

**Incident Reporting and Investigation Procedure**  
**HSE Management System**  
**PTCL Group**

Parent Procedure/Document	HSE Policy
Functional Area/Department	Health, Safety & Environment
Document Control Number	HSE_PR_01v02
Description	Incident Reporting and Investigation Procedure.
Date	09.10.2023
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First Draft	06-03-2020
Document Location	HSE Share point.
Distribution List	PTCL Group

**DOCUMENT CHANGE RECORD**

REV. NO	DESCRIPTION OF CHANGE	EFFECTIVE DATE
0	OH&S Incident management procedure.	06/03/2020
1	Incident Reporting and Investigation Procedure (Title and Procedure revised). The document change number is also revised.	09/10/2023

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Annexure "B"	DIR Report.
Annexure "C"	WHY Tree Analysis / SCAT
Annexure "D"	Annual Incident analysis.
Annexure "E"	One Slide Summary (OSS).
Annexure "F"	Template fact finding report.
Annexure "G"	Learning From Incident (LFI)

## **1.0 PURPOSE**

The purpose of this procedure is to document the process for reporting and investigating HSE incidents that occur in PTCL group Functions and Departments, in a way that:

1. Promotes thorough and efficient investigation in a timely manner.
2. Promotes uniform, accurate, clear, and concise documentation, and reporting.
3. Identifies and implements recommendations to prevent incident recurrence.
4. Involves the right people to get the information.
5. Ensures a clear understanding of key factors and learning.
6. Participating personnel obtain a positive learning experience.
7. Promotes an atmosphere of openness by improving communications and understanding about the incident.
8. Providing input to the development and implementation of HSE policies, procedures, guidelines, and standards.

## **2.0 SCOPE**

This Document describes the requirement for complying with the HSE Management System element on Incident Reporting and Investigation and is applicable for all departments and functions of PTCL Group. The applicability extends to staff including employees, Outsourced Service Providers (OSPs), contractors'/vendors' staff and public.

## **3.0 SUMMARY**

This procedure documents the rules and guidelines for the process to be used to report and investigate all HSE incidents that occur in the PTCL group functions and departments. The basic approach is to:

1. Define organizational responsibility for filing incident reports within the Company through forums discussed.
2. Involve appropriate people to conduct a purposeful and thorough investigation with an amount of effort being directly proportionate to criticality of the potential consequences.
3. Prompt communication of key factors and learning.
4. Orderly and timely implementation of recommendations for prevention of future occurrences.
5. Analysis of incidents to highlight trends and detection of significant changes to prevent recurrence.

## **4.0 DEFINITIONS AND ABBREVIATIONS**

### **4.1 EMPLOYMENT**

All work or activity performed in carrying out an assignment, including incidental and related activities not covered by the assignment, voluntary work, or activity while on duty with the consent of the Company.

**Voluntary work:** The work performed by the consent of an employee will be included in voluntary work except any injury or illness which results solely from voluntary participation in a wellness program or in a medical, fitness, or recreational activity such as blood donation, physical examination, flu shot, exercise class, racquetball, or baseball.

### **4.2 HSE INCIDENT**

An unplanned or unusual event, a series of events and circumstances, or a chronic or recurring condition that resulted in, or had the potential to result in, an adverse or undesirable safety, fire, occupational health, or environmental consequence. Undesirable consequences related to HSE incidents include, but are not limited to, the following:

1. Fires.
2. Work-related reportable injuries and illnesses.
3. Near miss.
4. Occupational Health incidents (as defined in this section).
5. Environmental Incident or Non-compliance.
6. Significant on- or off-site property or equipment damage (Off site property is defined as stand-alone location being used for PTCL Operations).
7. Noncompliance with government HSE standards or operating permits (legal requirements).
8. Unfavorable impact on the public.
9. Road Traffic Accident (RTA).

### **4.3 HIGH POTENTIAL INCIDENT**

Any incident that could have resulted in serious adverse effects like fatality or serious injuries under a different set of circumstances.

### **4.4 POTENTIAL CONSEQUENCE**

The possible outcome of an undesired event can be termed as potential consequence.

### **4.5 HUMAN FACTORS**

A discipline concerned with the design of machines, processes, operations, and work environments so that they do not exceed human capabilities and limitations.

### **4.6 INCIDENT REPORT**

Documentation of the results of an incident investigation, including description of the incident, details /learning of the investigation, key factors, system elements that need to be strengthened and recommendations to prevent future occurrences.

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**4.7 KEY FACTORS**

Circumstances that contributed to or may reasonably be believed to have contributed to the incident’s occurrence even though a clear causal connection cannot be found. These factors include human, physical, equipment or operating / managing categories / systems that are found to be deficient or otherwise capable of being improved.

Examples of different types of key factors are as follows:

- **Physical key factor** is a description of the physical failure or specific event associated with the incident (i.e., equipment, facilities, materials etc.)
- **A human behavior key factor** is a description of human errors (omission or commission), judgments, or inadequate decision making that may be directly associated with the incident. Errors in human performance may be related to skills, knowledge, or rule-based deficiencies.
- **An operating system failure key factor** is a description of the site, area, or functional operating or management system deficiencies that enabled the incident to occur. A management system is a set of interrelated or interacting elements that organizations use to direct and control how HSE is implemented, including written policies, training systems, communications, workflow responsibilities, and performance monitoring. System level key factors are intended to transcend the specific incident and strengthen the underlying system to prevent a similar event in another area of the business unit or in other business units.

**4.8 OCCUPATIONAL HEALTH INCIDENT**

An unusual occurrence involving chemical, physical, or biological Occupational Health hazards that could result in acute or chronic injury or illness. Examples of Occupational Health incidents are as follows:

- Personnel exposure exceeding a safe limit; Telecom engineers who work with transmission antennae are at risk of Electromagnetic waves which can have thermal and non-thermal effects like heating of tissues, burns and alteration of body’s immune system respectively.
- Signs or symptoms of exposure (e.g., pain from overexertion or overuse), physical signs (e.g., inflammation or difficulty breathing, Headache and sweating due to non-ionizing radiation), or symptoms of poor air quality (e.g., headache or fatigue).
- Loss of containment with significant release, spray, or splash of a hazardous material (e.g., chemical, biological, or radiological) that could result in adverse health effects in exposed individuals.

**4.9 OCCUPATIONAL / WORK RELATED INJURY**

Death and / or injury or occupational disease suffered by a person which arises out of and in the course of his/her employment, on or off the employee’s premises i.e., resulting from work activity or environment of employment.

**4.10 RECORDABLE INJURIES**

Work related Fatalities, LTI, RWC, Permanent disability and MTC are considered as recordable injuries.

**4.11 RECOMMENDATIONS**

Proposed modifications to equipment, facilities, operating procedures, engineering controls, or administrative controls deemed necessary by an investigation team or audit team to reduce risk and permit safe operation.

**4.12 TOTAL RECORDABLE INJURY RATE**

Annualized injuries per 200,000 working hours (i.e., per 100 employees). TRIR is calculated as follows:

$$TRIR = (\text{No. of recordable injuries}) \times 200,000 / \text{Working hours}$$

**4.13 ROOT CAUSE FAILURE ANALYSIS (RCFA)**

A systematic method or series of actions to identify a fundamental, underlying system-related key factor(s) or reasons why an incident occurred and document a correctable failure(s) in the HSE management system to prevent future occurrences.

**4.14 STAFF**

Staff includes Employees, Outsource Service Providers (OSP) & vendors’/contarctors’ staff.

**4.15 ABBREVIATIONS**

DIR	Detailed Investigation Report
EPA	Environmental Protection Agency
ESD	Emergency Shutdown
FAC	First-Aid Case
FIR	First Information Report
LTI	Lost Time Injury
MTC	Medical Treatment Case
OSHA	Occupational Safety and Health Administration
PIR	Pending Incident Report
PPE	Personal Protective Equipment
RCFA	Root Cause Failure Analysis
RWC	Restricted Workday Case
OSP	Outsource Service Provider
TRIR	Total Recordable Incident Rate
PSD	Power spectral density.
HSD	High speed diesel.
NEQS	National environmental quality standards.

**4.16 CLASSIFICATION OF INJURY AND INCIDENT**

Incidents (other than environmental incidents) have been classified into two major categories:

- 1. Work related:** Injury or illness will be considered to be work-related if an event or exposure in the work environment either caused or contributed to the resulting condition or significantly aggravated a pre-existing injury or illness. Work-relatedness is presumed for injuries and illnesses resulting from events or exposures occurring in the work environment.
- 2. Non work related:** Any injury or illness that occurs outside the course of work is known as non-work related. For instance, 1) the injury or illness is solely the result of an employee eating, drinking, or preparing food or drink for personal consumption or the employee doing personal tasks not related to work like self-medication. 2) The injury or illness is caused by a motor vehicle accident and occurs on a company parking lot outside company



premises or company access road while the employee is commuting to or from work will be considered non-work related.

Work related incidents can be categorized in following:

1. Personnel Safety Incident (Electrical /Work at height and others)
2. Road Traffic Accident (RTA)
3. Near miss

Following table further provide details of work-related Incidents:

Personnel Safety Incident	Vehicle/Road Traffic Accident	Near Miss
Injury/Illness	Injury/Illness	Environmental Concern
Fire/Explosion	Fire/Explosion	Other
Property/Equipment damage	Property/Equipment damage	
Other	Environment Damage	
	Major Spillage/Release	
	Operational Failure	
	Other	

#### **4.17 INJURIES**

Injury or occupational disease suffered by a person which arises out of and in the course of his/her employment, on or off the employees' premises, i.e., resulting from work activity or environment of employment.

