. No off site impact. Minor damage/quick clean-up
D1	>\$ 5 million. Extensive damage to unit/facility, impact at adjacent unit. Impact offsite (e.g. window breakage)
D2	\$ 0.5-5 million. Damage to large proportion. No impact off site
D3	\$ 100 k to \$ 500 k. Damage to a single major plant item. Widespread damage to minor equipment items, e. g. cabling, instrumentation and small bore pipework
D4	\$10 k to \$ 100 k. Localized damage to minor equipment items
	Back to Matrix
D5	< \$ 10 k Superficial damage
E1	National or international media coverage. Prosecution and heavy fine by regulator. Change of regulations at national level
E2	National media attention. Prosecution of regulator
E3	Regional media coverage. Extended involvement of regulator focusing on issues beyond immediate event
E4	Local media coverage. Increased regulator enforcement at site level e. g. improvement notice. Equipment repair plus testing
E5	Complaints from local neighborhood/community. No formal action by regulator
F1	> \$ 5 million > 1 year. Cabling, instrumentation and small bore pipework
F2	\$ 0.5-1 million 1 month replacement/extensive repair of major plant items e.g. vessels, compressors
F3	\$ 100 k to \$ 500 k > 1 week Replacement/extensive repair of a single major plant item Equipment repair/replacement of extensive testing
F4	< \$ 10k to \$ 100 k < 1 week Equipment repair plus testing
F5	< \$ 10 k < 1 day Repairs can be completed with unit on line
G1	Civil unrest in country requiring evacuation of staff. Bomb attack. Hostage taking/ Kidnap Murder. Serious sabotage
G2	Serious criminal act leading to prosecution. Serious breach of guidelines on handling security information. Major extortion/ bribery/ fraud
G3	Criminal act involving police investigation. Breach of company policies leading to dismissal. Bomb threat. Minor sabotage. Minor extortion/ bribery/ fraud
G4	Breach of company policies leading to formal disciplinary action
G5	Breach of company policies leading to informal warning
	Back to Matrix

THIRTEEN ELEMENTS OF BP'S HSE MANAGEMENT SYSTEM FRAMEWORK		
1.	Leadership and Accountability	<p>1.1. Leaders model positive HSE behaviors by personal example both on and off the job, and reinforce and reward positive behaviors.</p> <p>1.2. Leaders engage in clear, two-way communication with employees, contractors and others on HSE issues.</p> <p>1.3. Leaders integrate the HSE Expectations into business planning and decision making processes, ensuring that documented systems are in place to deliver these Expectations.</p> <p>1.4. Leaders establish clear HSE goals and objectives, roles and responsibilities, performance measures and allocate competent resources and, where necessary, specialist expertise.</p> <p>1.5. HSE Management systems are developed, documented, implemented and supported throughout the organization. These address health, safety, technical integrity, environmental, security, product and operational risks in accordance with the appropriate Expectations.</p> <p>1.6. Leaders' HSE performance is assessed against their annual objectives, based on feedback from line management, peers and others in the Business Unit.</p> <p>1.7. Leaders integrate Group HSE targets into their business activities. <i>(These include, for example, external verifications, climate change, sustainable development, biodiversity, and emissions reductions.)</i></p> <p>1.8. Leaders promote the sharing of HSE lessons learned inside and outside their Business Unit. Back to gHSEr table</p>
2.	Risk Assessment and Management	<p>2.1. Leaders put into place and promote the use of processes to identify hazards associated with BP's activities, assess risks, control the hazards and manage the risks to acceptable levels.</p> <p>2.2. Potential hazards and risks to personnel, facilities, the public, customers and the environment are assessed for existing operations, products, business developments, acquisitions, modifications, new projects, closures, divestments and decommissionings.</p> <p>2.3. Assessed risks are addressed by levels of management appropriate to the nature and magnitude of the risk. Decisions are clearly documented and resulting actions implemented through local procedures.</p> <p>2.4. Risks assessments and risk management/control measures are referenced in project approval documentation.</p> <p>2.5. Risk assessments are updated at specified intervals and as changes are planned.</p>
3.	People, Training and Behaviors	<p>3.1. Employees and contractors practice, encourage, and reinforce safe, healthy and environmentally sound behaviors.</p> <p>3.2. HSE roles, responsibilities and accountabilities are developed and used to define individual performance targets. These are documented, and feedback on personal performance is provided.</p> <p>3.3. Recruitment, selection and placement processes ensure that personnel are qualified, competent, and physically and mentally fit for their assigned tasks.</p> <p>3.4. BP's workforce has the required skills and training to competently perform their tasks in a healthy, safe and environmentally sound manner. Training is evaluated to determine its effectiveness.</p> <p>3.5. With employees' involvement, physical, chemical, biological, ergonomic and psychological health hazards are identified and the risks managed in the workplace.</p> <p>3.6. Each worksite has access to an appropriate level of medical support and to resources/facilities that promote health and wellness.</p> <p>3.7. A programme is in place to ensure that the performance of our workforce and others on our premises is not impaired by drugs and alcohol.</p> <p>3.8. New or transferred employees, contractors and other visiting personnel undergo appropriate site orientation/induction training which covers HSE rules and emergency procedures. Back to gHSEr table</p>
4.	Working with Contractors and Others	<p>4.1. Pre-qualification, selection and retention criteria are established for work performed by contractors, suppliers and others, including a system for assuring their compliance.</p> <p>4.2. Hazards and risks associated with contractor and procurement activities in our businesses are identified and effectively managed.</p> <p>4.3. Interfaces between BP and suppliers of services and products are identified and effectively managed.</p> <p>4.4. Clear deliverables and performance standards are agreed to and systems are put in place to assure HSE and technical compliance.</p> <p>4.5. Purchased products and services are, where possible, verified as meeting national/international health, safety and environmental standards.</p> <p>4.6. Joint venture and alliance partners have HSE management systems that are aligned with those of BP, meet legal compliance requirements and satisfy the Group's Expectations and targets.</p>
5.	Facilities Design and Construction	<p>5.1. Baseline technical, environmental and health data are collected before the development of any new operation, facility or major modification.</p> <p>5.2. Facilities are designed and constructed using technology which balanced commercial risks and financial benefits to manage technical risk and minimize or eliminate emissions, discharges, impacts on biodiversity and other environmental impacts.</p> <p>5.3. Project management systems and procedures addressing technical integrity and HSE accountabilities are documented and well understood. Design, procurement and construction standards are formally approved by the designated technical / engineering authority. Formal design review, verification and validation studies are carried out based on risk assessment.</p> <p>5.4. Operational, maintenance and HSE expertise are integrated early in the project / design stage. Experience from previous projects and current operations are applied.</p> <p>5.5. Potential hazards are identified and HSE risks assessed using appropriate risk assessment tools (e.g. quantified risk assessments, HAZOPS, and HSE reviews) at specific stages of a project from concept through to start-up, and risks are mitigated through risk management techniques.</p> <p>5.6. Deviations from design standards are identified and managed at an appropriate level, with the reasons documented and retained.</p> <p>5.7. Local regulatory requirements are met or exceeded. Where these are absent or inadequate, standards are set that protect people and the environment.</p> <p>5.8. Quality assurance and inspection systems are in place to ensure that facilities meet design and procurement specifications and that construction is in accordance with approved standards.</p> <p>5.9. Documented pre-startup reviews are carried out for all newly installed or modified equipment to confirm that construction is in accordance with design, all required verification testing is complete and acceptable, and all recommendations / deviations are closed and approved by the designated technical authority. Back to gHSEr table</p>
6.	Operations and Maintenance	<p>6.1. Post-startup reviews are carried out for all newly installed or modified equipment to confirm that construction is in accordance with design, all required verification testing is complete and acceptable, and all recommendations / deviations are closed and approved by the designated technical authority.</p> <p>6.2. Applicable regulatory requirements are met or exceeded and operational / technical / mechanical integrity is maintained by use of clearly defined and documented operational, maintenance, inspection and corrosion control systems.</p> <p>6.3. Key operating parameters are established and regularly monitored. The workforce understands their roles and responsibilities to maintain operations within these parameters.</p> <p>6.4. Clearly defined startup, operating, maintenance and shutdown procedures are in place with designated authorities identified (e.g. permit to work, hand-over, equipment and process isolation, etc.).</p> <p>6.5. Equipment that has been out of service for maintenance or modification is subject to documented inspection and testing prior to use.</p> <p>6.6. Reliability and availability of protective systems are maintained by appropriate testing and maintenance programmes, including management of temporary disarming or deactivation.</p> <p>6.7. Risks introduced by simultaneous operations are assessed and managed.</p> <p>6.8. HSE impacts associated with waste, emissions, noise, and energy use are monitored, and minimized.</p> <p>6.9. Comprehensive waste management programmes are in place to ensure that wastes are minimized, re-used, recycled, or properly disposed of.</p> <p>6.10. Decommissioning, remediation and restoration plans are established using risk-based studies for end of life equipment / facilities.</p> <p>6.11. A quality assurance programme exists to ensure that equipment replacement or modification maintains operations integrity.</p>
7.	Management of Change	<p>7.1. The health, safety, security, environmental, technical and other impacts of temporary and permanent changes are formally assessed, managed, documented and approved.</p> <p>7.2. Changes in legal and regulatory requirements, technical codes, and knowledge of health and environmental effects, are tracked and appropriate changes implemented.</p> <p>7.3. Effects of change on the workforce / organization, including training requirements, are assessed and managed.</p> <p>7.4. The impact on product quality of changes in manufacturing processes is assessed, associated hazards are evaluated and risks are controlled.</p> <p>7.5. The original scope and duration of temporary changes are not exceeded without review and approval.</p> <p>Back to gHSEr</p>

