Lewis Energy Group®

# STANDARD OPERATING PRACTICE

## Incident Reporting and Investigation

Lewis Energy Group
Version 1.2
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## Table of Contents



## Acronyms and Abbreviations

| | |
|---|---|
| BU | Business Unit |
| CFR | Code of Federal Regulations |
| EOC | Emergency Operations Center |
| SIS | Safety Incident System |
| SOP | Standard Operating Practice |
| SSE | Short Service Employee |

# 1.0 Purpose and Policy Statement

The purpose of this Standard Operating Practice (SOP) document is to provide a process and guidelines for the reporting and investigation of incidents involving Lewis Energy Group (LEG).

LEG has a commitment to provide a work environment where no injury is considered acceptable and all activities are undertaken without compromising safety and health. All work-related incidents shall be reported to the appropriate Person In Charge (PIC) immediately. An incident is defined by Lewis Energy as an unplanned event that could result in personal injury, vehicle/property damage, a near miss, safety observations, or any situations that impact the environment. Team Members must adhere to this SOP when there is an incident. Contractors must fully cooperate with this SOP while working on LEG properties.

# 2.0 Applicability

This program applies to all parties involved in an incident pertaining to LEG. This document also includes information on how to investigate and report an incident in the LEG Safety Incident System (SIS). A Risk Ranking System for Incident Investigations is included in Appendix A.

The following are key terms used throughout this SOP:

- Incident: an unplanned event that could result in personal injury, vehicle/property damage, a near miss, safety observations, or any situations that impact the environment.
- Near Miss: An event that does not result in an injury or damage. It is important to record and investigate a near miss to identify any weakness in the safety system that could possibly lead to an injury, illness or property damage.

# 3.0 Requirements/Responsibilities

## Internal Reporting

When an incident occurs that adversely affects LEG, the incident shall be reported to the PIC immediately in order for the LEG safety department to be notified, the incident investigated and documented in the SIS.

If the incident is extremely serious, the Team Member shall perform the duties of the PIC and safety department as outlined in Section 4 of this SOP until they arrive at the scene.

Contractors will review LEG Contractor Safety Requirements found in ISNetworld or schedule review of LEG Contractor Safety Requirements with LEG Safety Department prior to working on any LEG facility and must report incidents **immediately** and submit an initial Incident Report within 24 hours of the incident to the BU manager. If a third party worker is injured, LEG will notify the employer of third party worker as soon as possible. If the contractor learns of an incident, they should inform the LEG PIC/ safety department immediately so the incident may be properly Investigated and documented.

The Occupational Safety and Health Administration (OSHA) regulations (29 CFR 1904) require documentation of every work-related injury or illness which involves one or more of the following:

- Death
- Days away from work
- Restricted work or transfer to another job
- Medical treatment (excluding first aid) or
- Loss of consciousness

## External Reporting

Certain injury/illnesses must be reported to the OSHA office closest to the incident scene, the OSHA 24-hour hotline, or reported online. Employers are required to notify OSHA within 8 hours when a fatality occurs. Work-related inpatient hospitalizations, amputations, and losses of an eye are to be reported to OSHA within 24-hours.[1]

**All required safety and environmental incidents will be reported to regulatory agencies by the LEG management, regulatory and safety departments.**

## Incident Investigation

Following the reporting of an incident to the PIC, an incident investigation shall be performed as required in Appendix A (Risk Incident Investigation Level) by investigators from the LEG safety department, LEG BU management and if applicable, third party contractor management. The investigation shall be conducted to determine the root cause and necessary corrective actions. The investigation shall be performed by the BU manager, safety department, and, where applicable, other external personnel. A contractor representative will conduct investigations of incidents involving their employees jointly with the LEG investigation team. Where the incident involves a multi-employer worksite, the investigation should be shared with each employer at the site. Upon conclusion of the investigation, the safety investigator and involved parties will complete the Incident Investigation Form included in Appendix B of this SOP.

Section 4.0 of this SOP outlines the investigation approach to be followed.