Injuries have been classified into 06 categories.

#### **4.18 FATALITY**

Death resulting from a work-related injury or occupational illness.

#### **4.19 LOST TIME INJURY (LTI)**

Any work-related injury or occupational illness which prevents the employee from performing all the duties of his/her regularly assigned job on any workday following the incident on which the employee has been scheduled to work.

#### **4.20 RESTRICTED WORK CASE (RWC)**

Any work-related injury that results in restricting the employee to perform all or any part of his/her normal assignment during all or any part of the workday or shift. Record ability of restricted duty at times will be dependent upon the nature of the work performed by the employee. For example, a sprained ankle may not be 'Lost Workday' for an office assistant working at a desk since he/she can perform all his/her duties, but it probably would be for an operator, mechanic, or warehouse man.

#### **4.21 MEDICAL TREATMENT CASE (MTC)**

Any work-related injury in which treatment (other than first aid) is administered by a physician or by registered professional personnel under the standing orders of a physician. Medical treatment does not include first-aid treatment, even though provided by physician, or registered professional personnel.

Examples of Medical Treatment Case: -

- Abrasions - Treatment of abrasions that occur to deeper than full skin depth.
- Bruises - Treatment of a bruise by drainage of blood.
- Burns - The treatments of second- and third-degree burns.
- Casts - Application of a cast or other professional means of immobilizing an injured part of the body.
- Debridement - Surgical Debridement, that is, the removal of dead or damaged skin.
- Fractures -Treatment of fractures
- Infections - Treatment of infections arising out of an injury.
- Prescriptions - Administration of prescriptions medicines
- Sutures - The suturing (stitching of the edges) of any wound.

#### **4.22 FIRST-AID CASE (FAC)**

First-aid is limited to any one-time treatment and any follow up visit for the purpose of observation of minor scratches, cuts, burns, splinters and so forth, which do not ordinarily require prescription medication / medical care. First aid can be provided by a physician or nurse or certified first aider. Surveillance or observation, including overnight observation, which reveals no injury or illness shall be considered first aid if the employee reports to his/her next regular schedule.

#### **4.23 PERMANENT DISABILITY**

Permanent disability is a physical or mental impairment that indefinitely diminishes a worker's ability to perform the duties or normal activities that the worker performed before the accident or serious illness.

Here are some of the examples of Serious LTI / Permanent disability:

- Spinal Cord injury that caused partial or total paralysis.
- Traumatic Brain Injury.
- Loss of limb or Amputation.
- Back injury.
- Any injury that's resulted in not being able to walk again.
- Any injury that's resulted in permanent limited mobility.
- Carpel Tunnel syndrome.

#### **4.24 REPORTABLE INJURIES**

All the following injuries to staff along with the injuries caused to members of public by PTCL Group operations will be reportable:

1. Fatalities.
2. Lost time injury (LTI)
3. Restricted Workday Case (RWC).
4. Medical Treatment Case (MTC).
5. Permanent disability.

As per OSHA guidelines, injuries 1-5, as specified above are considered as recordable and used for the calculation of Total Recordable Injury Rate (TRIR).

Note: In some cases, an injured or ill employee will miss one or more scheduled days or shifts beside the day of injury or onset of illness, but it will be uncertain whether the employee was truly unable to work on the days missed. Such cases may arise when physician judges that the employee is able to work but the employee decides that he/she is not. In such cases, the supervisors / managers should not rely solely on the physician's opinion. The manager of the employee can make the final judgment himself, based on all the evidence at his/her disposal.

#### **4.25 LOSS POTENTIAL CALCULATION**

Corporate HSE will be calculating Loss Potential for all work-related incidents using below risk matrix. Based upon rating, investigation will be categorized and initiated (property damage is discussed along with injuries in consequences).

**Incident Probability x Potential Consequence = Degree of Risk**

**Example: 3 x 4 = 12**

Rating Scale	Description
	<b>Incident Probability</b>
5	Once every 0.5 year
4	Every 1 <sup>st</sup> year to 0.5 year
3	Every 3 <sup>rd</sup> year to 1.5 year
2	Every 6 <sup>th</sup> year to 3rd year
1	<Once every 6 <sup>th</sup> year
	<b>Potential Consequences</b>
5	Fatality or multiple fatalities / Extensive damage to property and/or long term (months) discontinuation of operations. Cost: >50k USD
4	Serious injury/illness (Permanent impairment)/ Major damage to property/short term (weeks) disruption in operations Cost: 10k - 50k USD
3	Lost time injury/illness/temporary disability (LTI/RWC)/ Considerable damage to property/ considerable (days) disruption in operations Cost: 5k - 10k USD
2	Medical aid injury (MTC)/ Minor damage to property/no effect on operation Cost: 2k - 5k USD

1	First aid injury (FAC)/Negligible damage to property/no effect on operation Cost: <2k USD
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Rating Scale	Incident Potential
13 to 25	<b>High Potential:</b> Team Investigation
6 to 12	<b>Medium Potential:</b> Department Investigation
1 to 5	<b>Low Potential:</b> Department Investigation

#### **4.26 OCCUPATIONAL ILLNESS**

An occupational illness is defined as any abnormal condition or disorder resulting from a non-instantaneous event or exposure in the work environment.

The basic difference between an injury or illness is the single incident concept. If the conditions resulted from something that happened in one instance, it is an injury. If the condition resulted from prolonged or multiple exposure to a hazardous substance or environmental factor, it is an illness.

Any abnormal condition or disorder such as dermatitis, rash, respiratory problem, poisoning, heat exhaustion and hearing loss, caused by an exposure to environmental factors associated with employment. Exposure may be caused by inhalation, absorption, ingestion or direct contact with dust, fumes, vapors, or mists.

A few examples of occupational illness are as under:

1. Heat stress signs or symptoms of heat stroke or heat exhaustion.
2. Lead, asbestos, or non-asbestos respirable fiber (NARF) material dispersed without pre-planning.
3. Asbestos-containing materials (ACM) purchased or used when a technically feasible non-ACM is available.
4. Storage of Personal Protective Equipment (PPE) that could result in chemical exposure (e.g., contaminated PPE).

All diagnosed illnesses are considered medical treatment cases if they are caused by work exposures. All occupational illness including but not limited to the following categories are recordable.

- a) Occupational skin diseases or disorder - Examples: Contact dermatitis, eczema, Contact Urticaria, Acne Folliculitis or rash caused by primary irritant and sensitizers or poisonous plants, chrome ulcers; chemical burns or inflammations; etc. (Direct contact causing tissue damage only, resulting from a thermal or chemical burn, is classified as an injury, not an illness case).
- b) Disorders due to physical agent (other than Toxic Materials) - Examples: Heatstroke, sun stroke, heat exhaustion and other effects of environment heat; freezing, frostbite and effects of exposure to low temperatures caisson disease; effects of ionizing radiation (isotopes, X-rays, radium), effects of non-ionizing radiation (welding flash, ultraviolet rays, microwaves, sun burn), etc.

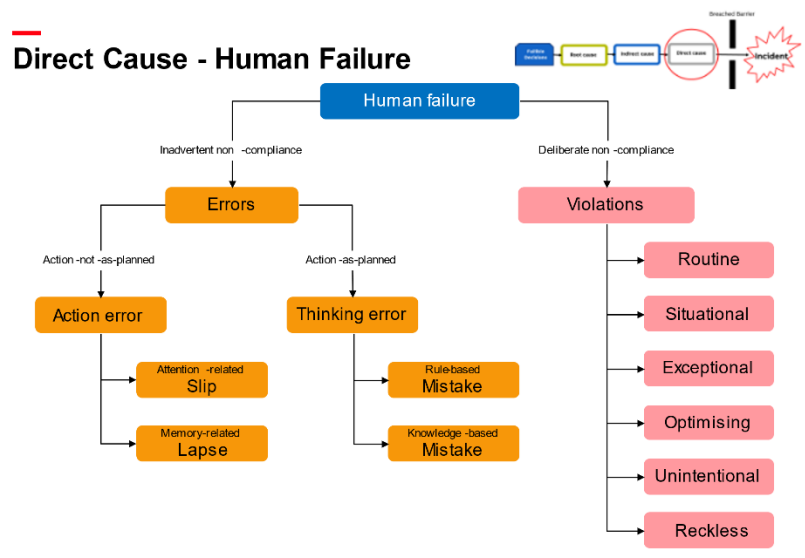
- a. While declaring an Occupational Illness the Doctor should thoroughly examine the case. Occupational Illness can be reported after a week.

NOTE: Conditions resulting from animal bites, such as insect or snakebites, or from one-time exposure to chemicals are injuries.

**4.27 HUMAN ERROR**

Given below are examples of certain incidents occurring due to human error which are also reportable and fall in any of the incident categories described in this section.

1. Mal-operation resulting in upset of normal operating parameters causing emergency / abnormal situation at operational areas/ facilities, wrong operations.
2. Human error during preventive maintenance / repair jobs, housekeeping etc. which caused tripping of an equipment.
3. Shutdown of wrong electrical breaker / switchgear.