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		table
8.	Information and Documentation	<p>8.1. A system is in place to securely manage drawings, design data and other documentation, including definition of responsibilities for maintaining this information.</p> <p>8.2. Applicable regulations, permits, codes, standards and practices are identified. The resultant operating requirements are documented and communicated to the workforce.</p> <p>8.3. Pertinent records are maintained, available and retained as necessary. Obsolete documentation is identified and removed from circulation.</p> <p>8.4. Scope and format of technical documentation will be agreed for each facility and will form part of the design input for new facilities and modifications.</p> <p>8.5. Employee health, medical and occupational exposure records are maintained with appropriate confidentiality and retained as necessary.</p> <p>Back to qHSEr table</p>
9.	Customers and Products	<p>9.1. Assessments are conducted for new products prior to marketing or distribution, to identify health, safety and environmental hazards and risks associated with normal use and foreseeable misuse.</p> <p>9.2. Periodic reassessments are conducted for all manufactured and re-branded products and intermediate streams. This includes a review of adverse effects reported or experienced by those handling these products.</p> <p>9.3. New uses or markets for existing products are evaluated to ensure that health, safety and environmental hazards and risks are identified and addressed.</p> <p>9.4. Records of assessment, background information and conclusions are kept up-to-date throughout the product's life and retained as necessary.</p> <p>9.5. Up to date information on health, safety and environmental hazards and risks relating to the use, storage, handling, transport and disposal of our products is available to the workforce, customers and others. Material Safety Data Sheets (MSDS), labels and other information are developed and issued to handlers and users in accordance with legislative and customer requirements, and as information changes.</p> <p>9.6. A system exists to collect and review adverse effects reported or experienced by those handling our products. Causes for concern are identified and actions are taken.</p> <p>9.7. An effective recall system exists for products where a defect could give rise to health, safety or environmental hazards.</p> <p>9.8. A system is in place to respond on a 24-hour basis to emergency requests for product health, safety and environmental information.</p>
10.	Community and Stakeholder Awareness	<p>10.1. Open and proactive communications are established and maintained with employees, contractors, regulatory agencies, public organizations and communities regarding the HSE aspects of our business.</p> <p>10.2. BP Amoco recognizes and responds to government and community HSE related Expectations and concerns about our operations and our products.</p> <p>10.3. HSE impacts of new business development on local communities are openly assessed, communicated, and integrated into the business case.</p> <p>10.4. HSE impacts of any divestment or decommissioning on existing operations, neighbors or local community (originally identified during the new business development stage) are reviewed, communicated and managed.</p> <p>10.5. Major business operations periodically issue an externally verified statement relating to HSE performance and programmes.</p>
11.	Crisis and Emergency Management	<p>11.1. Emergency management plans are based on the risks that potentially impact the business. These plans are documented, accessible, clearly communicated and align to the BP Amoco Group's emergency management system.</p> <p>11.2. Equipment, facilities and personnel needed for emergency response are identified, tested and available.</p> <p>11.3. Personnel are trained and understand emergency plans, their roles and responsibilities, and the use of crisis management tools and resources.</p> <p>11.4. Drills and exercises are conducted to assess and improve emergency response / crisis management capabilities, including liaison with and involvement of external organizations.</p> <p>11.5. Periodic updates of plans and training are used to incorporate lessons learned from previous incidents and exercises.</p> <p>Back to qHSEr table</p>
12.	Incidents Analysis and Prevention	<p>12.1. All health, safety, technical integrity, security and environmental incidents, including near misses, are openly reported, investigated, analyzed and documented.</p> <p>12.2. Major incidents are investigated by a multi-function / level team with participation and leadership from outside the Business Unit.</p> <p>12.3. Incident investigations, including identification of root causes and preventive actions, are documented and closed-out.</p> <p>12.4. Information gathered from incident investigations is analyzed to identify and monitor trends and develop prevention programmes.</p> <p>12.5. Lessons learned from investigations are shared across BP Amoco and personnel take appropriate action upon receipt of such information.</p> <p>12.6. Mutual sharing of lessons learned and good practice is encouraged within the wider energy and chemical industry.</p>
13.	Assessment, Assurance and Improvement	<p>13.1. HSE performance indicators (both inputs and outcomes) are established, communicated and understood throughout the organization.</p> <p>13.2. The workforce is actively involved in periodic self-assessments of the effectiveness of processes and procedures to meet the HSE Expectations.</p> <p>13.3. HSE performance indicators are regularly used to determine when and what management system changes are necessary. When changes occur in one HSE Element the impact on the entire management system is evaluated.</p> <p>13.4. A system exists to continually improve HSE behaviors through observation, recording and coaching.</p> <p>13.5. A documented, risk-based audit programme exists to periodically evaluate progress towards HSE targets, regulatory compliance, and the effectiveness of the Business Unit management system(s).</p> <p>13.6. The Business Unit, in co-operation with the audit team, plans audits which are objective and systematic. These are documented and conducted using expertise from inside and outside the unit.</p> <p>13.7. Findings from learning processes (e.g. audits, incident investigation, near misses, HAZOPS, etc.) are prioritized, tracked and used to systematically improve the HSE management system.</p> <p>13.8. The Business Unit leadership team reviews the management system to ensure it is continually delivering consistent, desired performance. Based on the review, new risk-based targets are considered and established wherever necessary.</p> <p>13.9. Business Units report HSE performance data, as part of the Group's HSE Reporting Requirements.</p> <p>13.10. A process is in place whereby assurance is regularly provided to the Chief Executive Officer demonstrating effective implementation of the BP Amoco HSE Commitment and Expectations. Annual self-assessments against these Expectations are carried out by each Business Unit, along with external audits at least every three years.</p> <p>Back to qHSEr table</p>

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Multiple minor (recordable) injuries amongst persons on-site. Recordable injury (medical treatment) to single person off-site. Non-permanent injury (DAFW) to person on-site. Multiple minor (recordable) injuries amongst persons on-site. First Aid or less. No impact to persons off-site. Recordable injury (medical treatment) to single person on-site. No impact to persons off-site. Tr@ction offers both an actual and potential severity matrix for ranking the severity of an incident. The potential severity matrix follows the actual in succession of the Tr@ction screens.

[Actual Severity Matrix:](#)

Severity Levels	Health	Safety	Environment	Property Damage	Reputation	Business Interruption/Unit Outage
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	A	B	C	E	F	G
1	A1	B1	C1	E1	F1	G1
2	A2	B2	C2	E2	F2	G2
3	A3	B3	C3	E3	F3	G3
4	A4	B4	C4	E4	F4	G4
5	A5	B5	C5	E5	F5	G5

Potential Severity Matrix:

Severity Levels	Health	Safety	Environment	Property Damage	Reputation	Business Interruption/Unit Outage
	A	B	C	E	F	G
1	A1	B1	C1	E1	F1	G1
2	A2	B2	C2	E2	F2	G2
3	A3	B3	C3	E3	F3	G3
4	A4	B4	C4	E4	F4	G4
5	A5	B5	C5	E5	F5	G5

* Definitions for recurrence in the Potential Risk Matrix :-

High - There is a greater than 1 in 10 chance of outcome being realised

Medium - There is between a 1 in 10 and 1 in 1000 chance of outcome being realised

Low - There is less than a 1 in 1000 chance of outcome being realised

Probability

Severity Index Descriptions

Index	Health
1	<ul style="list-style-type: none">Multiple person on-site with over-exposure to harmful effects with onset of severe or life-threatening irreversible health effects e.g. occupationally induced cancer, kidney damage, asbestosis and mesothelioma, genetic or harm to the unborn.Single persons off-site with over-exposure to harmful effects with onset of severe or life-threatening irreversible health effects e.g. cancer, kidney damage, asbestosis and mesothelioma, genetic or harm to the unborn.Multiple persons off-site with over-exposure to harmful effects causing moderate or worse irreversible health effects e.g. asthma, noise induced hearing loss
2	<ul style="list-style-type: none">Multiple persons on-site with over-exposure to harmful effects with resultant moderate irreversible health effects e.g. asthma, occupational noise induced hearing lossSingle person on-site with over-exposure to harmful effects with onset of severe or life-threatening irreversible health effects e.g. cancer, kidney damage, asbestosis and mesothelioma, genetic or harm to the unborn.Single person off-site with over-exposure to harmful effects with resultant moderate irreversible health effects e.g. asthma, occupational noise induced hearing lossMultiple persons off-site with over-exposure to harmful effects with mild to moderate reversible health effects e.g. irritation, nausea
3	<ul style="list-style-type: none">Multiple persons on-site with over-exposure to harmful effects with reported and confirmed mild to moderate reversible health effects, e.g. irritation, nauseaSingle person on-site with over-exposure to harmful effects with resultant moderate irreversible health effects e.g. asthma, occupational noise induced hearing lossSingle person off-site with over-exposure to harmful effects with mild to moderate reversible health effects e.g. irritation, nausea
4	<ul style="list-style-type: none">Potential for on-site over-exposure but no reported ill-health effectsSingle person on-site with reported symptoms of mild to moderate reversible health effect, e.g., irritation, nausea-confirmed by medical authorityPotential for off-site exposure but no effects identified
5	<ul style="list-style-type: none">Single person on-site with over-exposure to harmful effects, but no reported ill-health effect e.g. monitoring result shows occupational exposure limit has been exceeded, or one-off event such as failure of local controls or PPENo impact off-site or detectable off-site exposure