# 4.0 Conduct the Incident Investigation – A Four-Step Approach

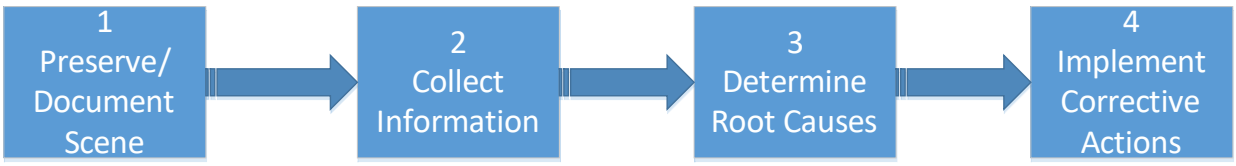
The objective of the incident investigation is to determine the contributing factors, underlying root cause, and ultimately prevent the recurrence of the incident. This incident investigation procedure establishes uniform investigation requirements to ensure that incidents are evaluated, controls and procedures are implemented to reduce or prevent future occurrences, and new hazard information is communicated to employees.

[1] OSHA Part 1904 Subpart E.

A four-step approach to conducting an incident investigation has been developed. The four steps are outlined below with corresponding forms located in Appendix B for LEG management and Team Members to follow. When conducting an incident investigation:

- Preserve/document the scene
- Collect information
- Determine Root Causes
- Implement Corrective Actions

**Four-Step Process to an Investigation**




## Step 1: Preserve/Document the Scene

**Preserve the Scene:**
Immediately upon notification of an incident, the PIC shall secure the scene to prevent potential injuries or damage and to prevent evidence from being removed or altered. This can be done with tape, cones, guards or other secure means. Once the scene is secure, the PIC shall initiate the following:

- Take precautions to prevent injury to Team Members or persons in the area.
- Provide emergency first aid to any injured personnel.
- Make provisions as needed for the injured to be transported to the appropriate medical facility.
- Remove all unnecessary and uninvolved personnel to a safe place.
- Notify the leg safety department; and
- Assure that nothing is removed or tampered with.

Initial response to hazardous material releases depend upon the material released and the area impacted. Once the scene is secured, hazardous materials should be contained until clean up can be performed. Contact the LEG safety department for recommended actions.

**Document the Scene:**
Once the accident scene has been preserved, it is important to begin gathering evidence from as many sources as possible. One of the biggest challenges an investigator faces is determining what information is relevant. Investigators shall gather data that will help determine what happened, how it happened, and why it happened. Identifying information that answers these questions is the purpose of documenting the accident scene.

To effectively document the scene, investigators must come prepared by putting together an accident investigation kit for use during the investigation. There are many ways to document the scene, so it may become quite difficult for one person to effectively complete all actions. The most effective strategy is to document as much as possible, even if the investigator doesn't think the information is relevant. It is easy to discard clues or leads later if they prove to not be useful to the investigation. It is not as easy to discover material evidence late into the investigation. All items found at the scene shall be considered important and potentially relevant material evidence. All evidence shall be labeled and stored in a secure location free from environmental exposure. Consequently, a team approach is the most efficient strategy to use when investigating serious accidents.

Basic Equipment for documenting the scene:

- Camera
- Tape recorder
- Ground loop Impedance Tester
- Sound level meter
- Tape measure, 25 and 50 ft. length
- Clipboard, paper, pencils, etc.
- Rain gear
- Rubber boots
- Plastic bags with ties
- Personal Protective Equipment
    - Eye protection
    - Hand protection
    - Clothing (FRC where required)
    - Respirators
    - Hearing protection
- String
- Stakes
- Warning tape

The BU manager/designee and safety department along with/or contract investigators, as necessary, shall document the incident facts. (use forms attached). Investigations can also include documentation of the scene by video recording, photographing and sketching. All video/photographs taken must be approved by the LEG legal department or safety manager. If during the course of the investigation, criminal activity is suspected, the LEG security department shall be notified immediately. The BU manager/designee should then gather the preliminary information by:

- Preparing a list of witnesses to the incident, including Team Members, members of the general public (if applicable) and informing them of the possibility of future interviews by the incident investigators.
- Preparing a list of Team Members or other personnel who were involved in the incident.
- Documenting events immediately preceding the incident/injury.
- Identifying unsafe conditions and/or Team Member actions which may have contributed to the incident/injury.