**4.28 EQUIPMENT/ PROPERTY DAMAGE**

Equipment/property that fails/damage to function as designed and thus creates a safety concern. e.g.:

1. Failure of equipment which could have serious consequences. For example, FM200 fire suppression system and fire alarms.
2. Hoists and Cranes that fail to function safely.
3. Gaskets / flanges / packing failure resulting in leakage of hazardous material.
4. Relief devices:
  - Failed to open.
  - Failed to reset.
  - Failed to open at the prescribed set pressure including PSD rupture below the set pressure.
  - Devices (Safety Critical sensation line) plugged with process / foreign material.
  - Inlet and / or exit piping plugged with process material.
5. Nonfunctioning safety equipment e.g., fire suppression system, smoke detector, PPEs, alarms, extinguishers, safety showers / eye wash fountain etc.

**4.29 ELECTRICAL FAILURES**

1. Sparking / short circuiting in un-classified area but the breaker does not trip.
2. Sparking in classified area.
3. Breakers control power failures.
4. Errors in operation of electrical switches or equipment e.g., pump does not stop from local on / off switch.
5. Inadvertent contact of mechanical equipment with un-insulated power lines. E.g., crane boom hitting overhead power lines.
6. Short circuiting and / or electric shock to an employee.
7. Protections operated,
8. Protections failure,
9. Flash,
10. Transient Tripping (Boiler, Turbine, and critical / major equipment),
11. Breaker Flash,
12. Pickaxe cases etc.

**4.30 ENVIRONMENTAL INCIDENT**

Any incident which has an environmental impact inside and/or outside PTCL group property limits and may or may not lead to a formal complaint will be considered as environmental incident e.g., Kerosene, HSD, Fuel oil spill contaminating ground soil. (Details are mentioned below), noise, effluent streams, NEQS excursion etc. Moreover, following will also be declared as Environmental Incidents:

1. Release of any non-process material.
2. Chemical spills in significant amount (see relevant EPA guidelines) causing soil contamination.
3. Equipment leaking hydraulic oils etc.
4. Death of migratory birds in substantial number within plant operating area.
5. Death of any other wildlife that might have been caused by plant operations.
6. Death of any other wildlife that has not been caused by plant operations should be used for documentation only.
7. Death of animals or aquatic life in the canal cause for which is established to be plant effluent.
8. Wastewater Stripper of plant bypassed.
9. Hazardous gases odor complaint from outside site boundary and concentration is reported 50% of TLV.
10. Hazardous odors complain from within the plan boundary limit, roads, non-operating areas, and concentration is more than 75% of Threshold Limit Values (TLV).
11. Hazardous gases concentration above TLV due to unplanned activity that caused panic and concern for people working at plant.
12. Outside complaint for any release / discharge of material that creates concern to public and surrounding communities e.g., foam carry over from cooling tower to surrounding communities.

**4.31 PERSONNEL SAFETY INCIDENTS**

Incidents including but not limited to Electric shock/Electrocution, fall from height, struck by object, Electric Flash, Slip & Trip, Fall of Object, etc.

**4.32 FIRE & EXPLOSION**

All fire incidents, such as follows, e.g.:

1. Minor fire on welding generators.
2. MSAG Fires.
3. Smoke/ fire at designated smoking area.

**4.33 PROPERTY/EQUIPMENT DAMAGE**

**Definition:** The physical damage or destruction to tangible property of the organization is known as Property/equipment damage. For instance,

1. Damage to outer wall.
2. Grass cutting machine blade damage.

**4.34 SPILLAGE/RELEASE**

Examples of spillage or release from vehicles are:

1. Heavy Fuel Oil / High Speed Diesel / Oil leakage from tanker/Vehicle, while it is stationary.

**4.35 NEARMISS**

An incident with clear potential for undesirable consequences (e.g., adverse impact on people, property, the environment, or the business), even though no actual consequences occurred. Some examples of significant near-miss occurrences relating to HSE may include:

- Activation of hazard-control systems and safety-protective devices (e.g., relief device or ruptured discs, interlocks, water spray, or fire suppression systems).
- Excursions of process parameters beyond pre-established critical control points (e.g., temperatures, pressures, or flows) or those for which emergency shutdown or intervention is indicated.
- Function failures of safety critical devices (e.g., relief devices that fail bench tests at set points, interlock test failures, or uninterruptible power supply system malfunctions).
- An unprotected exposure to hazardous agent, chemical or energy (e.g., thermal, electrical, or mechanical) that had the potential but did not result in injury.

Note: These examples are provided for illustrative purposes only and are not all inclusive.



**4.36 REPEAT INCIDENT**

Incident to be classified as repeat if it happens at the same unit during same activity due to same cause.

Note: Incident will be considered as a repeated incident if it is reoccurred within 12 months of its last occurrence.

**4.37 AMBIGUOUS CASES**

At times some incidents cannot be clearly classified based on the criteria / examples given in this document. These incidents would be studied in detail by the respective HSE Departments and based on this study, would be classified. The members of this study group would be:

- Representative Function HSE.
- Doctor.
- Representative Corporate HSE.

The incident classification decision would be considered final based on this group’s recommendation and can only be changed by the group VP HSE & Sustainability. Similarly, in case of doubt, decision for making OSS/ detailed report / investigation of an incident through a team by HSE department would be final.

**5.0 INCIDENT REPORTING AND INVESTIGATION**

**5.1 REPORTING of WORK-RELATED INCIDENTS**

Prompt reporting of the incident to immediate Supervisor, Manager or relevant interfaces is essential to accord ‘HSE’ the place and priority it deserves and to take immediate steps to prevent recurrence.

All injured persons depending on the condition of the patient, should be sent to nearby Healthcare facility immediately. In case transportation of the patient could be hazardous, Health Care doctor should be asked for advice.

All work-related accidents (Employee, Contractor, Public) shall be immediately reported to Corporate HSE within timelines stipulated in Table below by respective Function- HSE.

Corporate HSE shall share preliminary accident (Fatal, LTI) details with leadership based on initial/immediate report, in the form of OSS (One slider summary-Annexure E).

To report the incident, the details of personnel accidents shall be filled on Annexure A by respective department. In case of difference of opinion, a decision regarding classification of the injury (LTI, RWC, MTC & FAC) shall be made by Director Corporate HSE & sustainability (or his/her designate).

Note: Disciplinary action would be taken against an employee who conceals work-related incidents with consequences of injury or property damage, as per disciplinary department (Employee advocacy).

**5.2 RESPONSIBILITY FOR REPORTING AN INCIDENT:**

1. In case an employee is involved in an incident; he or she should immediately report the incident to his or her immediate people manager. If the employee is a victim, then the team members should report in place of him/her. In case the people manager is not available, report the incident directly to respective functional HSE and Corporate HSE through mediums like email (**ehs@ptclgroup.com**), HSE WhatsApp hotline (**0334-1111473**) or online incident reporting portal (**Annexure A**) on Vibe Pro. Immediate reporting in case of severe incidents like fatalities via informal and formal means.
2. Contractor’s personnel shall immediately report the incident to their direct supervision onsite and then to PTCL personnel. The contractor/vendor must ensure direct supervision of his employees at the work site with full responsibility. If contractor’s supervision is not available, the contractor employee should report the incident to the relevant PTCL Supervisor or respective function HSE through HSE WhatsApp hotline.
3. The supervisor in charge of the equipment or personnel (PTCL Group, contractors and OSP) involved in the incident bears the responsibility of reporting the incident and providing specific details for the investigation of the event. He/she is also responsible for reporting the incident to the respective Corporate HSE. Any person regardless of involvement, if they have witnessed the incident or have the knowledge, are liable to report.

**5.3 SITE SUPERVISOR / SITE INCHARGE:**

- a. In event of an incident occurrence, Supervisor should arrange provision of first aid to the victim immediately.
- b. Ensure that the victim is rushed to the nearest hospital by the fastest means available.
- c. Would immediately inform his/her people Manager / Senior Manager of the department, respective Corporate HSE.

**5.4 People MANAGER (Function / DEPT.):**

**Definition:** In people management, the manager who is immediately responsible for the member below in the hierarchy is known as people manager.

- a. Ensure Accident / Incident Reporting procedure is implemented within their areas of responsibility and necessary training on this procedure is carried out.
- b. On receipt of information about any accident / incident, shall inform respective Line Management, relevant functional HSE, keeping Corporate HSE in the loop.
- c. On receipt of any personnel accident, shall share on portal known as (**Annexure A**).
- d. Responsible to follow up on the injured employee and liaise with hospital staff concerned and Health Care doctor.
- e. Would ensure that the incident site and incident related evidence are recorded.
- f. Any alteration/corrective action, if necessary, shall be communicated and shared with the HSE Team.

**5.5 FUNCTION HEAD:**

- a. Ensure Accident / Incident Reporting & Investigation procedure is implemented within their respective Function.
- b. Ensure to facilitate investigation process.
- c. Ensure timely closure of accident / incident investigation recommendations.

**5.6 REPORTING AN INCIDENT**

The initial incident / injury occurrence information will be submitted by the respective first line supervisor with copies to the concerned area in-charges, respective functional HSE and CORPORATE HSE as per below mentioned timelines. Incidents/near miss can be reported through Incident Reporting portal.