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	Safety
1	<ul style="list-style-type: none"> Multiple fatalities amongst persons on-site Fatality to single person off-site Multiple permanent injuries to person off-site
2	<ul style="list-style-type: none"> Fatality to single person on-site Multiple permanent injuries amongst persons on-site Permanent injury to single person off-site Multiple non permanent injuries to persons off-site
3	<ul style="list-style-type: none"> Permanent injury to single person on-site Multiple non permanent injuries(DAFWC) amongst persons on-site Non permanent injury to single person off-site
4	<ul style="list-style-type: none"> Non permanent injury (DAFW) to person on-site Multiple minor (recordable) injuries amongst persons on-site
5	<ul style="list-style-type: none"> Recordable injury (medical treatment) to single person on-site No impact to persons off-site
	Environment
1	<ul style="list-style-type: none"> Large uncontrolled release of hazardous material, e. g. > 10,000 barrels, 1,000 barrels in sensitive area, > 100 Te of classified material Impact for beyond the facility boundary Long term damage affecting extensive area off site and prolonged clean-up
2	<ul style="list-style-type: none"> Uncontained release of reportable quantity, e. g. >100 barrels, 10 Te classified material Impact on immediate neighborhood beyond facility boundary long term damage affecting limited area off site and prolonged clean-up
3	<ul style="list-style-type: none"> Uncontained release of minimum reportable quantity No long term impact beyond facility boundary Prolonged damage on site
4	<ul style="list-style-type: none"> Release contained site No prolonged damage
5	<ul style="list-style-type: none"> Contained releases of hazardous material. No off-site impact Minor damage/quick clean-up
	Property Damage
1	<ul style="list-style-type: none"> \$ 5 million Extensive damage to unit/facility Impact at adjacent unit
2	<ul style="list-style-type: none"> \$ 0,5-1 million Damage to large proportion

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	<ul style="list-style-type: none"> No impact off site
3	<ul style="list-style-type: none"> \$ 100 k to \$ 500 k Damage to a single major plant item Widespread damage to minor equipment items, e. g. Cabling, instrumentation and small bore pipework
4	<ul style="list-style-type: none"> \$10 k to \$ 100 k localized damage to minor equipment items
5	<ul style="list-style-type: none"> < \$ 10 k Superficial damage

	Reputation
1	<ul style="list-style-type: none"> National or international media coverage Prosecution and heavy fine by regulator Change of regulations at national level
2	<ul style="list-style-type: none"> National media attention Prosecution of regulator
3	<ul style="list-style-type: none"> Regional media coverage Extended involvement of regulator focusing on issues beyond immediate event
4	<ul style="list-style-type: none"> Local media coverage Increased regulator enforcement at site level e. g. improvement notice
5	<ul style="list-style-type: none"> Complaints from local neighborhood/community No formal action by regulator

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	Business Interruption/Unit Outage
1	<ul style="list-style-type: none">➤ > \$ 5 million➤ > 1 year➤ Cabling, instrumentation and small bore pipework
2	<ul style="list-style-type: none">➤ \$ 0,5-1 million➤ 1 month➤ replacement/extensive repair of mayor plant items e.g. vessels, compressors
3	<ul style="list-style-type: none">➤ \$ 100 k to \$ 500 k➤ > 1 week➤ Replacement/extensive repair of a single major plan item➤ Equipment repair/replacement of extensive testing
4	<ul style="list-style-type: none">➤ < \$ 10k to \$ 100 k➤ < 1 week➤ Equipment repair plus testing
5	<ul style="list-style-type: none">➤ < \$ 10 k➤ < 1 day➤ Repairs can be completed with unit on line

	Security/Criminal Act
1	<ul style="list-style-type: none">➤ Civil unrest in country requiring evacuation of staff➤ Bomb threat➤ Hostage taking➤ Serious sabotage
2	<ul style="list-style-type: none">➤ Serious criminal act leading to prosecution➤ Serious breach of guidelines on handling security information
3	<ul style="list-style-type: none">➤ Criminal act involving police investigation➤ Breach of company policies leading to dismissal
4	<ul style="list-style-type: none">➤ Breach of company policies leading to formal disciplinary action
5	<ul style="list-style-type: none">➤ Breach of company policies leading to informal warning

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Appendix D - Model Terms of Reference Template

INCIDENT INVESTIGATION TEAM

The following Investigation Team members and leadership have been agreed by the President; Performance Unit Leader and Manager, HSE.

<u>Name</u>	<u>Position</u>
1.
2.
3.
4.
5.
6...etc	

The Team Leader appointed by (Position.....) is (Name.....).

The Team Leader will:

- provide methodology guidance for the Investigation Team
- ensure compliance with the Terms of Reference
- ensure compliance with BP references for incident investigation
- ensure consensus among Team Members regarding report contents
- ensure persons accountable for actions agree with action(s) and date(s)
- report directly to (position), who is the Owner for this Investigation Team
- provide daily progress updates to the Owner for the duration of the investigation.

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OBJECTIVES

1. Identify and review immediate causes of the incident.
2. Identify and analyze relative people, positions, parts and papers.
3. Identify and review system causes of the accident.
4. Map evidence; establish chronological list of events to identify critical factors.
5. Utilize "Comprehensive List of Causes; A Tool for System Cause Analysis" to analyze the incident.
6. Develop recommendations, corrective actions and lessons learned for the Owner's review and approval.

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Focus is on prevention of recurrence of a like-in-kind incident and communications of positive optics.

(Owner)

References:

BP "Getting HSE Right", Element 12

BP Standards and Practices, Standard 2 Incident Reporting.

Appendix C – Model Terms of Reference Template

INCIDENT INVESTIGATION TEAM

~~The following Investigation Team members and leadership have been agreed by the President, Performance Unit Leader and Manager, HSE.~~

	<i>Name</i>	<i>Position</i>
1.
2.
3.
4.
5.
6...etc

~~The Team Leader appointed by (Position.....) is (Name.....).~~

~~The Team Leader will:~~

- ~~• provide methodology guidance for the Investigation Team~~
- ~~• ensure compliance with the Terms of Reference~~
- ~~• ensure compliance with BP/Amoco references for incident investigation~~
- ~~• ensure consensus among Team Members regarding report contents~~
- ~~• ensure persons accountable for actions agree with action(s) and date(s)~~
- ~~• report directly to (position), who is the Owner for this Investigation Team~~
- ~~• provide daily progress updates to the Owner for the duration of the investigation.~~

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OBJECTIVES

- ~~1. Identify and review immediate causes of the incident.~~
- ~~2. Identify and analyze relative people, positions, parts and papers.~~
- ~~3. Identify and review system causes of the accident.~~
- ~~4. Map evidence; establish chronological list of events to identify critical factors.~~
- ~~5. Utilize "Comprehensive List of Causes; A Tool for System Cause Analysis" to analyze the incident.~~
- ~~6. Develop recommendations, corrective actions and lessons learned for the Owner's review and approval.~~

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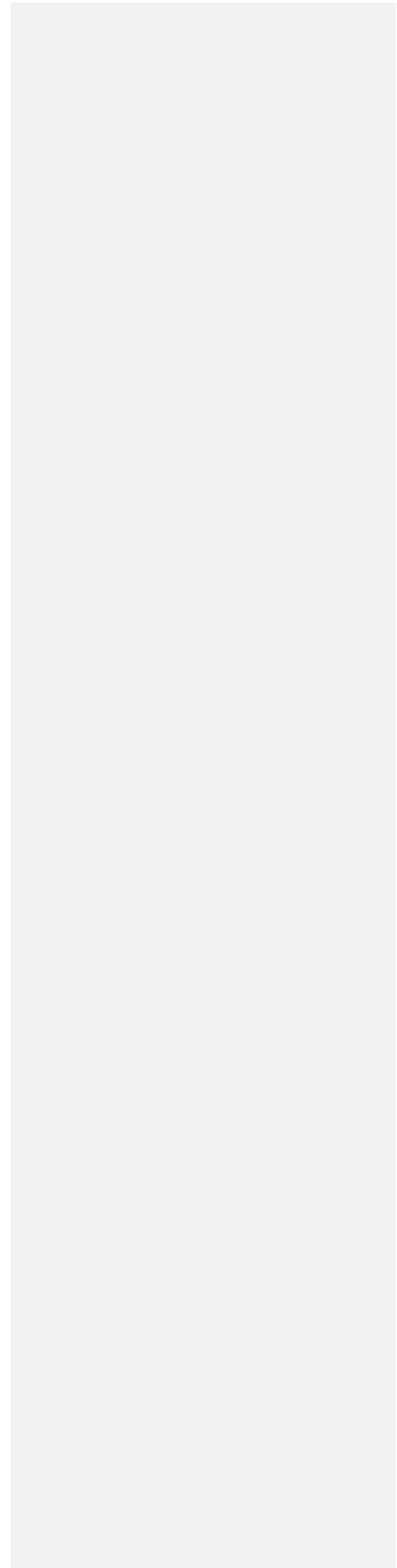
~~Focus is on prevention of recurrence of a like-in-kind incident and communications of positive optics.~~

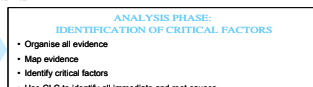
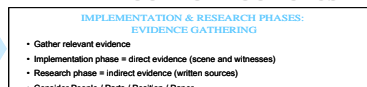
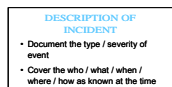
~~.....(Owner)~~

References:

BP/Amoco "Getting HSE Right", Element 12
BP Standards and Practices, Standard 2 Incident Reporting.