- Photographing (only if approved) the scene including machinery, equipment, vehicle tools and other equipment involved. (Photographs of an injured or deceased person should not be taken).
- Measuring the dimensions and sketching the accident scene and objects involved in the incident.
- Noting other possible contributing factors, including environmental conditions, at the time of the incident – noise, temperature, precipitation, wind, traffic, etc.

**A Note on Photo Documentation:**
When photographs are taken at a scene, they shall be marked confidential and include information provided in the "Preserve and Document the Scene" form in Appendix B.

## Step 2: Collect Information

Incident information is collected through interviews, document reviews and other means. Collect physical, paper and personnel evidence. The Incident Investigation Form in Appendix B can be used as a guide to help ensure information pertinent to the incident is collected.

Interviews of persons involved in or witness to the incident shall begin as soon as feasibly possible after the incident has occurred. The interview process shall be performed by the safety department or security department. Giving a witness interview is considered a duty of LEG Team Members when an incident occurs. If a Team Member declines to be interviewed, the interviewer shall document the person's name and reason, if given, for declining. Witnesses other than LEG Team Members may decline an interview; however, documentation must be prepared by the interviewer with information as to whom and why the interview was declined. Interviewing new witnesses or re-interviewing initial witnesses or other people involved, up to and including the highest levels of LEG management, may be necessary as more information becomes available.

Because some questions will need to be designed around the interviewee, each interview shall be a unique experience. The "Collect Information Checklist Tool" located in Appendix B can be used as a guide during the information collection period.

Although the LEG investigation team shall conduct the majority of the investigation, to be most effective, the investigation should also include a team in which the participants work together. The PIC, safety manager or their designee(s) shall fully investigate the incident and document the causes and effects of the incident to include recommendations to prevent recurrence. This report will include the Team Member(s) account of the incident and shall be submitted to LEG Corporate Counsel.

## Step 3: Determine Root Cause

The root cause of an incident is exactly what the term implies: The underlying reasons why the incident occurred in the workplace. Finding the root cause goes beyond the obvious proximate or immediate factors.

Asking a series of questions – who, where, what, when, why and how did the incident occur, until a root cause is determined.

The "Sample Questions for Identifying Root Causes" in Appendix B can be used as a guide when identifying root causes.

Root cause should never be speculation or assumption. Information from the incident investigation shall be evaluated to conclude an accurate technical and scientific reasoning of the root cause.

### Step 4: Develop and Implement Corrective Actions

To the extent reasonably possible, corrective actions shall be developed to address the root cause(s) identified, be supported by LEG senior level management, have assigned responsible Team Member(s) and a completion date. The corrective action(s) should be developed and implemented to prevent the incident from occurring. The investigation is not complete until corrective actions are implemented, if applicable.

Specific corrective actions address the root cause(s) directly and shall be designed where no additional risks are introduced that could expose personnel to harm. Some corrective actions may be general, across-the-board improvements to workplace safety environment. Corrective actions to consider include but are not limited to:

- Strengthening the written comprehensive safety and health management system.
- Revising safety procedures to clearly establish responsibility and accountability.
- Changing safety inspection processes to include Team Members along with BU supervisors or other management representatives.
- Making changes to pre-written Job Safety Analysis (JSA) or making sure the corrective actions are communicated to Team Members during JSA discussion.

Implementation of corrective actions shall be verified and validated – were the corrective actions implemented and did they address the root cause(s)?