Description of Reporting	Timeline
<b>INTERNAL REPORTING</b>	
On receipt of information for all work related fatal and LTI accidents. Immediate initial information to be shared by respective Dept with Corporate HSE & Function – HSE	04 Hours
Initial Information (Fatal & Serious Injury LTI) to be shared by Corporate HSE with respective Leadership (Fatal will be shared with P&G CEO as well, this however, isn't applicable to contractual staff)	As soon as possible Max. 02 Hours
<b>(Annexure A) online portal</b> form to be filled and submitted by line.	24 hours
Detailed Investigation Reports (DIR) <b>(Annexure B)</b> to be compiled & submitted by functional HSE for LTI and below. For LTI and above, Corporate HSE will share the DIR. Corporate HSE to share fact finding report <b>(Annexure F)</b> with concerned stakeholders.	Team Investigation – 10 working days Dept. Investigation – 10 working days
DIR – to be shared by Respective Functional HSE (For LTI and below) with CORPORATE HSE and Leadership and for LTI and above, Corporate HSE to management.	After Management approval within 5 days.

After any incident, an Initial Information Form (Annexure A) is submitted and for LTI and above, Annexure E is to be submitted as well.

1. **Department Investigation:** All Incidents including LTI and below (except serious injury) should be investigated by either cross region/zone Team Lead within functions (from related BO, PE and/or Technology wing) or by an individual as deem fit by respective functional HSE Head. Investigation Team lead should also carry out detail Why Tree Analysis (WTA). The report should be submitted within next 10 working days to the respective functional HSE, Line Management and Corporate HSE Department.
2. **Team Investigation:** For Serious Injury, LTI and Fatal, an investigation team is appointed by the VP Corporate HSE & Sustainability. Investigation team will be led by the Corporate HSE. It shall consist of all relevant members including members from same function and cross functions. Detailed investigation with WTA/SCAT will be done by the team and final report should be submitted to the Director Corporate HSE within next 10 working days. Advanced tools like SCAT template, WTA to be used in this category.
3. For other categories like property damage and fire (i.e., MSAG and electrical), the same protocols would be followed with a change in timeline of 20 working days.

This report will be prepared & approved by as per following protocol.

<b>Personnel Safety Incidents</b>	
<b>Category</b>	<b>Approving authority</b>
LTI and below	Group Director HSE & Sustainability
Serious Injury LTI & Fatality	Group VP Corporate HSE and Sustainability and Group Chief People Officer (GCPO)

The decision to designate type of investigation lies with respective HSE Head except serious injury LTI and Fatality, for which Corporate HSE Director will designate investigation team.

## **6.0 DETAILED REPORT NOTICE NUMBERING SYSTEM**

Numbering of Detail investigation report (DIR) reports are defined as under and will be issued by the functions filling the form. e.g.:

- Dept / YYYY / DIR / XXXXXX.

## **7 . 0 STATUS OF PENDING INCIDENT REPORTS / RECOMMENDATIONS**

The Corporate HSE Department will issue status of pending incident reports and recommendations on monthly basis. The status will also be stewarded in HSE Steerco meeting at regular intervals.

- Upon completion of a recommendation, the concerned Manager should record his/her action and inform the Corporate HSE Department either through email or in writing.

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- If the target date of a particular recommendation or detail report needs to be revised or if a particular recommendations or detail report needs to be dropped/ deleted, For LTI and below accidents & its Recommendations, relevant function VP can approve one time Targetdate extension with solid justification. Any subsequent extension shall be approved by relevant CXO. For Fatal and serious accidents & its Recommendations, relevant CXO can approve one time Targetdate extension with solid justification. Any subsequent extension shall be approved by P&GCEO.

## **8 . 0 DISTRIBUTION OF REPORTS**

Learning from incidents (LFI) (**Annexure G**) of potential recordable injuries should be distributed by Corporate HSE for LTI and above. With regards to distribution of detailed report, a balance needs to be struck between distributing to all those who might learn something from the investigation and overloading employees with these reports. Excessive distribution discourages the reading of any of the reports, restricted distribution limits opportunity for learning. The report approving authority should keep this in view, while deciding the distribution list. However, the functional Field Director and VP concerned will be taken in the loop while the distribution of the report.

## **9.0 REPORTING of NON-WORK-RELATED INCIDENTS**

### **9.1 NEAR-MISS**

Any employee can report a near-miss incident to respective People Manager and HSE incident portal.

### **9.2 LOST TIME INJURIES (LTI)**

Report to be submitted by the employee’s respective People Manager and on HSE incident portal.

### **9.3 TRAFFIC ACCIDENT TO PTCL GROUP EMPLOYEES OUTSIDE PREMISES**

All non-work-related traffic accidents will be reported. The PTCL group employee involved in the accident is responsible for sending the report to Corporate HSE Department through his/her supervisor.

## **10.0 INCIDENT REPORTS & RECOMMENDATIONS**

### **10.1 INCIDENT REPORT RECORDS**

1. The incident reports of last 10 years shall be maintained by CORPORATE HSE Department on shared portal.

**10.2 STATUS OF PENDING INCIDENT REPORTS / RECOMMENDATIONS**

The Corporate HSE Department will issue monthly status of recommendations for team investigation reports. Respective function HSE will share monthly status of recommendations for departmental investigation reports with Corporate HSE.

The status will also be stewarded in HSE Steerco meeting on quarterly basis.

**10.3 TYPES OF RECOMMENDATIONS AND COMPLETION TARGET DATE**

All HSE Incidents and injuries are investigated which result in generation of recommendations to prevent reoccurrence. It is mandatory to comply with the approved recommendations. To ensure that all recommendations are properly and timely closed, four broad categories have been developed. The objective is to set a timeline standard for the completion of different categories of recommendations. The definition of each category is given below:

**10.4 PROCEDURAL**

All the safeguards which can be achieved by providing an approved procedure, standing order or instruction fall under this category.

**10.5 SIMPLE JOBS**

Any recommendation which can be complied with by doing routine maintenance or a minor job which does not require engineering fall under this category.

**10.6 SHUT DOWN / PREVENTIVE MAINTENANCE – PM JOBS**

All the jobs which cannot be handled on a running plant / live line and can only be worked on during a Shutdown / PM are covered in this category.

**10.7 ENGINEERING JOBS**

Recommendations requiring engineering would fall under this category and would have to go through the control of change protocol.

**11.0 TIMELINE OF DIFFERENT CATEGORIES**

CATEGORY OF JOB	MAXIMUM TIME
Procedural	02 months
Simple Job	04 months
Shutdown / PM Job	Shutdown / PM
Engineering Job	01 Year

**12.0 REPLICATION OF INCIDENT REPORT RECOMMENDATIONS**

Those incident report recommendations which may be of importance for other functions (Functions other than where incident took place) with respect to elimination of hazard / safety system deficiency or improvement in systems should be replicated to other functions as well. Such recommendations should be marked to relevant personnel looking after other units by functional HSE in case of LTI and below, and Corporate in serious LTI and Above.

**13.1 EXTENSION OF INCIDENT REPORTS’ RECOMMENDATIONS TARGET DATE**

The Corporate HSE Department will extend target date of incident reports / recommendations after completion of following protocol:

1. For LTI and below accidents & its Recommendations, relevant function VP can approve one time Target date extension with solid justification. Any subsequent extension shall be approved by relevant CXO.
2. For Fatal and serious accidents & its Recommendations, relevant CXO can approve one time Target date extension with solid justification. Any subsequent extension shall be approved by P&GCEO.

Note: Approval for extension in target date may be obtained via email system, however, relevant justification / approving details shall be recorded. First extension can only be extended up to the original time frame given e.g., 2 months etc.

**13.2 WAIVER REQUIREMENT**

At times some recommendation might be found not workable and dropped for serious LTIs and fatal incidents. This change should be documented, associated risk shall be understood, and a waiver shall be taken from P&GCEO by relevant CXO. The types of such situations could be assigned recommendation not feasible due to engineering concerns, the risk associated is not high etc.

Note: A manual waiver form will be designed until Safety Management Information System is developed and implemented.

**14.0 COMMUNICATION**

The organization shall have a well-established method of communication to employees regarding HSE incidents Safety Committee Meetings. The objective is to ensure that the learning from the incidents is well understood, and the incident reoccurrence can be avoided. This forum also solicits feedback on safety concerns / suggestions which shall also be addressed.

**14.1 SITE COMMUNICATION**

**14.1.1 MORNING MEETING**

All incidents should be reported and discussed in the “Morning Meeting” which is held at a regular interval/ frequency during the week or through daily Toolbox Talks (TBT).

**14.1.2 HSE INCIDENT ONE-SLIDE SUMMARY (OSS) (Annexure E) COMMUNICATION**

1. All One slide summary (Annexure E) pertaining to LTI and above annexure will be issued by respective corporate HSE to all relevant employees

**14.1.3 DETAIL INVESTIGATION REPORT**

Detailed investigation reports should be issued by respective function HSE / CORPORATE HSE Department to relevant stakeholders.

**15.0 INCIDENT ANALYSIS**

Analysis of incidents provides a valuable opportunity to learn about break down or deficiencies in HSE Management System. Annual incidents analysis is maintained in format (Annexure D) by respective functional HSE and corporate HSE respectively as per the given criteria.