Appendix ~~DE~~ – ~~System Cause Analysis~~Comprehensive List of Causes Chart





ACTIONS						POSSIBLE IMMEDIATE CAUSES						CONDITIONS					
1-1	Following Procedures	2-1	Use of Tools or Equipment	3-1	Use of Protective Methods	4-1	Inspection / Lack of Awareness	5-1	Protective Systems	6-1	Tools, Equipment & Vehicles	7-1	Work Place Environment / Layout				
1-1	Violation by Individual	2-1	Improper use of equipment	3-1	Lack of knowledge of hazards present	4-1	Inspector decision making or lack of judgment	5-1	Inadequate guards or protective devices	6-1	Defective equipment	7-1	Fire or explosion				
1-1	Violation by group	2-2	Improper use of tool	3-2	Personal protective equipment not used	4-2	Distraction by other concerns	5-2	Defective guards or protective devices	6-2	Improperly prepared equipment	7-2	Noise				
1-1	Improper placement or actions for the equipment	2-3	Improper use by supervisor	3-3	Improper use of proper personal protective equipment	4-3	Insufficient training and/or supervision	5-3	Inadequate foot and/or hand protection	6-3	Improperly prepared equipment	7-3	Defective electrical systems				
1-1	Operation of equipment without authority	2-4	Use of defective tool (saw)	3-4	Improper placement of equipment, (equipment)	4-4	Horseplay	5-4	Defective personal protective equipment	6-4	Defective tools	7-4	Engaged systems, other than electrical				
1-1	Improper placement of equipment, (equipment)	2-5	Improper placement of tool, (tools)	3-5	Severing of energized equipment	4-5	Severing of energized equipment	5-5	Inadequate warning equipment	6-5	Inadequate hand protection	7-5	Redundant safety layout				
1-1	Overexertion of physical capability	2-6	Improper use of equipment	3-6	Equipment or materials not secured	4-6	Failure to warn	5-6	Defective warning systems	6-6	Improperly prepared tools	7-6	Temperature extremes				
1-1	Improper motion or position for the equipment	2-7	Improper motion or position for the equipment	3-7	Dislodged guards, warning systems or safety devices	4-7	Use of drugs or alcohol	5-7	Defective vehicles	6-7	Hazardous chemicals	7-7	Unprotected height				
1-1	Inspector lifting	2-8	Severing of equipment at inspector speed	3-8	Equipment or materials not secured	4-8	Routine activity without thought	5-8	Inadequate safety devices	6-8	Inadequate vehicle for the purpose	7-8	Mechanical hazards				
1-1	Inspector handling	2-9	Other	3-9	Defective guards, warning systems or safety devices	4-9	Other	5-9	Defective safety devices	6-9	Improperly prepared vehicle	7-9	Slopes or falls of nature				
1-1	Shortcuts	2-10	Personal protective equipment not available	3-10	Other	4-10	Other	5-10	Other	6-10	Other	7-10	Slippery floors or walkways				
1-1	Other	2-11	Other	3-11	Other	4-11	Other	5-11	Other	6-11	Other	7-11	Other				

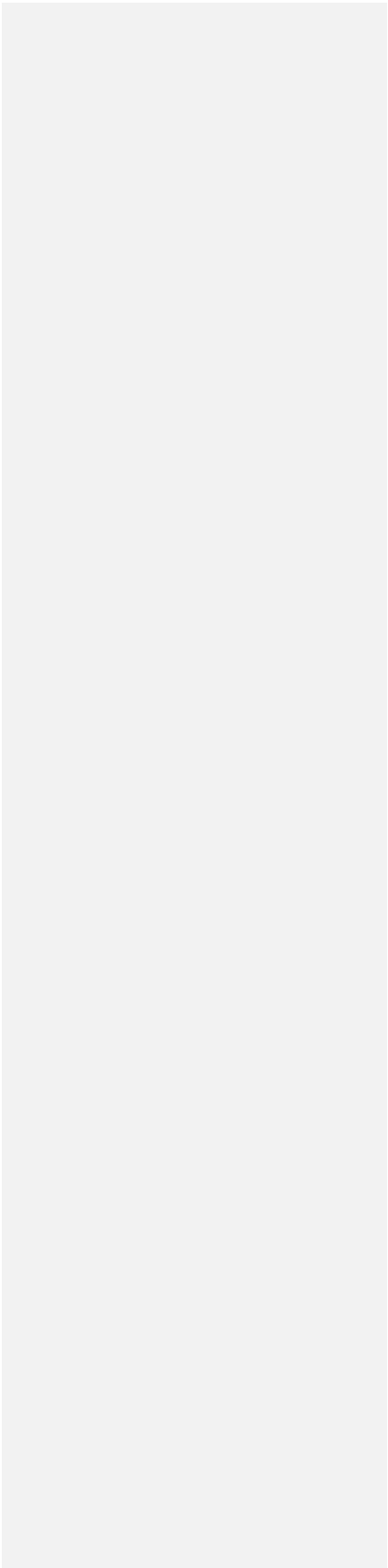
PERSONAL FACTORS										POSSIBLE SYSTEM CAUSES										JOB FACTORS									
1. Physical Capability		2. Physical Condition		3. Mental State		4. Personal Stress		5. Improper performance		6. Skill Level		7. Training / Knowledge		8. Management / Supervision		9. Contractor Selection & Oversight		10. Engineering / Design		11. Work Planning		12. Purchasing, Material Handling & Inventory Control		13. Tools & Equipment		14. Work Rules / Policies / Standards / Procedures (PSP)		15. Communication	
1.1	Vision deficiency	2.1	Previous injury or overexertion	3.1	Post Concussion Memory failure	4.1	Frustration	5.1	Improved performance is rewarded	6.1	Inadequate assessment of task	7.1	Inadequate knowledge	8.1	Lack of contractor pre-qualifications	9.1	Lack of oversight	10.1	Inadequate technical design	11.1	Work planning	12.1	Inadequate item control	13.1	Assessment of needs and risks	14.1	Lack of PSP for the task	15.1	Communication
1.2	Hearing deficiency	2.2	Fatigue	3.2	Emotional disturbance	4.2	Confusing demands	5.2	Improper supervision	6.2	Inadequate practice of skill	7.2	Inability to comprehend	8.2	Unclear reporting	9.2	Unclear reporting	10.2	Design input obsolete	11.2	Confusing preventive maintenance	12.2	Assessment of specifications to vendor	13.2	Inadequate standards or specifications	14.2	Lack of PSP for the task	15.2	Communication
1.3	Other sensory deficiency	2.3	Due to lack of rest	3.3	Fears or phobias	4.3	Conflicting demands	5.3	Improper supervision	6.3	Inadequate practice of skill	7.3	Inadequate training	8.3	Unclear reporting	9.3	Unclear reporting	10.3	Design input not correct	11.3	Assessment of specifications to vendor	12.3	Inadequate standards or specifications	13.3	Inadequate standards or specifications	14.3	Lack of PSP for the task	15.3	Communication
1.4	Reduced respiratory capacity	2.4	Due to lack of rest	3.4	Low mechanical aptitude	4.4	Conflicting demands	5.4	Improper supervision	6.4	Inadequate practice of skill	7.4	Inadequate training	8.4	Unclear reporting	9.4	Unclear reporting	10.4	Design input not available	11.4	Assessment of specifications to vendor	12.4	Inadequate standards or specifications	13.4	Inadequate availability	14.4	Lack of PSP for the task	15.4	Communication
1.5	Other permanent physical disabilities	2.5	Due to sensory overload	3.5	Low mechanical aptitude	4.5	Conflicting demands	5.5	Improper supervision	6.5	Inadequate practice of skill	7.5	Inadequate training	8.5	Unclear reporting	9.5	Unclear reporting	10.5	Design input not available	11.5	Assessment of specifications to vendor	12.5	Inadequate standards or specifications	13.5	Inadequate availability	14.5	Lack of PSP for the task	15.5	Communication
1.6	Temporary disabilities	2.6	Due to sensory overload	3.6	Low mechanical aptitude	4.6	Conflicting demands	5.6	Improper supervision	6.6	Inadequate practice of skill	7.6	Inadequate training	8.6	Unclear reporting	9.6	Unclear reporting	10.6	Design input not available	11.6	Assessment of specifications to vendor	12.6	Inadequate standards or specifications	13.6	Inadequate availability	14.6	Lack of PSP for the task	15.6	Communication
1.7	Inability to sustain body position	2.7	Due to sensory overload	3.7	Low mechanical aptitude	4.7	Conflicting demands	5.7	Improper supervision	6.7	Inadequate practice of skill	7.7	Inadequate training	8.7	Unclear reporting	9.7	Unclear reporting	10.7	Design input not available	11.7	Assessment of specifications to vendor	12.7	Inadequate standards or specifications	13.7	Inadequate availability	14.7	Lack of PSP for the task	15.7	Communication
1.8	Restricted range of body movement	2.8	Due to sensory overload	3.8	Low mechanical aptitude	4.8	Conflicting demands	5.8	Improper supervision	6.8	Inadequate practice of skill	7.8	Inadequate training	8.8	Unclear reporting	9.8	Unclear reporting	10.8	Design input not available	11.8	Assessment of specifications to vendor	12.8	Inadequate standards or specifications	13.8	Inadequate availability	14.8	Lack of PSP for the task	15.8	Communication
1.9	Disturbance sensitivities or allergies	2.9	Due to sensory overload	3.9	Low mechanical aptitude	4.9	Conflicting demands	5.9	Improper supervision	6.9	Inadequate practice of skill	7.9	Inadequate training	8.9	Unclear reporting	9.9	Unclear reporting	10.9	Design input not available	11.9	Assessment of specifications to vendor	12.9	Inadequate standards or specifications	13.9	Inadequate availability	14.9	Lack of PSP for the task	15.9	Communication
1.10	Inadequate size or strength	2.10	Due to sensory overload	3.10	Low mechanical aptitude	4.10	Conflicting demands	5.10	Improper supervision	6.10	Inadequate practice of skill	7.10	Inadequate training	8.10	Unclear reporting	9.10	Unclear reporting	10.10	Design input not available	11.10	Assessment of specifications to vendor	12.10	Inadequate standards or specifications	13.10	Inadequate availability	14.10	Lack of PSP for the task	15.10	Communication
1.11	Diminished capacity due to medication	2.11	Due to sensory overload	3.11	Low mechanical aptitude	4.11	Conflicting demands	5.11	Improper supervision	6.11	Inadequate practice of skill	7.11	Inadequate training	8.11	Unclear reporting	9.11	Unclear reporting	10.11	Design input not available	11.11	Assessment of specifications to vendor	12.11	Inadequate standards or specifications	13.11	Inadequate availability	14.11	Lack of PSP for the task	15.11	Communication
1.12	Other	2.12	Due to sensory overload	3.12	Low mechanical aptitude	4.12	Conflicting demands	5.12	Improper supervision	6.12	Inadequate practice of skill	7.12	Inadequate training	8.12	Unclear reporting	9.12	Unclear reporting	10.12	Design input not available	11.12	Assessment of specifications to vendor	12.12	Inadequate standards or specifications	13.12	Inadequate availability	14.12	Lack of PSP for the task	15.12	Communication
1.13	Other	2.13	Due to sensory overload	3.13	Low mechanical aptitude	4.13	Conflicting demands	5.13	Improper supervision	6.13	Inadequate practice of skill	7.13	Inadequate training	8.13	Unclear reporting	9.13	Unclear reporting	10.13	Design input not available	11.13	Assessment of specifications to vendor	12.13	Inadequate standards or specifications	13.13	Inadequate availability	14.13	Lack of PSP for the task	15.13	Communication
1.14	Other	2.14	Due to sensory overload	3.14	Low mechanical aptitude	4.14	Conflicting demands	5.14	Improper supervision	6.14	Inadequate practice of skill	7.14	Inadequate training	8.14	Unclear reporting	9.14	Unclear reporting	10.14	Design input not available	11.14	Assessment of specifications to vendor	12.14	Inadequate standards or specifications	13.14	Inadequate availability	14.14	Lack of PSP for the task	15.14	Communication
1.15	Other	2.15	Due to sensory overload	3.15	Low mechanical aptitude	4.15	Conflicting demands	5.15	Improper supervision	6.15	Inadequate practice of skill	7.15	Inadequate training	8.15	Unclear reporting	9.15	Unclear reporting	10.15	Design input not available	11.15	Assessment of specifications to vendor	12.15	Inadequate standards or specifications	13.15	Inadequate availability	14.15	Lack of PSP for the task	15.15	Communication
For each identified critical factor, consider if any of the listed root cause categories apply. If "yes," circle the specific root cause. If none of the root causes in the category apply, then check the "not applicable" box at the bottom of the column.																													