## 5.0 Incident Report

Upon completion of the incident investigation, the safety department along with the PIC at the time of the incident will provide a report with recommendations for future prevention of an incident. The report will document an accurate and detailed chronological description of the events related to and following the incident. The report shall be submitted to the appropriate LEG management Team Members within 30 days of the final date of the investigation. The LEG safety department will review any Incident Investigation Report involving contractors and will forward them to LEG management.

## 6.0 Safety Incident System

The Safety Incident System (SIS) is the LEG clearing house for all reported incidents. Once an incident occurs, it shall be reported to the safety tech/supervisor that represents the BU immediately after the incident occurrence. The safety tech/supervisor completes the SIS report in the LEG system. All incidents that occur on LEG property will be reported by the safety tech/supervisor.

## 7.0 Definitions/Terminology

Causal Factors – are human errors or equipment problems that directly led to the loss event or allowed the consequences of the event to be more severe. Elimination of the causal factors will prevent recurrence of the losses or reduce the consequences of the event.

Days Away – the number of days away from work after an injury. Does not include the initial day of injury, or the day the employee returns to work. The days are counted continuously including weekends, holidays, normal days off, etc. as if Team Member were required to work, until the employee is able to return to work.

Days Away Incident – a work related injury or illness which prevents the injured party from performing any work on the next scheduled workday.

First Aid Case – a work related injury or illness that is treated with one of the methods on the First Aid treatment list. Any other treatment is considered Medical Aid.

Incident – an event or occurrence resulting in a personal injury, illness, spill, release to the environment, regulatory noncompliance, property damage, fire, motor vehicle damage, equipment failure or other loss.

Incident Owner – a Team Member that validates the incident information, initiates the investigation, assigns the investigation team leader and approves the investigation report and action items. This is usually the Business Unit Supervisor or manager.

Medical Treatment Case – a work related injury or illness that requires medical treatment but does not result in days away, restricted workdays, or transfer to another job.

Motor Vehicle Incident – is any vehicle incident involving a company owned, leased, rented or a LEG Team Member personal vehicle being used during work hours or for work purpose.

Near Miss – is an event that occurred but did not result in an injury, illness, equipment damage or impact to the environment.

Property Damage – includes incidents which involve damage to LEG owned, rented, operated, or leased equipment. Property damage also includes damage caused by LEG operations to third party assets. This includes operations being performed by contractors on behalf of LEG. Fires and line strikes will be classified as property damage incidents.

Release – is an unplanned discharge of gas or vapor into the atmosphere, including relief valve discharges.

Recordable Incident – is an injury or illness case that includes fatalities, days away from work, restricted work or transfer to another job, medical treatment beyond first aid, fractured or cracked bones or teeth, punctured eardrum or loss of consciousness.

Restricted Duty Work Case – work related injury or illness that physically prevents an individual from performing any part of their normal job duties.

Root Causes – are the management system weaknesses that allowed the causal factor(s) to occur. Management systems are the processes a company has in place to control the work process and to encourage personnel to take the appropriate actions and discourage them from taking inappropriate actions. These systems are also intended to ensure equipment performs properly.

## 8.0 Document Control

| Version | Change Date | Change Description | Changed by | Approved by | Approval Date |
|---|---|---|---|---|---|
| 1.1 | 10/17/19 | • Capitalize Team Member<br>• Update Cover Page<br>• Reformat Appendices<br>• Update TOC | Colin Clark | Ken Phillips | 10/17/19 |
| 1.2 | 5/29/24 | Remove EOC SIS duties | Colin Clark | Ken Phillips | 5/29/24 |
| | | | | | |
| | | | | | |

NOTE: Changes to this document shall be reviewed by the Sub-Committee and approved by the Executive Safety Committee. Any document revisions are to be noted on the Document Review Change Log. This form shall be kept current to maintain audit compliance.