Thorough analysis of groups of incident investigation reports can point to corrective actions that might not be evident when studying an individual case. Inadequate policies, procedures or Management Systems often are apparent after looking at the forest not the trees. The incident analysis helps management to identify and locate major sources of accidents, pinpoint the nature and size of accident problem, reveal the need for engineering changes (if any), correcting inefficiencies in operating / maintenance procedures, disclose unsafe practices, enable to target safety efforts, and evaluate safety program’s effectiveness.

The analysis can provide the guidance to direct safety efforts along the most effective path. It also provides objective support and justification for training program and other safety management activities.

Observations / trend and quality of recommendations generated are to be presented to HSE Steerco Meeting for further necessary action.

The aspects to be covered in the analysis report are given below, but not limited to:

1. Fatalities
2. LTIs
3. Injuries.
4. Fires.
5. High Potential incidents.
6. Repeat Incidents.

Root Cause and HSE Management System violated are also highlighted alongwith the analysis of peoples / equipment and procedure related causes.



**16.0 TRAINING**

A key element in successful accident prevention is proper training of all employees required to investigate incidents. Training of all new and transferred employees is to be conducted on regular basis along with refreshers on need basis. The details of the training are discussed in the Learning and Development SOP and HSE master training matrix.

The training should focus to enable the 1st line Supervisors and team leaders to understand the following:

1. The company’s philosophy and policy on incident reporting, analysis and follow-up.
2. Process of incident reporting.
3. Taking immediate corrective actions.
4. Finding causes aimed at fact finding.
5. Securing the incident site.
6. Preserving evidence.
7. Effective use of witnesses.
8. Interviewing techniques.
9. Fault tree analysis to identify key factors responsible for the incident.
10. Preparing of detailed incident report with recommendations to prevent recurrence.

The training provides a common criterion to be used for incident investigation throughout the organization based on which a comprehensive incident analysis is possible at the end of the year.

**17.0 INCIDENT INVESTIGATION PROCESS AND GUIDELINES**

**17.1 PURPOSE OF INVESTIGATION**

The primary objective of an incident investigation is to prevent recurrence through understanding and addressing the key factors underlying the incident. Every incident is a symptom of a system failure, not just physical failures, or human error. Few incidents occur because of a single key factor or action. Incident investigations should follow formal logical methodologies to identify system related key factors. The incident investigation process contributes to the continuous improvement of HSE systems and performance by

- Identifying & implementing actions to prevent incident recurrence.
- Promoting an atmosphere of openness by improving communications and understanding about the incident
- Identifying conditions that could potentially contribute to the occurrence of future incidents and providing an opportunity to share this information broadly.
- Providing input to the development and improvement of HSE policies, procedures, guidelines, and standards.

The purpose of an incident investigation must not be to put blame or find fault. An incident investigation should be constructive—not detrimental to a company’s safety program.

Detailed guidelines for incident investigation.

- Accept the investigation as an opportunity to learn. Focus on the following:
- What failed? Who failed? What would better do the job? Are there any other places where this could happen again? Do we need to provide additional controls? Should we alter our operations /procedures? Could something worse could have happened?
- While starting interview, the investigation officer should stress that injury prevention is his/her primary purpose. A visit to the incident location is important.
- During the interview, put the injured employee at his/her ease. Measure and record distance and dimensions where required. Make notes of the area surrounding the incident scene e.g., Lighting, temperature, surface conditions state of maintenance, housekeeping, potentially distracting reflections, sound, or odor. Write or record your observations.
- The injured employee should be asked what he/she thinks could have been done to prevent the injury.
- If there were witnesses, they should also be interviewed, and their suggestions and comments recorded. Promptness is essential in obtaining statements from the witness, to prevent time from distorting their observations. Involvement in the investigation of minor injuries / Near miss incidents should generally be limited to the immediate work group, to the witnesses and to the immediate supervisor.
- Do not become distressed if during an investigation what a person says happened and your own findings do not coincide. Things happen fast and people simply cannot remember all that happened. Little clues, bits of information, must be assembled before what really happened can be accurately reconstructed.
- After the interview, the supervisor should decide what corrective measures are required, along with the dates by which they should be accomplished. Be realistic while making recommendations on how to prevent recurrence of the incident. The incident reports should also cover the underlying management systems violated.

The following information will aid in improving incident investigations and developing a sound safety program.

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### **17.2 REPORTING OF THE INCIDENT**

Every incident is a sign of some failure within the safety program. The problem must be corrected. For example, if an injury is not reported immediately, two consequences may result:

- The injury may become more serious through lack of proper medical attention.
- Another employee may find himself in the same situation and be seriously hurt because no action was taken to eliminate the factors involved in the initial injury. An unreported injury cannot be investigated. The methods managers use to investigate incidents should not cause employees to hesitate reporting what they consider to be even very minor incidents / injuries. Management’s attitudes and methods are the key for encouraging employees to report all incidents. Several methods followed are:
  - Immediately investigate all reports of incidents with more focus on serious injuries / incidents.
  - Do not blame the employee during an investigation. This is not the place to do so.
  - Do not embarrass an employee by implying that the incident resulted from the employee’s own fault.
  - If possible, do take immediate action to correct all deficiencies.
  - Review with employees’ other accidents which occur at the site.

### **17.3 TIMING OF THE INVESTIGATION**

Upon being informed of an incident, management should investigate incidents because:

- The circumstances surrounding the accident may change due to changes in operations, weather, or personnel.
- Witnesses to the accident may be unavailable later because of vacation, illness, or shift work.
- People involved in the accident may forget details and unknowingly substitute conjecture (guessing) or opinion for fact.
- Witnesses may discuss the incident and influence each other’s versions of the details of the incident.
- An employee may be able to fabricate a plausible story to hide a serious unsafe action.
- In case of injury, the injured employee may be in extreme pain, emotionally upset, or hospitalized. In these cases, the injured employee’s statement may have to be taken later. There is, however, no reason to wait for an injured employee to return to work before discussing the injury with him. If the employee is willing, one or two supervisors should conduct an interview in the hospital or at home to determine the causes of the accident and then take prompt action to prevent another employee from being hurt in the same way. If the employee is unwilling, management should explain the purpose for the discussion and the need for cooperation. An employee’s unwillingness to cooperate is usually used by failure to understand why his/her help is needed.

### **17.4 MANAGEMENT INVOLVEMENT IN INCIDENT INVESTIGATION**

Several reasons exist for upper management’s active involvement in the investigation of serious injuries or incidents with serious injury potential:

- Lower management and contractor employees can see management’s concern for and commitment to a good safety performance.
- The investigation is likely to be more thorough because the higher-level manager can ask more probing questions on the basis of his/her experience.
- The higher-level manager, by example, trains lower-level managers in injury investigation techniques.

- Recommendations to prevent recurrence carry more weight and are more likely to be implemented. Active involvement includes interviewing the witnesses, reviewing the scene of the injury, and offering opinions during the investigation. Simply signing the report form does not mean being actively involved.

**17.5 INVESTIGATION PROCESS**

A good incident investigation has several steps:

- Gather everyone who can contribute to the injury investigation.
- Collect all the facts.
- Determine the causes of the incident. Use Fault Tree Analysis methodology to identify key factors. The ‘why tree’ process shown in the example given in Annexure C.
- Example of Fault Tree Analysis is the preferred methodology.
- Recommend ways to prevent similar incidents.
- Make a report.
- Follow up on the implementation of all recommendations.

**17.6 GATHER PEOPLE FOR THE INVESTIGATION**

The investigation team should call on anyone who can help accomplish the purpose of the incident investigation.

The investigating supervisor should, therefore, remind all concerned the purpose of incident investigation. It is important that everyone feel relaxed and that a good relationship exists between the employees involved in the incident and the investigating group so that a completely honest discussion of the incident will be better ensured.

**17.7 COLLECT ALL THE FACTS**

1. First, the injured employee or employee involved in the incident should be interviewed.
2. The employee should be asked to explain what he/she was doing, how he/she was doing it, and how he/she thinks the incident happened.
3. If possible, this interview should occur in familiar surroundings, preferably at the scene of the accident. This placement will make it easier for the employee to demonstrate the exact location and to point out other things that would be difficult to explain away from the scene.
4. The supervisor should allow the concerned employee to tell the whole story without interruption so that the group will have an overall idea of the circumstances surrounding the incident. Freedom from interruption also tends to relax the employee and to make him more responsive to questions from the group.
5. The following types of questions do not establish facts and may hinder the search for facts at this time:
  - a. Were you trained in this part of the job?
  - b. Didn't you know you had to wear gloves?
  - c. Why didn't you get another ladder?
6. Following the interview with the injured employee/employee involved in the incident, the supervisor should interview any witness to the incident. If possible, witnesses should be interviewed separately so that they will not influence each other's stories.
7. The technique used to interview witnesses should be the same as that used to interview the injured employee.
8. After the injured employee and the witnesses have made their statements, the investigating supervisor, team or committee should inspect the scene of the incident and the equipment involved to see if there are any unsafe conditions.
9. Also examine any applicable written work procedures to determine if the injured employee had been given specific instructions on the safety hazards of the job.
10. Finally, determine if the training given to the employee was adequate for the job.