CORRECTIVE PHASE: PROPOSALS FOR CORRECTIVE ACTION

- Align with 'Getting HSE Right' elements

ELEMENTS OF GETTING HSE RIGHT												
Leadership and Accountability	Risk Assessment and Management	People, Training and Behaviours	Working with Contractors and Others	Facilities Design and Construction	Operations and Maintenance	Management of Change	Information and Documentation	Customers and Products	Community and Stakeholder Awareness	Crisis and Emergency Management	Incidents Analysis and Prevention	Assessment, Assurance and Improvement

Appendix E—Incident Investigation Report



Incident Investigation Report

The Incident Investigation Report is a tool used to document and report information and track recommended actions for incidents and near misses and must be completed for all incidents.

Use Accident & Incident Reporting Data Base ([Tr@ction](#)) to document an Incident.

For Minor Incidents, the computer record in the Accident and Incident Data Base ([Tr@ction](#)) may be the only report.

Sites that do not have access to [Tr@ction](#) must complete the form below and submit the form to their designated Accident & Incident Data Base Recorder, or to Central HSE for input to [Tr@ction](#).

For Major Incidents a separate report must be produced. When appropriate the Site Manager may require a written report (including the form below) until supporting materials such as photographs and witness statements in addition to the accident and incident data base record for Minor Incidents.



REPORT TITLE-→_____

INCIDENT REPORT NO-→_____

SYNERGY REPORT NO-→_____

TYPE OF INCIDENT

(tick-off one)-↓

(tick-off one or more)-↓

<input type="checkbox"/> Accident (requires page 3)	<input type="checkbox"/> Personal Injury	<input type="checkbox"/> Road Accident
<input type="checkbox"/> Near miss	<input type="checkbox"/> Spill to environment	<input type="checkbox"/> Gas leak
	<input type="checkbox"/> Property damage	<input type="checkbox"/> Fire/explosion

TIME AND PLACE OF THE INCIDENT

Facility/Site-	Area/module-	dd/mm/yy-	Time-	Area responsible unit-

WORK PROCESS

(tick-off)-

☐ Production/Injection ☐ Pipe-laying ☐ Lifting ☐ Maintenance ☐ Diving ☐ Leisure
☐ Construction/mods ☐ De-oiling ☐ Catering ☐ Office work ☐ Storage ☐ Security
☐ Oil transportation ☐ Survey ☐ Drilling ☐ Inspection ☐ Pipe coating ☐ Deck operation
☐ Wireline/wellservice ☐ Sea transport ☐ Road transport ☐ Air transport ☐ Other (Specify)-→_____

SURROUNDING FACTORS

Company involved-	System involved-	Equipment involved-	Substances involved-

DESCRIPTION OF THE INCIDENT

(Describe what happened)

LOSS POTENTIAL(What might have been worst probable **not worst imaginable outcome** of this event? Circle a letter on the matrix.)

Oil Spill-Onshore	Oil Spill-Offshore	People	Cost \$
>100 BBL	>100 BBL	Fatality	Damage/loss >500 K
10-100 BBL	10-100 BBL	Permanent Disability	Damage/loss 100K-500K
1-10 BBL	1-10 BBL	Hospital Stay	Damage/loss 50-100K
0.1-1 BBL	0.1-1 BBL	Professional Medical Treatment	Damage/loss 10-50K
<0.1 BBL	<0.1 BBL	Simple First Aid	Damage/loss <10K

A1	A2	A3	A4	A5
B1	B2	B3	B4	B5
C1	C2	C3	C4	C5
D1	D2	D3	D4	D5
E1	E2	E3	E4	E5
<in 5- years	>in 5- years	>in 1- year	>in 6- months	>in 14- days

IMMEDIATE CAUSES					
SUBSTANDARD ACTS			SUBSTANDARD CONDITIONS		
<input type="checkbox"/> Operating equipment without authority <input type="checkbox"/> Failure to warn <input type="checkbox"/> Failure to secure <input type="checkbox"/> Failing to keep the workplace tidy <input type="checkbox"/> Making safety device/equipment inoperable <input type="checkbox"/> Using defective equipment <input type="checkbox"/> Incorrect use of machine and equipment <input type="checkbox"/> Failing to use PPE properly <input type="checkbox"/> Improper work position for the task <input type="checkbox"/> Servicing/working on equipment in operation <input type="checkbox"/> Improper lifting <input type="checkbox"/> Lack of respect for barriers/signs <input type="checkbox"/> Using defective tools <input type="checkbox"/> Failing to select PPE properly <input type="checkbox"/> Improper loading/placement <input type="checkbox"/> Horse play <input type="checkbox"/> Improper speed <input type="checkbox"/> Outside BP control			<input type="checkbox"/> Inadequate guards or barriers <input type="checkbox"/> Defect equipment <input type="checkbox"/> Substandard housekeeping <input type="checkbox"/> Inadequate ventilation <input type="checkbox"/> Fire hazards <input type="checkbox"/> Inadequate maintenance <input type="checkbox"/> Temperature extreme <input type="checkbox"/> Climate extreme <input type="checkbox"/> Inadequate warning system <input type="checkbox"/> Slippery or uneven surface <input type="checkbox"/> Restricted access <input type="checkbox"/> Inadequate protective equipment <input type="checkbox"/> Loose/falling objects <input type="checkbox"/> Inadequate lighting <input type="checkbox"/> Defect tools <input type="checkbox"/> Wrong substances <input type="checkbox"/> Explosion hazards <input type="checkbox"/> Inadequate warning signs <input type="checkbox"/> Force major <input type="checkbox"/> Flooding <input type="checkbox"/> Outside BP control		
BASIC CAUSES					
PERSONAL FACTOR			JOB FACTOR		
<input type="checkbox"/> Lack of respect for procedure <input type="checkbox"/> Risk not properly identified <input type="checkbox"/> Lack of knowledge <input type="checkbox"/> Lack of skill <input type="checkbox"/> Lack of experience <input type="checkbox"/> Physical stress <input type="checkbox"/> Lack of physical ability to do the job <input type="checkbox"/> Lack of motivation <input type="checkbox"/> Distraction <input type="checkbox"/> Failure to follow procedure <input type="checkbox"/> Lack of training <input type="checkbox"/> Psychological stress <input type="checkbox"/> Failure to follow instructions <input type="checkbox"/> Lack of psychological ability to do the job			<input type="checkbox"/> Inadequate procedure/instructions <input type="checkbox"/> Inadequate accountability <input type="checkbox"/> Inadequate supervision <input type="checkbox"/> Inadequate shift hand over <input type="checkbox"/> Inadequate standards <input type="checkbox"/> Inadequate maintenance program <input type="checkbox"/> Inadequate equipment <input type="checkbox"/> Inadequate specification <input type="checkbox"/> Inadequate planning <input type="checkbox"/> Lack of procedure/instructions <input type="checkbox"/> Inadequate monitoring <input type="checkbox"/> Inadequate design <input type="checkbox"/> Inadequate purchasing <input type="checkbox"/> Inadequate tools <input type="checkbox"/> Outside BP control		
LACK OF CONTROL					
A — B — C (tick off) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 1. Leadership and Accountability A — inadequate requirements/guidelines <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 2. Risk Assessment and Management B — requirements/guidelines not appropriate <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 3. People, Training and Behaviors C — requirements/guidelines not complied <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 4. Working with Contractors and Others <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 5. Facilities Design and Construction <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 6. Operations and Maintenance <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 7. Management of Change <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 8. Information and Documentation <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 9. Customers and Products <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 10. Community and Stakeholder Awareness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 11. Crisis and Emergency Management <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 12. Incident Analysis and Prevention <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 13. Assessment, Assurance and Improvement <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 14. External factors beyond control					
ACTIONS TO PREVENT RECURRENCE					
	Action	Responsible person	Priority (1, 2 or 3)	Due date	Completion date

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CONSEQUENCES

PERSONAL INJURY (use extra pages 3 if needed for multi injuries)