# *Appendix A*

## A RISK RANKING SYSTEM FOR INCIDENT INVESTIGATIONS

## RISK INCIDENT INVESTIGATION LEVEL CHART

## Risk Ranking System for Incident Investigations:

All incidents that occur on Lewis Energy properties shall be evaluated for their loss severity potential and probable rate of recurrence. Incidents having a risk-based potential in the green section shall be discussed and informally investigated. Selected incidents in the yellow section and all incidents in the red section shall be formally investigated based upon risk potential.

| | | Probability of Reoccurrence | | |
|---|---|---|---|---|
| | | **Rare** Unlikely to happen again; should not recur | **Occasional** Possibility of occurring again sometime | **Frequent** Possibility of occurring again very likely |
| **Loss Severity Potential** | **Minor (Level I)** Near-miss or no injury / Release w/ minimal impact / Minimal equipment damage | | | |
| | **Significant (Level II)** Significant near miss or recordable injury / Release with short-term impact / Significant equipment or vehicle damage that is repairable | | | |
| | **Serious (Level III)** Recordable injury with lost time or restricted duty / Release with serious or long-term impact / equipment or vehicle damage that is not repairable | | | |
| | **Major (Level IV)** Fatality/multiple injuries /Catastrophic release /Catastrophic equipment/vehicle damage / Significant citation | | | |

## Risk Incident Investigation Level:

| Investigation Level | Investigation Team[1] | Investigation Method | Method of Communicating Cause/Corrective Actions[2] |
|---|---|---|---|
| Green | LEG Site Supervisor or designee | Informal[4] / Discussion | Document in SIS. Safety Alert for select incidents within 15 days of occurrence |
| Yellow | LEG Site Supervisor and/or HSE Representative, Peer(s), Contractor[3] | Formal[5] (most incidents) / Informal (select incidents) | Document in SIS. Safety Alert for select incidents within 15 days of completion of incident investigation |
| Red | HSE Representative, Operations Manager, Peer(s), Contractor[3], Legal, Consulting Expert | Root Cause Analysis (e.g., Taproot, or RCFA) | Document in SIS. Safety Alert for select incidents within 30 days of completion of incident investigation |

**Notes:**

[1] These are the minimum members of investigation team. Team composition will vary depending upon nature of incident being investigated but will **ALWAYS** include upper level management.

[2] HSE has lead in drafting safety alerts/advisories, with review by appropriate involved parties.

[3] Include contractor representative(s) on investigation team if incident under investigation involved contractors.

[4] Informal Investigation: Investigate and correct immediate and proximate causes. Monitor frequency of incidents by cause for evidence of safety program system inadequacies.

[5] Formal Investigation: Record of incident and corrective actions. Monitor frequency of incidents for evidence of safety program system inadequacies.

# *Appendix B*

## FORMS

Incident Investigation Form

Preserve and Document the Scene

Collect Information Checklist Tool

Sample Questions for Identifying Incident Root Causes

**SECTION A: Information** **Step 1**

Company Name: _____ Date: _____

Investigator (or) Team Name(s) and Titles:

| Name: | Title: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Type of incident: ☐ Injury/illness ☐ Hazardous material release ☐ Property damage

**SECTION B: Incident Description/Injury Information** **Step 1 and Step 2**

1) Name of Injured Team Member: _____
2) Team Member's first language: _____
3) Team Member's Job Title: _____
4) Type of employment: ☐ Full-time ☐ Part time ☐ Temp ☐ Other
5) Length of time with Company: _____
6) Length in current position at time of incident: _____
7) Description of severity of injury: _____
8) Date and time of incident: _____
9) Location of Incident: _____
10) Detailed description of incident: Include relevant events leading up to, during and after the incident. (*It is preferred that the information is provided by the injured employee*.)
    _____
    _____
    _____
    _____
    _____
11) Description of incident from eyewitness, including relevant events leading up to, during and after the incident. Include names of persons interviewed, job titles and date/time of interviews.
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    _____
    _____
    _____
    _____
    _____

12) Description of incident from additional Team Member's with knowledge, including relevant events leading up to, during and after the incident. Include names of persons interviewed, job titles and date/time of interviews.

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13) Description of other possible contributing factors including weather conditions, noise, temperature, precipitation, wind, traffic, etc.