### **17.8 DETERMINE THE CAUSES**

1. Often the causes for an incident are obvious; sometimes they are not obvious. In both cases, however, the supervisor must look for the underlying causes and root causes of the incident.
2. Underlying causes: the direct or obvious causes of an incident and are usually an unsafe act or unsafe condition like not wearing Personal Protective Equipment while the root causes are deeper reason, or a set of events that allowed the immediate underlying causes to develop, like poor safety culture and lack of managerial involvement/visible safety leadership.
3. The supervisor may find that an injury is related to management’s failure to properly carry out its safety responsibility. For example, if an employee using a grinding wheel and wearing no safety shield is injured by a piece of flying metal, the cause of the injury may be recorded as “unsafe practice by employee - failure to wear proper protective equipment.” The real cause of the injury, however, may be that management failed to precisely specify what protective equipment was required; to provide the proper protective equipment for the employee’s use; to train the employee in the use of the equipment; or to take corrective action when it became known that employees were using the machinery while not wearing protective equipment.
4. If the investigator determines that an unsafe act was a contributing cause of an incident, he/she should attempt to find out why the employee acted unsafe.
  - Was the employee trying to save time or effort?
  - Was he/she under emotional stress?
  - Was this the way the employee was trained?
  - Did he/she have any deadline to meet?
  - Is this standard practice?
  - Was it inconvenient for the employee to act safely?
  - Like it or not, management cannot expect its employees to go to great lengths to avoid committing unsafe acts.
  - If certain personal protective equipment is required for a job, and if that personal equipment is stored in an area remote from the job, the inconvenience of obtaining the equipment may be the reason why the employee did not wear the proper personal protective equipment.
5. If there was an unsafe condition, its source must be determined and corrected.
6. Determination of the causes of an incident is one of the most important parts of the incident investigation— from causes come the recommendations to prevent recurrence. If the investigating team / committee makes a wrong decision about the cause of the incident, the purpose of the investigation will not be fulfilled. Therefore, it is important that team / committee members be knowledgeable regarding the activities involved in the accident. The committee / team does not just report facts; it interprets the statements it receives, the observations it makes, and the opinions of others.

### **17.9 MAKE RECOMMENDATIONS**

Once the probable causes of an accident have been discovered, recommendations must be made to prevent the occurrence of similar incidents or injuries. These recommendations may apply to a particular situation or job or to the entire site.

**BASIC INFORMATION ABOUT THE INCIDENT**

Typical entries are the date and time of incident, in case of injury, the time the employee reported for medical attention, the location of the accident, the nature of the injury or illness, the part of the body affected, and a simple statement of the treatment given to the employee.

**A DESCRIPTION OF THE INCIDENT**

Here, the investigator should write the details of the incident. Consideration should be given to background information relevant to the incident description. The investigator should consider the person’s position when the accident occurred.

**18.0 OTHER POINTS**

1. A list of all existing unsafe conditions and the reasons for them.
2. A description of any unsafe act that led to this accident.
3. The basic causes of incident, including the underlying causes.
4. The ways the employee could have prevented this accident.
5. The corrective / preventive action that management has taken or will take to prevent the accident’s recurrence. A recommendation has three important parts.
  - a. A clear description of the recommended action(s) to be taken to prevent recurrence.
  - b. The name and position of the person responsible for implementation.
  - c. Target date for completion of recommended action
6. The investigating supervisor’s signature, title, the date, and the department manager’s approval.
7. In case of injury, the classification of the incident as a first aid case, a medical treatment case, a restricted workday case, or a lost workday case.
8. The copies of the report should be sent to the department manager and the CORPORATE HSE Department. Copies of the injury investigation report should also be placed in the employee’s personnel file if disciplinary action was taken.
9. It is important that upper management review incident investigation reports to improve the quality of investigation and reporting. If a report is superficial, the manager should return the report to the investigating supervisor and require that the incident be re-investigated, or the report rewritten as necessary. Good incident investigations result in fewer incidents.

**18.1 CHECK POINTS FOR CLOSING AN INVESTIGATION**

The investigating committee members should ask themselves the following questions before closing an investigation:

1. Was the extent of the investigation commensurate with the maximum injury / loss potential of the incident?

2. Have underlying causes been uncovered?
3. Were safety management system deficiencies considered?
4. Will the recommended actions prevent the incident from occurring?
  - a. On the next shift?
  - b. To employees doing similar work in other site areas?
  - c. To new or transferred employees?
5. Do the recommendations fall within the scope of authority of the investigating committee?
6. Is someone identified as being responsible for completing the action of each recommendation?
7. Are there completion target dates for each recommendation?
8. Is there a follow-up person or method defined?
9. Is the distribution of the information from the investigation appropriate?

### **18.2 FOLLOW-UP**

Follow up of the injury / incident recommendations should be stewarded through Pending Incident Report Recommendations (PIRR) status report to be issued monthly by Corporate HSE Department.

Note: Interpretation of meanings / requirements of this Procedure lies with Corporate HSE. Their verdict will be considered full and final.



## Annexure A Online Report Form

The screenshot shows the top portion of the PTCL Incident Reporting form. At the top, there is a green header with the PTCL logo and navigation links: Corporate Site, About PTCL, Applications, Report an Incident, Departments, and Projects. Below this is a sub-header titled "PTCL Incident Reporting". The form contains three input fields: "For:" (a dropdown menu), "EPI:" (a text box), and "Contact:" (a text box). A green bar below these fields is titled "Incident Details". Underneath, there are two more dropdown menus: "Incident Type:" and "Incident Category:". Small text definitions are provided for Incident, Near-Miss, and Accident.

The screenshot shows the middle and bottom portions of the PTCL Incident Reporting form. It includes a section for "Incident Nature:" with a text box and a definition of Occupational Health and Safety. Below this is the "Incident Summary:" text box and the "Date / Time:" field with a calendar icon. A green bar titled "Incident Location" contains four dropdown menus for "Zone:", "Region:", "City:", and "Address:". Below these is an "Attachment:" field with a file upload button and a list of supported file types (docx, pdf, png, jpg). At the bottom right, there are "Submit" and "Close" buttons.