Date/WFC: <input type="checkbox"/> Yes <input type="checkbox"/> No Recordable: <input type="checkbox"/> Yes <input type="checkbox"/> No Injury class: <input type="checkbox"/> Recordable fatality- <input type="checkbox"/> Permanent- disability <input type="checkbox"/> Occupational- illness <input type="checkbox"/> Restricted-work <input type="checkbox"/> First-aid- treatment	Type of injury: <input type="checkbox"/> Squeezed <input type="checkbox"/> Cut <input type="checkbox"/> Fracture <input type="checkbox"/> Burn <input type="checkbox"/> Foreign-body <input type="checkbox"/> Electrical-shock <input type="checkbox"/> Internal-injury <input type="checkbox"/> Chemical exposure <input type="checkbox"/> Stretched/twisted <input type="checkbox"/> Poisoning <input type="checkbox"/> Radiation <input type="checkbox"/> Welding flash <input type="checkbox"/> Other <input type="checkbox"/> Bruise <input type="checkbox"/> Psychological <input type="checkbox"/> Wound <input type="checkbox"/> Strain/sprain <input type="checkbox"/> Concussion	Type of event: <input type="checkbox"/> Hit against <input type="checkbox"/> Hit by <input type="checkbox"/> Fall to lower-level <input type="checkbox"/> Fall to same level <input type="checkbox"/> Stuck in <input type="checkbox"/> Hooked by <input type="checkbox"/> Squeezed-between <input type="checkbox"/> Contact with(current/temp/chem-etc.) <input type="checkbox"/> Overload/strain <input type="checkbox"/> Bite/sting <input type="checkbox"/> Inhalation <input type="checkbox"/> Injection	Body-part-injured: <input type="checkbox"/> Ankle <input type="checkbox"/> Arm /- shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Foot <input type="checkbox"/> Hand <input type="checkbox"/> Head <input type="checkbox"/> Skin <input type="checkbox"/> Knee <input type="checkbox"/> Chest <input type="checkbox"/> Thigh /leg <input type="checkbox"/> Back <input type="checkbox"/> Throat <input type="checkbox"/> Tooth <input type="checkbox"/> Toe <input type="checkbox"/> Ear <input type="checkbox"/> Eye <input type="checkbox"/> Other <input type="checkbox"/> Internal- lesions <input type="checkbox"/> Mouth <input type="checkbox"/> Extensive- injuries <input type="checkbox"/> Wrist
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Name	Company	Age	Sex	Experience in present inst./location	Experience in present position	Shift	Employment contract
			<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Day shift <input type="checkbox"/> Night shift <input type="checkbox"/> Overtime <input type="checkbox"/> Leisure <input type="checkbox"/> Training	<input type="checkbox"/> Permanently employed <input type="checkbox"/> Contractor <input type="checkbox"/> Subcontractor <input type="checkbox"/> Substitute <input type="checkbox"/> Third party <input type="checkbox"/> Visitor

~~SPILLS and LOSS OF CONTAINMENT~~

Type of discharge	Total Volume	Volume not recovered	Discharge to:
			<input type="checkbox"/> Sea/water <input type="checkbox"/> Air <input type="checkbox"/> Ground

PROPERTY DAMAGE

Description	Loss in \$

LESSONS LEARNED

MANAGEMENT COMMENTS (Note if this is a major or high potential incident reportable to London)

SIGNATURE

Investigator	Supervisor for activity	Site/facility manager

Appendix FF – Guidelines for Reporting and Recording Occupational Injuries and Illnesses

Introduction

It is recognized, that a well-established incident reporting and recording process is essential for successful functioning of an HSE Management System. The process can help drive continuous improvement in HSE performance through the prevention of future similar incidents and as an output measure to drive prevention programs.

It is easier to eliminate or mitigate risks at the stage of near miss rather than deal with consequences of more serious incidents. If we work to eliminate the minor incidents we can prevent the more serious ones.

Reporting and recording of all incidents feeds databases, with which trend analyses can be conducted to determine where to focus HSE efforts. BP uses Tr@ction system for this purpose.

These Guidelines are designated as practical aid to help managers, supervisors and others in reporting and recording practices. While we recognize that we must also report on oil spills, environmental emissions and other losses, these Guidelines focus on Health & Safety reporting.

There is a dual purpose to the compilation of injury and illness data. First is governmental recording, and second is the internal use of the data to manage our health and safety programs.

This revised Guideline reflects changes to the required governmental recording in the United States of America. Regardless of location, all BP organizations must comply with governmental requirements for recording occupational injuries and illnesses.

Why use the USA OSHA guidelines for the basis of our reporting and recording? Most of the other companies (Exxon-Mobil, Shell, Dupont and Conoco) that we like to compare our performance to use the OSHA basis – and unless we do as well, we lose this ability to compare and benchmark.

Since we use the data internally to assess safety performance, we also have an ethical obligation to make the data as accurate as reasonably possible.

Recording

Prompt reporting of incidents is essential. Before we can report we must be able to accurately classify our incidents. The Injury and Illness Reporting Decision Tree in Appendix G is an aid in this effort. In order to be accurate we must consider:

- **Work relationship** – An injury or illness is presumed to be work related if the event or exposure takes place in the work environment. The work environment is defined as the establishment and other locations where one or more employees are working or are present as a condition of their employment. The work environment includes not only physical locations, but also the equipment or materials used by the employee during the course of his or her work. Essentially, it is when one is acting in the interest of the employer. There are nine exceptions to the work-related rule:
 1. General public
 2. Voluntary participation in recreation
 3. Signs/symptoms surface at work but are non work-related event or exposure
 4. Food/drink for personal consumption (unless employer provides catering)
 5. Personal tasks outside normal working hours
 6. Grooming / self medication
 7. Commuting to work (even if BP is providing the bus to bring employees to the office or Terminal)
 8. Cold or influenza
 9. Mental illness (two exceptions: 1. post traumatic stress syndrome tied to specific workplace incident, and, 2. employee voluntarily provides employer with an opinion from licensed health care professional stating employee's mental illness is work-related)

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Further information is available in form of the “Occupational Injury and Illness Information – Accurate Determinations & Consistent Reporting” booklet. This guide is available by request to the Business Unit Resource Safety Team.

- **BP Premises** – A site operated by a BP company or a marine vessel owned or operated by a BP company. Further clarification of premises is addressed in Appendix H, Upstream HSE Accountabilities and Boundaries – Activity Circles.

Our premises include pipeline right of way as well as our more typical operating facilities and BP offices. Contractor offices that conduct engineering and design activities are not our premises and we do not count their performance against the BU on Operate 1 reporting. Some Projects may keep track for internal overall Project HSE performance, but these man-hours and incidents do not impact our BU HSE performance and are not reportable to ExCo. Typically, Contractor offices do not count in our statistics.

- **Employment status** – we count both Company and Contractor incidents that are work related. Accounting for Contractor incidents is a function of premises, as well as the nature of work and whether it is at a 3rd Party fabrication site. A definition for Contractor follows in the next section.
- **Contractor** – A contractor is any non-BP person who is on BP premises under contract, for business purposes. (There are some exceptions.) Contractors that are doing fabrication or construction work on sites that are not our premises count in a special category on the Operate1 Report, but do not impact BU HSE Performance. Only those fab-site man-hours dedicated to our project, and incidents that are fatalities and lost time incidents are reported in this special category. We do not count fab-site medical treatment cases that aren't DAFWC, nor do we count any of their Safety Inputs.
- **Third party** – Is any person who is not an employee or contractor of BP, and the only incidents we count for them is a fatality associated with our work.
- **Near Miss** – An undesired event that, under slightly different circumstances, could have resulted in harm to people, damage to assets, environmental harm or unplanned operational shutdown. A near miss is an incident involving the unintentional transfer of energy but has no negative consequence.
- **First Aid Case** – The following is the list of recognized first aid treatments. If it isn't on the list and it is a medical treatment then it will count as a recordable injury or illness.
 1. Using a non prescription med at non prescription strength
 2. Administering tetanus immunizations
 3. Cleaning, flushing or soaking wounds on the surface of the skin
 4. Using wound coverings such as bandages, Band-Aids, gauze pads, etc.; or using butterfly bandages or Steri-Strips
 5. Using hot or cold therapy
 6. Using any non-rigid means of support, such as elastic bandages, wraps, non-rigid back belts, etc.
 7. Using temporary immobilization devices while transporting an accident victim
 8. Drilling of a fingernail or toenail to relieve pressure, or draining fluid from a blister
 9. Using eye patches
 10. Removing foreign bodies from the eye using only irrigation or a cotton swab
 11. Removing splinters or foreign material from areas other than the eye by irrigation, tweezers, cotton swabs or other simple means
 12. Using finger guards
 13. Using massages
 14. Drinking fluids for relief of heat stress.
- **Recordable Injury/Illness Case (Medical Treatment)** – RII cases are all work-related injuries and illnesses that result in loss of consciousness, restriction of work or motion, transfer to another job, or require treatment beyond first aid.
- **Restricted Work Case** – The employee is kept from performing one or more of the routine functions of his or her job, or from working the full workday that he or she would otherwise have been scheduled to work. Or, a physician or other licensed health care professional

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recommends that the employee not perform one or more of the routine functions of his or her job, or not work the full workday that he or she would otherwise have been scheduled to work.