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**SECTION C: Identify the Potential Root Causes: What caused or allowed the Incident to Happen? Step 3**

The potential Root Causes are the underlying reasons the incident occurred, and are the factors that need to be addressed to prevent future incidents. If safety procedures were not being followed, why were they not being followed? It is common to find factors that contributed to the incident in several of these areas: equipment/machinery, tools, procedures, training or lack of training, work environment and operating a vehicle. If these factors are identified, you must determine why these factors were not addressed before the incident. Never assume a root cause. Root Causes should always be determined by technical and scientific facts of the event.

Ask questions such as – Why did the incident occur (immediate cause)? Why did that immediate cause occur? Why did that occur? – until a root cause is determined.

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**SECTION D: Recommended Corrective Actions to Prevent Future Incidents** **Step 4**

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_____
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_____
_____

**SECTION E: Corrective Actions Taken/Root Causes Addressed** **Step 4**

_____
_____
_____

**SECTION A – Preserve the Scene**

**Preserve the Scene:**
Immediately upon notification of an incident, the PIC shall secure the scene to prevent potential injuries or damage and evidence from being removed or altered. This can be done with tape, cones, guards or other secure means. Once the scene is secure, the PIC shall initiate the following:

- Take precautions to prevent injury to Team Members or persons in the area.
- Provide emergency first aid to any injured personnel.
- Make provisions as needed for the injured to be transported to the appropriate medical facility.
- Remove all unnecessary and uninvolved personnel to a safe place.
- Notify Safety Department
- Assure that nothing is removed or tampered with.

Initial response to hazardous material releases depend upon the material released and the media impacted. Once the scene is secured, hazardous materials should be contained, to pad if possible, until clean up can be implemented. Contact the LEG safety department for recommended actions.

**SECTION B – Document the Scene (Video and Photograph)**

Interviewees must be aware they are being video recorded and/or photographed. It is recommended that investigators obtain permission from the interviewee prior to the interview.

**Tips for Video Documentation:**

**Any time equipment is used at an incident scene where the potential for flammable gases may be present, the atmosphere will be sampled by a trained Team Member with monitoring equipment experience.**

- Video the scene as soon as possible; doing this early on will pick up details that may later add valuable information to the investigation.
- Scan slowly 360 degrees left and right to establish location.
- Narrate what is being taped, and describe objects, size, direction, location, etc.
- If vehicles were involved, record direction of travel, going and coming.

**Tips for Photograph Documentation:**

- Always make notes about the photos taken.
- Start by taking distance shots first then move in to take closer photos of the scene.
- Take photos at different angles to show the relationship of objects. Take panoramic photos to help present the entire scene.
- Take notes on each photo
- Identify and document the photo type, date/time/location taken, subject, weather conditions, measurements, etc.
- Identify the person taking the photo.
- Indicate the locations where photos were taken.
- Do not photograph injured or deceased persons.