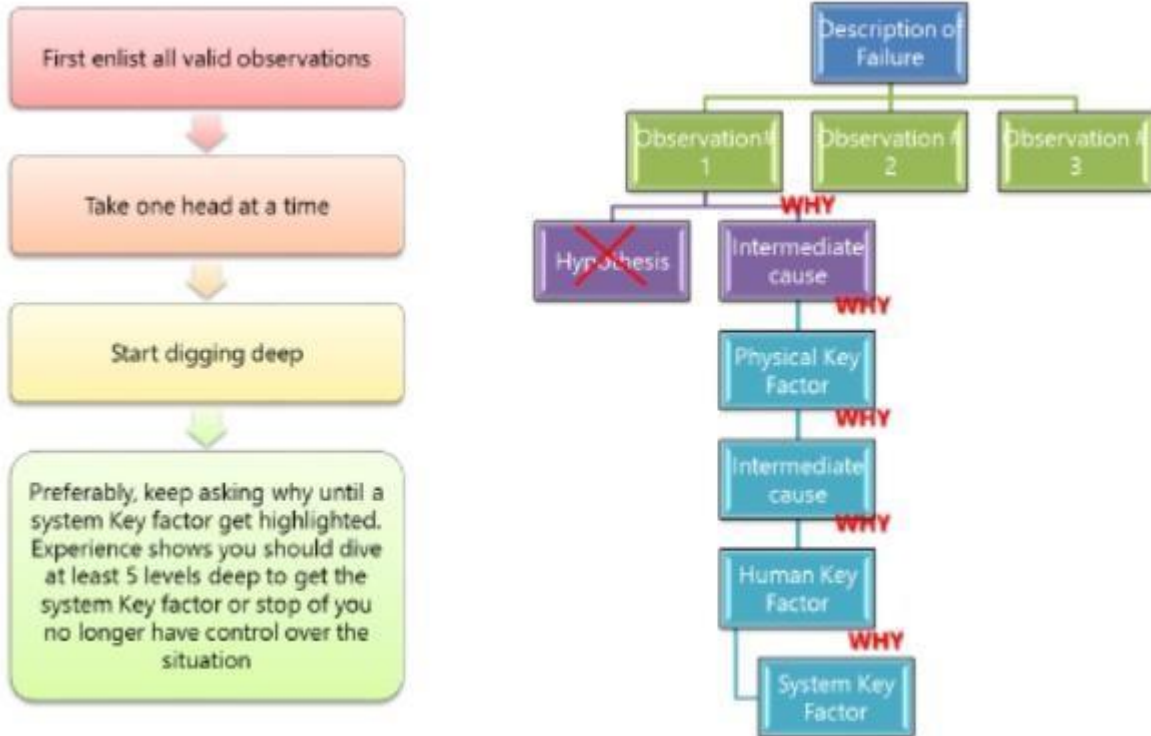
## Annexure B

<b>Detailed Investigation report (DIR)</b>			
<b>DIR ID:</b>			
This form is completed by assigned team/person by respective CORPORATE HSE which require Detailed reporting.			
<b>Report Due on / WHY Tree investigation Required?</b>			
<input type="checkbox"/> YES		<input type="checkbox"/> NO	
<b>Names of team members DIR is assigned to:</b>			
<b>Incident Title</b>			
<b>Date / Time / Area</b>			
<b>Incident Category (Please tick the appropriate box)</b>			
<input checked="" type="checkbox"/> Work Related		<input type="checkbox"/> Non Work-Related	
<b>Incident Classification (Please tick the appropriate box)</b>			
<input type="checkbox"/> Personnel Safety	<input type="checkbox"/> Vehicle/RTA	<input type="checkbox"/> Near-miss	<input type="checkbox"/> Other
<b>Company</b>			
<input type="checkbox"/> PTCL Employee	<input type="checkbox"/> Contractors	<input type="checkbox"/> Sub-contractors	<input type="checkbox"/> Other
<b>Effected PTCL Personnel Name</b>			
<b>Effected Contractor Personnel Name</b>			
<b>Incident Type</b>			
<input type="checkbox"/> Injury/illness	<input type="checkbox"/> Property/Equipment Damage	<input type="checkbox"/> Major spillage/Release	<input type="checkbox"/> Vehicle/Road Traffic Accident
<input type="checkbox"/> Fire/explosion	<input type="checkbox"/> Environmental Damage	<input type="checkbox"/> Operational Upset	<input type="checkbox"/> Others
<b>Injury Classification</b>			
<input type="checkbox"/> Fatality	<input type="checkbox"/> Permanent Disability	<input type="checkbox"/> LTI	
<input type="checkbox"/> Medical Treatment Case	<input type="checkbox"/> Restricted Work Case	<input type="checkbox"/> First Aid Case	
<b>Incident Description:</b>			

Tick the possible cause of the incident				
<b>People Related</b>				
<input type="checkbox"/> Lack of communication	<input type="checkbox"/> Improper use of PPEs	<input type="checkbox"/> Lack of Training		
<input type="checkbox"/> Judgement	<input type="checkbox"/> Careless act	<input type="checkbox"/> Others		
<b>Equipment/Material related</b>				
<input type="checkbox"/> Design	<input type="checkbox"/> Maintenance/Inspection	<input type="checkbox"/> Manufacturing defect		
<input checked="" type="checkbox"/> Equipment Failure	<input type="checkbox"/> Operation	<input type="checkbox"/> Others		
<b>Supervision at the time of the incident</b>				
<input type="checkbox"/> Daily supervised	<input type="checkbox"/> Indirectly supervised			
<input type="checkbox"/> Not supervised	<input type="checkbox"/> Supervision not feasible			
<b>Procedure related</b>				
<input type="checkbox"/> Not available	<input type="checkbox"/> Incorrect	<input type="checkbox"/> Not clear		
<input type="checkbox"/> Not followed	<input type="checkbox"/> Inadequate	<input type="checkbox"/> Not applicable		
<b>Key Findings (List in logical order, pertinent facts uncovered during investigation)</b>				
<b>Tick the management system element violated</b>				
<input type="checkbox"/> Management Commitment	<input type="checkbox"/> Audit and Observation	<input type="checkbox"/> Others		
<input type="checkbox"/> Policies and procedures	<input type="checkbox"/> Incident Investigation			
<input type="checkbox"/> Integrated Organization Structure	<input type="checkbox"/> Contractors and safety			
<input type="checkbox"/> Line management accountability and responsibility	<input type="checkbox"/> Safety information			
<input type="checkbox"/> Goals, Objectives and Plans	<input type="checkbox"/> Risk assessment			
<input checked="" type="checkbox"/> Safety personnel	<input type="checkbox"/> Procedure and performance standards			
<input checked="" type="checkbox"/> Effective Communication	<input type="checkbox"/> Management of change-Technology			
<input checked="" type="checkbox"/> Motivation and awareness	<input type="checkbox"/> Management of change- Facilities			
<input checked="" type="checkbox"/> Training and Development	<input type="checkbox"/> Emergency preparedness and contingency planning			
<b>Recommendations</b>				
<b>Recommendation</b>	<b>Responsibility</b>	<b>Completion Date</b>	<b>DRI (Directly Responsible Individual)</b>	<b>Status</b>
<b>Online Report Initiated by / Submission Date Time</b>				
<b>Conclusion</b>				
<b>Reason for submitting the report late (if applicable)</b>				
<b>Remarks</b>				
<b>Repeat Incident</b>				

**ANNEXURE C**  
**WHY TREE TECHNIQUE**

The 5-Why method helps to determine the cause-effect relationships in a problem or a failure event. It can be



used whenever the real cause of a problem or situation is not clear. Using the 5-Whys is a simple way to try solving a stated problem without a large, detailed investigation requiring many resources. When problems involve human factors, this method is the least stressful on participants. It is one of the simplest investigation tools easily completed without statistical analysis. Also known as a Why Tree, it is supposedly a simple form of root cause analysis. By repeatedly asking the question, 'Why?' you peel away layers of issues and symptoms that can lead to the root cause. Most obvious explanations have yet more underlying problems. But it is never certain that you have found the root cause unless there is real evidence to confirm it. You start with a statement of the situation and ask why it occurred. You then turn the answer to the first question into a second Why question. The next answer becomes the third Why question and so on. By refusing to be satisfied with each answer you increase the odds of finding the underlying root cause of the event. Though, this technique is called '5-Whys', five is a rule of thumb. You may ask Why before finding the root of a problem (there is a school of thought that 7 'whys' is better; that 5 'whys' is not enough to uncover the real latent truth that initiated the event).

## SCAT Assessment Chart

### GENERAL Systematic Cause Analysis Technique (SCAT)

LOSS Category or Potential Loss Category							
Health		Safety		Environment		Quality	
Personnel	Occupational Illness	Personnel	Injury	Environment	Accidental Discharge	Non productive Time	Your Company
	Non Occupational Illness	Automotive	Light		Physical Damage		Contractor
			Heavy		Sanctions and Scrutiny	Other	Third Party
		Assets	Equipment		Inappropriate Disposal		Reputation Time
			Products			Process Other	
			3rd Party				
			Computer				
		Information	Your Company				
			Contractor				
			3rd Party				

INCIDENT or Potential Incident			
Struck Against (Running or Bumping Into)	Contact With (Electricity, Heat, Cold, Radiation, Caustics, Toxics, Biological, Noise)	Misplaced/Misaid	Fraud/Bribery/Blackmail
Struck By (Hit By Moving Object)	Abnormal Operations	Unplanned/Undesired Energy Release	Deliverable Service/Product/Failure
Fall From Elevation to Lower Level	Product/Materials/Goods Contamination	Disease	Data/Information Quality/Integrity Delivery Failure
Fall On Same Level (Slip and Fall, Trip Over)	Overstress, Overpressure, Overexertion, Overextension, Overexposure, Ergonomic	Ingestion/Inhalation/Absorption	Sales/Invoicing Failure
Caught In (Pinch and Nip Points)	Tools/Equipment/Systems Failure/Malfunction	Theft/Burglary/Vandalism	Logistics Failure
Caught On (Snagged, Hung)	Unplanned/Undesired Environmental Release	Armed Assault/Armed Robbery/Hi-Jacking	Regulatory/Contract/License Violation
Caught Between or Under	Explosion/Fire	Abduction/Kidnapping/Unlawfully Detained	Media Exposure

IMMEDIATE CAUSE	
Substandard Acts	Substandard Conditions
Operating Equipment Without Authority	Inadequate Guards or Barriers
Failure to Warn/Intervene	Inadequate or Improper Protective Equipment
Failure to Secure/Protect	Defective Tools, Equipment or Materials
Operating at Improper Speed	Congestion or Restricted Action
Making Safety Devices Inoperative	Inadequate Warning System
Using Defective Equipment	Fire & Explosion Hazards
Failing to Use PPE Properly	Poor Housekeeping/Disorder
Improper Loading	Noise Exposure
Improper Placement	Radiation Exposure
Improper Lifting	Temperature Extremes
Improper Position for Task	Inadequate or Excess Illumination
Servicing Equipment in Operation	Inadequate Ventilation
Horseplay/Fooling Around	Presence of Harmful Materials
Under Influence of Alcohol and/or Other Drugs	Inadequate Policy/Standards/Procedures/Work Instruction/Practice/ Rules
Using Equipment Improperly	Inadequate Information / Data
Failure to Follow Policy/Standards/Procedures/Work Instruction/Practice/Rules	Inadequate Job/Work Preparation / Planning
Failure to Identify Hazard/Risk	Inadequate Support / Assistance
Failure to Check/Monitor/Observe	Inadequate Communications Hardware/Software/Process
Failure to React/Correct	Road Conditions
Failure to Communicate/ Coordinate	Weather Conditions
Using Unauthorized Equipment	Insufficient Resources
Improper Handling	Downhole Conditions
Improper Filing/Archiving/Recordkeeping	Wellbore Surface Conditions