- **Routine Functions** – For record keeping purposes, an employee's routine functions are those work activities the employee regularly performs at least once a week.
- **Days Away From Work Case (DAFWC)** – A work-related injury or illness that would prevent the injured person from working on the day following that which the injury occurred, whether or not he or she is actually scheduled to work the following shift. If the medical professional declares that the individual is not fit to return to work on the day following the injury, then the case is classified as a DAFWC even if the following day is not a scheduled workday. If a person subsequently must have corrective surgery or otherwise miss work as a result of the work related injury, and does so during a scheduled absence then the injury is still considered a DAFWC.
- **High Potential (HiPo) Incident** – Is an incident or near miss, including a security incident, where the most serious probable outcome is a Major Incident.
- **Major Incident (MIA)** – Is an incident, including a security incident, involving any one of the following:
 - a fatality associated with BP operations
 - multiple serious injuries
 - significant adverse reaction from authorities, media, NGO's or the general public
 - cost of accidental damage exceeding US\$ 500,000
 - oil spill of more than 100 barrels, or less if it at a sensitive location
 - release of more than ten tonnes of a classified chemical.
 - Note: An incident must always be treated as a Major Incident for investigation purposes if personal injury resulting in a day away from work case or an oil or chemical release beyond company premises has occurred.
- **Recordable Fatality** – a fatality is deemed recordable unless the circumstances indicate that the event is not relevant to the measurement of the health and safety performance of the Company. Fatalities arising, for example, from suicide, inexplicable personal behaviour or natural causes would normally be excluded.
- **Incident severity** – all incidents should be reported. Incident severity is determined per the Tr@ction Severity Matrix (See Appendix C).
- **Road Accident** – are accidents involving vehicles, which occur on the road and result in damage or a work-related injury. This includes work related operation of vehicles by BP employees and product delivery vehicles operated by BP contractors.
 - A zero-cost threshold is applied and reporting is irrespective of whether the accident was judged preventable or non-preventable.
 - A BP operated vehicle is a delivery, or other vehicle, driven by a BP employee for work related purposes, although the vehicle may be owned, hired or leased.
 - A contractor operated delivery vehicle is either a company branded vehicle or a vehicle under a BP term contract (i.e. for more than one year) where the same driver is employed on a regular basis.

Reporting

All incidents must be reported. Some incidents such as Fatalities and other Major Incident Announcements must be promptly reported with 24 hours to London. All recordable incidents, including DAFWC as well as man-hours are reported monthly to London through Tr@ction generated Operate 1 reports. Near misses and other minor incidents are only reported locally.

The standard Incident Report Form is found on the HSE Website.

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Safety inputs include STOP Cards, ASA Observations, Safety Training Hours and Percent Action Closure. It is important to note that safety input frequencies are calculated on a 200,000-manhour basis, just the same as our outputs.

More detailed information on Safety Input and Output reporting can be obtained from BP Upstream Reporting Guidelines, which are available upon request from AzBU HSE.

Local Performance Unit reporting systems should be in place to analyze and resolve STOP and ASA observations. This should include monthly management review of outstanding actions. Significant actions are managed with Tr@ction and include actions that result from a MIA, HiPo or key audits such as *getting HSE right*.

References

1. Occupational Injury and Illness Information – Accurate Determinations & Consistent Reporting
2. Upstream Reporting Guidelines (Supplement to Group Reporting Guidelines)

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~~HEALTH & SAFETY~~

~~GUIDELINES FOR REPORTING AND RECORDING~~

~~OCCUPATIONAL INJURIES AND ILLNESSES~~

~~Azerbaijan Business Unit~~

~~-~~

~~INTRODUCTION~~

~~It is recognized, that a well-established incident reporting and recording process is essential for successful functioning of an HSE Management System. The process can help drive continuous improvement in HSE performance through the prevention of future similar incidents and as an output measure to drive prevention programs.~~

~~It is easier to eliminate or mitigate risks at the stage of near miss rather than deal with consequences of more serious incidents. If we work to eliminate the minor incidents we can prevent the more serious ones.~~

~~Reporting and recording of all incidents feeds databases, with which trend analyses can be conducted to determine where to focus HSE efforts. BP uses Tr@ction system for this purpose.~~

~~These Guidelines are designated as practical aid to help managers, supervisors and others in reporting and recording practices. While we recognize that we must also report on oil spills, environmental emissions and other losses, these Guidelines focus on Health & Safety reporting.~~

~~There is a dual purpose to the compilation of injury and illness data. First is governmental recording, and second is the internal use of the data to manage our health and safety programs.~~

~~This revised Guideline reflects changes to the required governmental recording in the United States of America. Regardless of location, all BP organizations must comply with governmental requirements for recording occupational injuries and illnesses.~~

~~Why use the USA OSHA guidelines for the basis of our reporting and recording? Most of the other companies (Exxon-Mobil, Shell, Dupont and Conoco) that we like to compare our performance to use the OSHA basis—and unless we do as well, we lose this ability to compare and benchmark.~~

~~Since we use the data internally to assess safety performance, we also have an ethical obligation to make the data as accurate as reasonably possible.~~

~~RECORDING~~

~~Prompt reporting of incidents is essential. Before we can report we must be able to accurately classify our incidents. In order to be accurate we must consider:~~

- ~~•**Work relationship**—An injury or illness is presumed to be work related if the event or exposure takes place in the work environment. The work environment is defined as the establishment and other locations where one or more employees are working or are present as a condition of their employment. The work environment includes not only physical locations, but also the equipment or materials used by the employee during the course of his or her work. Essentially, it is when one is acting in the interest of the employer. There are nine exceptions to the work-related rule:~~

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1. General public
2. Voluntary participation in recreation
3. Signs/symptoms surface at work but are non work-related event or exposure
4. Food/drink for personal consumption (unless employer provides catering)
5. Personal tasks outside normal working hours
6. Grooming / self medication
7. Commuting to work (even if BP is providing the bus to bring employees to the office or Terminal)
8. Cold or influenza
9. Mental illness (two exceptions: 1. post traumatic stress syndrome tied to specific workplace incident, and, 2. employee voluntarily provides employer with an opinion from licensed health care professional stating employee's mental illness is work-related)

Further information is available in form of the "Occupational Injury and Illness Information — Accurate Determinations & Consistent Reporting" booklet. This guide is available by request to the Business Unit Resource Safety Team.

• **BP Premises** — A site operated by a BP company or a marine vessel owned or operated by a BP company.

For the purpose of corporate report only:

1. A Drilling rig operating on a BP licensed block is considered BP premises.
2. A ship on term charter to BP is considered BP premises.
3. A supply base managed and operated by a contractor is not considered BP premises.
4. A contractor's base or manufacturing site is not considered BP premises even if it is used solely for supporting a BP contract.
5. Contract Accountable Manager may require the contractor to report other accidents and incidents in connection with BP work, but these will not be entered into Tr@ction or reported to the corporate center.

• **Employment status** — we count both Company and Contractor incidents that are work-related. Accounting for Contractor incidents is a function of premises, as well as the nature of work and whether it is at a 3rd Party fabrication site. A definition for Contractor follows in the next section.

The Injury and Illness Reporting Decision Tree found in Attachment 1 displays a concise process to facilitate the classification. Further clarification can be found in the following definitions.

DEFINITIONS

• **Contractor** — A contractor is any non-BP person who is on BP premises under contract, for under contract, for business purposes. (There are some exceptions.) — Contractors that are doing fabrication or construction work on sites that are not our premises count in a special category on the Operate1 Report, but do not impact BU HSE Performance. Only those fab-site manhours dedicated to our project, and incidents that are fatalities and lost time incidents are reported in this special category. We do not count fab-site medical treatment cases that treatment cases that aren't DAFWC, nor do we count any of their Safety Inputs.

• **Third party** — is any person who is not an employee or contractor of BP, and the only incidents we count for them is a fatality associated with our work.

• **Premises** — Our premises include pipeline right of way as well as our more typical operating facilities and BP offices. Contractor offices that conduct engineering and design activities are

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not our premises and we do not count their performance against the BU on Operate 1 reporting. Some Projects may keep track for internal overall Project HSE performance, but these manhours and incidents do not impact our BU HSE performance and are not reportable to ExCo. Typically, Contractor offices do not count in our statistics.

•**Near Miss** – an undesired event that, under slightly different circumstances, could have resulted in harm to people, damage to assets, environmental harm or unplanned operational shutdown. A near miss is an incident involving the unintentional transfer of energy but has no negative consequence.

•**First Aid Case** – The following is the list of recognized first aid treatments. If it isn't on the list and it is a medical treatment then it will count as a recordable injury or illness.

1. Using a non-prescription med at non-prescription strength
2. Administering tetanus immunizations
3. Cleaning, flushing or soaking wounds on the surface of the skin
4. Using wound coverings such as bandages, Band-Aids, gauze pads, etc.; or using butterfly bandages or Steri-Strips
5. Using hot or cold therapy
6. Using any non-rigid means of support, such as elastic bandages, wraps, non-rigid back belts, etc.
7. Using temporary immobilization devices while transporting an accident victim

8. Drilling of a fingernail or toenail to relieve pressure, or draining fluid from a blister
9. Using eye patches
10. Removing foreign bodies from the eye using only irrigation or a cotton swab
11. Removing splinters or foreign material from areas other than the eye by irrigation, tweezers, cotton swabs or other simple means
12. Using finger guards
13. Using massages
14. Drinking fluids for relief of heat stress.

•**Recordable Injury/Illness Case (Medical Treatment)** – RII cases are all work-related injuries and illnesses that result in loss of consciousness, restriction of work or motion, transfer to another job, or require treatment beyond first aid.

•**Restricted Work Case** – The employee is kept from performing one or more of the routine functions of his or her job, or from working the full workday that he or she would otherwise have been scheduled to work. Or, a physician or other licensed health care professional recommends that the employee not perform one or more of the routine functions of his or her job, or not work the full workday that he or she would otherwise have been scheduled to work.

•**Routine Functions** – For recordkeeping purposes, an employee's routine functions are those work activities the employee regularly performs at least once a week.

•**Days Away From Work Case (DAFWC)** – a work-related injury or illness that would prevent the injured person from working on the day following that which the injury occurred, whether or not he or she is actually scheduled to work the following shift. If the medical professional declares that the individual is not fit to return to work on the day following the injury, then the case is classified as a DAFWC even if the following day is not a scheduled workday. If a person subsequently must have corrective surgery or otherwise miss work as a result of the work-related injury, and does so during a scheduled absence then the injury is still considered

•**High Potential (HiPo) Incident** – is an incident or near miss, including a security incident, where the most serious probable outcome is a Major Incident.