## Collect Information Checklist Tool

*Lewis Energy Group*

| WHO? | WHERE? |
|---|---|
| ☐ Who was Injured? | ☐ Where did the incident occur? |
| ☐ Who saw the incident? | ☐ Where was the Team Member at the time? |
| ☐ Who was working with the Team Member? | ☐ Where was the BU supervisor at the time? |
| ☐ Who had instructed/assigned the Team Member? | ☐ Where were other Team Members at the time? |
| ☐ Who else was involved? | ☐ Where were other Team Members or personnel who were involved at the time? |
| ☐ Who else can help prevent recurrence? | ☐ Where were witnesses when the incident occurred? |
| **WHAT?** | **WHY?** |
| ☐ What was the incident? | ☐ Why was the Team Member injured? |
| ☐ What was the injury? | ☐ Why and what did the Team Member do? |
| ☐ What was the Team Member doing? | ☐ Why wasn't protective equipment used? |
| ☐ What had the Team Member been told to do? | ☐ Why weren't specific instructions given? |
| ☐ What tools was the employee using? | ☐ Why was the Team Member in the position? |
| ☐ What machine was involved? | ☐ Why was the Team Member using the tools, machine or vehicle? |
| ☐ What operation was the Team Member performing? | ☐ Why didn't the Team Member check with the BU supervisor when noted things were not as they should be? |
| ☐ What instructions had the Team Member been given? | ☐ Why did the Team Member continue working under the circumstances? |
| ☐ What specific precautions were necessary? | ☐ Why wasn't the BU supervisor there at the time? |
| ☐ What specific precautions was the Team Member given? | **WHEN?** |
| ☐ What protective equipment was the Team Member using? | ☐ When did the incident occur? |
| ☐ What had other Team Members done that contributed to the incident? | ☐ When did the Team Member start the job? |
| ☐ What problem or questions did the Team Member encounter? | ☐ When were the hazards pointed out to the Team Member? |
| ☐ What did the Team Member or witnesses do when the incident occurred? | ☐ When did the Team Member's supervisor check the job? |
| ☐ What extenuating circumstances were involved? | **HOW?** |
| ☐ What did the Team Member or witnesses see? | ☐ How did the Team Member get injured? |
| ☐ What will be done to prevent recurrence? | ☐ How could the Team Member have avoided it? |
| ☐ What safety rules were violated? | ☐ How could fellow workers have avoided it? |
| ☐ What new rules are needed? | ☐ Could it have been prevented? |

| |
|---|
| 1. Did a written or well-established procedure exist for employees to follow? |
| 2. Did job procedures or standards properly identify the potential hazards of job performance? |
| 3. Were there any hazardous environmental conditions that may have contributed to the incident? |
| 4. Were the hazardous environmental conditions in the work area recognized by employees or supervisors? |
| 5. Were actions taken by Team Members, BU supervisors or both to eliminate or control environmental hazards? |
| 6. Were Team Members trained to deal with any hazardous environmental conditions that may arise? |
| 7. Was sufficient space provided to accomplish the job task? |
| 8. Was there adequate lighting to properly perform all the assigned tasks associated with the job? |
| 9. Were Team Members familiar with job procedures? Was a JSA conducted and elimination of task hazards discussed? |
| 10. Was there any deviation from the established job procedures? |
| 11. Were the proper equipment and tools available and being used for the job? |
| 12. Did any mental or physical conditions prevent the Team Member from properly performing their job? |
| 13. Were there any tasks in the job considered more demanding or difficult than usual? |
| 14. Was there anything different or unusual from normal operations? |
| 15. Was the proper PPE specified for the job? |
| 16. Were Team Members trained in the proper use of the assigned PPE? |
| 17. Did the employees use the assigned PPE? |
| 18. Was PPE damaged or not properly functioning? |
| 19. Were Team Members trained and familiar with the emergency procedures, including the use of emergency equipment and was it available? |
| 20. Was there any indication of misuse or abuse of equipment and/or materials at the incident site? |
| 21. Is there any history of equipment failure, were all safety alerts and safeguards operational and was the equipment functioning properly? |
| 22. If applicable, are all employee certification and training records up-to-date? |
| 23. Was there any shortage of personnel on the day of the incident? |
| 24. Did on-site supervisors or safety detect, anticipate, or report an unsafe hazardous condition? |
| 25. Did on-site supervisors recognize deviations from the normal job procedure? |
| 26. Did on-site supervisors or employees participate in job review sessions, especially for those jobs performed on an infrequent basis? |
| 27. Were on-site supervisors made aware of their responsibilities for the safety of their work area and Team Members? |
| 28. Were on-site supervisors properly trained in the principles of incident prevention? |
| 29. Was there a history of personnel problems or conflicts with or between on-site supervisors and Team Members or between Team Members themselves? |
| 30. Did on-site supervisors conduct regular safety meetings with their Team Members? |
| 31. Were the proper resources required to perform the job or task readily available and in proper condition? |
| 32. Did on-site supervisors ensure Team Members were trained and proficient before assigning them to their jobs? |