•**Major Incident (MIA)** – is an incident, including a security incident, involving any one of the following:

- a fatality associated with BP operations
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- significant adverse reaction from authorities, media, NGO's or the general public
- cost of accidental damage exceeding US\$ 500,000
- oil spill of more than 100 barrels, or less if it at a sensitive location
- release of more than ten tonnes of a classified chemical

Note: —An incident must always be treated as a Major Incident for investigation purposes if personal injury resulting in a day away from work case or an oil or chemical release beyond company premises has occurred.

•**Recordable Fatality** — a fatality is deemed recordable unless the circumstances indicate that the event is not relevant to the measurement of the health and safety performance of the Company. Fatalities arising, for example, from suicide, inexplicable personal behaviour or natural causes would normally be excluded.

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•**Incident severity** — all incidents should be reported, whether a STOP card, ASA, near miss or more serious incident including a loss of some sort. Only those incidents, which are OSHA recordable are reported on our Business Unit performance to the Group Business Centre in London. Incident severity is determined per the Tr@ction Severity Matrix.

•**Road Accident** — are accidents involving vehicles, which occur on the road and result in damage or a work-related injury. This includes work-related operation of vehicles by BP employees and product delivery vehicles operated by BP contractors.

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- A zero-cost threshold is applied and reporting is irrespective of whether the accident was judged preventable or non-preventable.
- A BP operated vehicle is a delivery, or other vehicle, driven by a BP employee for work-related purposes, although the vehicle may be owned, hired or leased.
- A contractor operated delivery vehicle is either a company branded vehicle or a vehicle under a BP term contract (i.e. for more than one year) where the same driver is employed on a regular basis.

REPORTING

All incidents must be reported. Some incidents such as Fatalities and other Major Incident Announcements must be promptly reported with 24 hours to London. All recordable incidents, including DAFWC as well as man-hours are reported monthly to London through Tr@ction generated Operate 1 reports. Near misses and other minor incidents are only reported locally.

The standard Incident Report Form is found on the HSE Website.

Safety inputs including STOP Cards, ASA Observations, Near Misses and Safety Training Hours are captured and reported. It is important to note that safety input frequencies are calculated on a 200,000-manhour basis, just the same as our outputs. The exception at this writing is that for safety training hours, the basis is BP manhours only.

Safety inputs are being revised as this Guideline is being published, so refer to the Upstream Reporting Guidelines (Supplement to Group Reporting Guidelines) when they are finalized. Safety training hours may change to include all BP led training. The coming year may also see Near Misses move to the Output side of the equation. Another potential change is the likely inclusion of action tracking as a performance metric.

Local Performance Unit reporting systems should be in place to analyze and resolve STOP and ASA observations. This should include monthly management review of outstanding actions. Significant actions are managed with Tr@ction and include actions that result from a MIA, HiPo or key audits such as *getting HSE right*.

Appendix 2, HSE Accountability Boundaries gives a description of the limits of recording and reporting including those for Contractors.

REFERENCES

1. Occupational Injury and Illness Information — Accurate Determinations & Consistent Reporting
2. Upstream Reporting Guidelines (Supplement to Group Reporting Guidelines)

APPENDICES

- F1. Injury and Illness Reporting Decision Tree
- F2. HSE Accountability Boundaries

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Appendix [FG4](#) - Injury and Illness Reporting Decision Tree

If in the work environment, assumed work-related unless:

- Member of general public,
- Signs & symptoms surface at work but result solely from non-work-related event or exposure,
- Voluntary participation,
- Eating, drinking, preparing own food,
- Doing personal tasks outside working hours,
- Personal grooming, self-medication, intentional self-inflicted injury,
- Company parking lot while commuting,
- Common cold or flu, or
- Mental illness.

Other work-related exceptions:

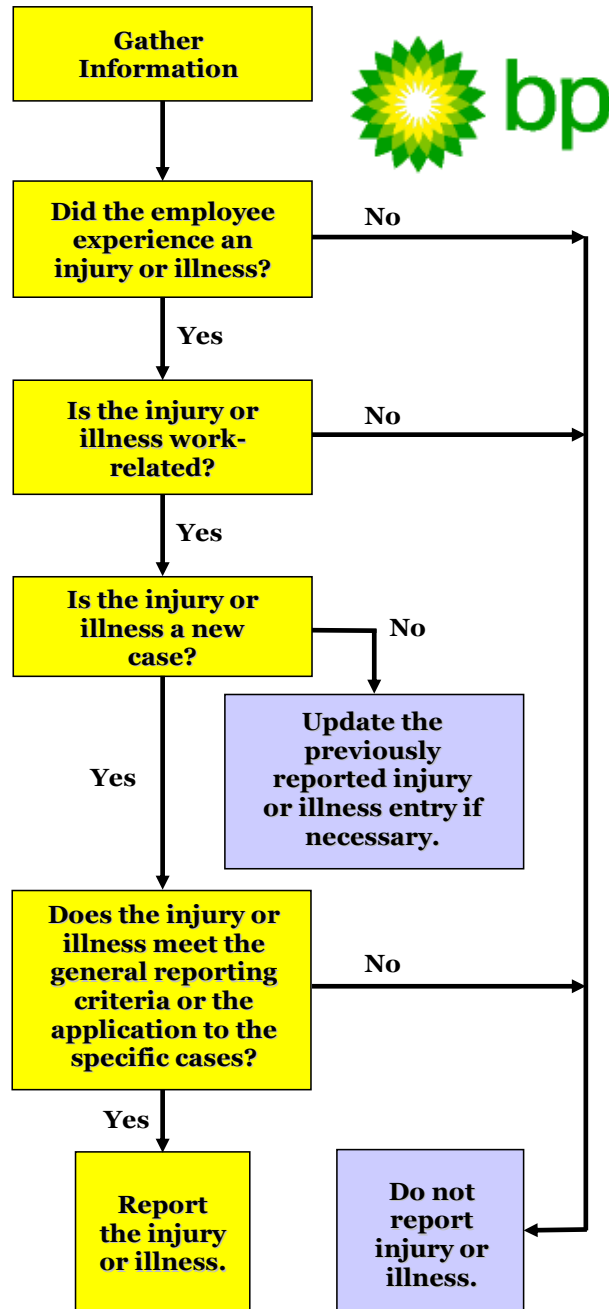
- Home away from home &
- Personal detour while on company business.

General Reporting Criteria:

- Death,
- Days away from work,
- Restricted work or transfer to another job,
- Medical treatment beyond first aid,
- Loss of consciousness, or
- A significant injury or illness diagnosed by a physician or other licensed health professional:
 - Cancer,
 - Chronic irreversible disease,
 - Fractured or cracked bone, or
 - Punctured eardrum.

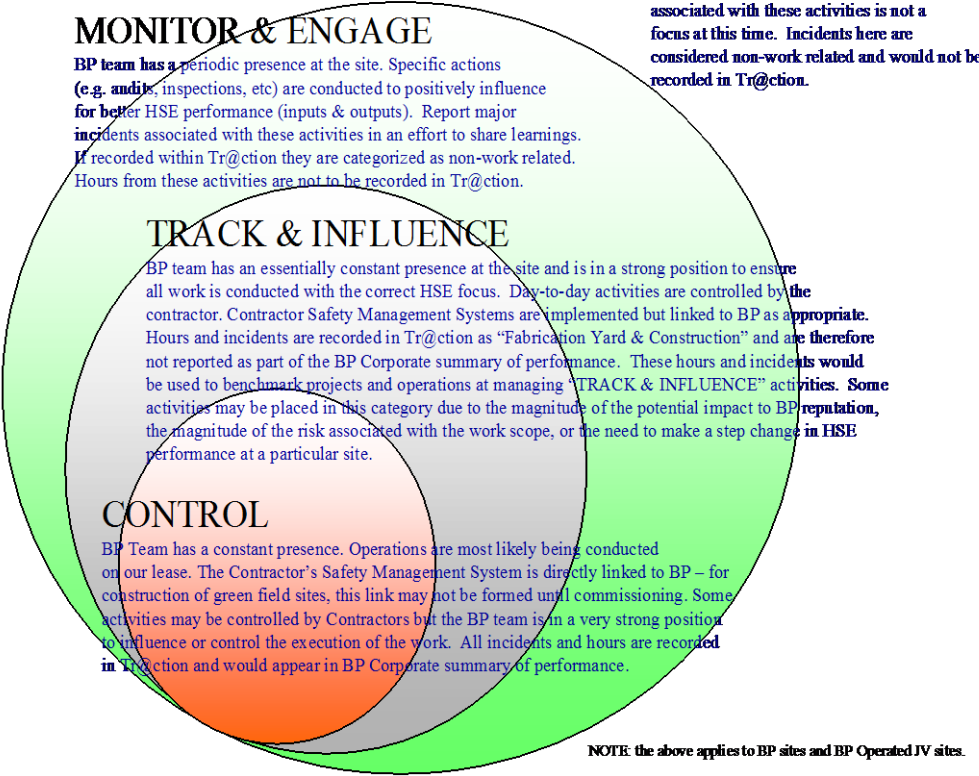
First aid treatments:

- Non-prescription medication in non-prescription strength,
- Tetanus immunizations,
- Cleaning, soaking, flushing wounds on surface of skin,
- Use of bandaids, Steri-Strips or butterfly bandages,
- Hot or cold therapy,
- Non-rigid means of support,
- Temporary immobilization devices while transporting an accident victim,
- Drilling finger or toe nail,
- Eye patch,
- Removing foreign bodies from eye using irrigation or cotton swab,
- Removing splinters or other foreign material from places other than the eye by simple means,
- Using finger guards,
- Using massages, or
- Drinking fluids for relief of heat stress.



Appendix F2—HSE Accountability Boundaries

ACTIVITY CATEGORIES



ACTIVITY CATEGORIES (Includes Employees, Contractors & Subcontractors)