ROOT CAUSES

Personal Factors		Job Factors					
Inadequate Physical/Physiological Capability	Inappropriate height, weight, size, strength, reach, etc	Inadequate Leadership and/or Supervision	Unclear or conflicting reporting relationships	Inadequate Maintenance/Repair	Inadequate repetitive	Communication of needs	
	Restricted range of body movement		Unclear or conflicting assignment of responsibility		Inadequate standards or specifications	Scheduling of work	
	Limited ability to sustain body positions		Improper or insufficient delegation		Inadequate design criteria/specifications	Unauthorized modification implemented	
	Substance sensitivities or allergies		Oversight inadequate policy, procedure, practices or guidelines		Inadequate design development	Examination of units	
	Sensitivities to sensory extremes (temperature, sound, etc)		Oversight objectives, goals, or standards that conflict		Inadequate design review	Repair quality	
	Vision deficiency		Inadequate workshop planning or programming		Inadequate design qualification testing	Testing	
	Hearing deficiency		Inadequate Team Building		Inadequate design commercialization/launch	Part substitution	
	Other sensory deficiency (touch, taste, smell, balance)		Inadequate Long Term Planning		Inadequate customer order information or processing	Assessment of needs	
	Respiratory incapacity		Inadequate instructions, orientation, and/or training		Inadequate production line tooling/component systems	Lubrication and servicing	
	Other permanent physical capabilities		Providing inadequate reference documents, directives, and guidance publications		Inadequate receiving inspection and acceptance	Authorized modification not implemented	
Inadequate Mental / Psychological Capability	Temporary disabilities	Inadequate Engineering/Manufacturing	Lack of identification and evaluation of task exposures	Inadequate Tools/Equipment/Systems	Inadequate removal and replacement of unsuitable items	Scheduling of Work	
	Fears and phobias		Lack of supervisory/management job knowledge		Inadequate removal/replacement of unsuitable/deteriorated items	Part Replacement	
	Emotional disturbance		Inadequate communication/implementation of lessons learned		Inadequate assessment of job needs and risks	Adjustment/assembly	
	Mental illness		Inadequate matching of individual qualifications and job task requirements		Inadequate human factors/ergonomics considerations	Cleaning or reworking	
	Intelligence level		Inadequate performance measurement and evaluation		Inadequate standards or specifications		
	Inability to comprehend		Inadequate or incorrect performance feedback		Inadequate salvage and reclamation		
	Poor coordination		Engineering		Inadequate removal and replacement of unsuitable/deteriorated items		
	Slow reaction time		Inadequate design, standards, procedures, guidelines		Inadequate development of standards/procedures/work instructions		
	Low mechanical aptitude		Inadequate design criteria/specifications		Inadequate communication of standards/procedures/work instructions		
	Low learning aptitude		Inadequate design review		Inadequate maintenance of standards/procedures/work instructions		
Physical or Physiological Stress	Memory failure	Inadequate Procurement/Purchasing	Inadequate design qualification testing	Inadequate Standards/Procedures/Work Instructions	Inadequate inventory/stock control	Inventory and evaluation of exposures and needs	
	Slurry or illness		Manufacturing		Inadequate control of waste	Coordination with process design	
	Fatigue due to task load or duration		Inadequate research on material/equipment		Inadequate assembly	Employee involvement	
	Fatigue due to lack of rest		Inadequate specifications on requisition orders		Inadequate testing	Procedure/practices/rules	
	Fatigue due to sensory overload		Inadequate requisition/ordering systems		Inadequate user instructions/manuals	Distribution	
	Exposure to health hazards		Inadequate identification of hazardous materials			Transmission of appropriate languages	
	Exposure to temperature extremes		Your Company		Inadequate identification of needs	Training	
	Oxygen deficiency		Inadequate identification of needs		Inadequate tendering process	Reinforcing with signs, color codes and job aids	
	Atmospheric pressure variation		Inadequate bid		Inadequate contract with client	Tracking of work flow	
	Constrained movement		Inadequate pre-contract meetings		Inadequate mobilization	Updating	
Mental or Psychological Stress	Blood Sugar inefficiency	Inadequate Contracting	Inadequate execution/compliance with contract	Excessive Wear and Tear	Inadequate monitoring of compliance with standards/procedures/work instructions		
	Drugs		Contractor/Suppliers		Inadequate routine status meetings	Inadequate planning of use	
	Emotional overload		Inadequate identification of needs		Inadequate demobilization	Improper extension of service life	
	Fatigue due to mental task load or speed		Inadequate tendering process		Inadequate post-contract meeting	Improper loading of rate of use	
	Fatigue due to task load or duration		Inadequate contractor selection			Inadequate maintenance	
	Fatigue due to lack of rest		Inadequate contract with contractor/supplier			Use by unqualified or untrained people	
	Fatigue due to sensory overload		Inadequate pre-contract meetings			Inadequate communication between organizations	
	Exposure to health hazards		Inadequate mobilization			Inadequate communication between work groups	
	Exposure to temperature extremes		Inadequate execution/compliance with contract			Inadequate communication between shifts	
	Oxygen deficiency		Inadequate performance monitoring			Inadequate horizontal communication between peers	
Lack of Knowledge	Atmospheric pressure variation	Inadequate Contracting	Inadequate routine status meetings	Inadequate Communications	Inadequate vertical communication between supervisor and person		
	Constrained movement		Inadequate identification of needs		Inadequate communication methods		
	Blood Sugar inefficiency		Inadequate tendering process		No communication method available		
	Emotional overload		Inadequate contractor selection		Incorrect instructions		
	Fatigue due to mental task load or speed		Inadequate contract with contractor/supplier		Inadequate communication due to job turnover		
	Fatigue due to task load or duration		Inadequate pre-contract meetings		Inadequate communication of safety and health data, regulations or guidelines		
	Fatigue due to lack of rest		Inadequate mobilization		Overused terminology not used		
	Fatigue due to sensory overload		Inadequate execution/compliance with contract		Verification/repair feedback techniques not used		
	Exposure to health hazards		Inadequate performance monitoring		Inadequate message length		
	Exposure to temperature extremes		Inadequate routine status meetings		Messages too long		
Lack of Skill	Oxygen deficiency	Inadequate Contracting	Inadequate demobilization	Inadequate Logistics/Delivery	Speech interference		
	Atmospheric pressure variation		Inadequate identification of needs		Inadequate packages/container		
	Constrained movement		Inadequate tendering process		Inadequate paper/documentation		
	Blood Sugar inefficiency		Inadequate contractor selection		Inadequate customer clearance		
	Emotional overload		Inadequate contract with contractor/supplier		Inadequate transportation (mode of transport, availability, vehicle standards/specifications)		
	Fatigue due to mental task load or speed		Inadequate pre-contract meetings		Inadequate storage/warehousing		
	Fatigue due to task load or duration		Inadequate mobilization		Inadequate handling/transportation		
	Fatigue due to lack of rest		Inadequate execution/compliance with contract		Incorrect/inadequate signs/signposts/delivered		
	Fatigue due to sensory overload		Inadequate performance monitoring				
	Exposure to health hazards		Inadequate routine status meetings				
Improper Motivation	Oxygen deficiency	Inadequate Contracting	Inadequate demobilization	Inadequate Marketing and Sales	Inadequate understanding of market needs		
	Atmospheric pressure variation		Inadequate identification of needs		Inadequate development of client relationships		
	Constrained movement		Inadequate tendering process		Inadequate customer satisfaction monitoring		
	Blood Sugar inefficiency		Inadequate contractor selection		Inadequate knowledge of competitors		
	Emotional overload		Inadequate contract with contractor/supplier		Inadequate communication of capabilities/technologies		
	Fatigue due to mental task load or speed		Inadequate pre-contract meetings		Inadequate responses to service delivery not/requirements		
	Fatigue due to task load or duration		Inadequate mobilization		Inadequate understanding/expectation of operational capabilities		
	Fatigue due to lack of rest		Inadequate execution/compliance with contract				
	Fatigue due to sensory overload		Inadequate performance monitoring				
	Exposure to health hazards		Inadequate routine status meetings				
Abuse or Misuse	Oxygen deficiency	Inadequate Contracting	Inadequate demobilization	Inadequate Marketing and Sales	Overall/give/overpromising		
	Atmospheric pressure variation		Inadequate identification of needs				
	Constrained movement		Inadequate tendering process				
	Blood Sugar inefficiency		Inadequate contractor selection				
	Emotional overload		Inadequate contract with contractor/supplier				
	Fatigue due to mental task load or speed		Inadequate pre-contract meetings				
	Fatigue due to task load or duration		Inadequate mobilization				
	Fatigue due to lack of rest		Inadequate execution/compliance with contract				
	Fatigue due to sensory overload		Inadequate performance monitoring				
	Exposure to health hazards		Inadequate routine status meetings				

## Annexure D

### Annual Incident Analysis Report Format

#### Annual Incident Analysis Report [Year]

**1. Introduction:**

- Purpose of the report.
- Scope of the analysis (e.g., incidents, accidents, near-misses).
- Overview of the reporting period.

**2. Incident Data Collection:**

- Total number of incidents recorded during the year.
- Incident classification by type and severity.

**3. Incident Frequency and Severity:**

- Incident frequency rate (Number of incidents per X hours worked or per X employees).
- Incident severity distribution (Percentage of minor, moderate, severe incidents).

**4. Root Cause Analysis:**

- Summary of significant incidents investigated.
- Identified root causes using analysis methods.

**5. Trend Analysis:**

- Trends and patterns observed in incident data.
- Analysis of incidents by departments, job roles, time of day, and days of the week.

**6. Leading and Lagging Indicators:**

- Leading indicators used to measure proactive safety efforts.
- Lagging indicators to assess past safety performance.

**7. Benchmarking:**

- Comparison of incident rates with industry benchmarks or previous years' data.

**8. Recommendations:**

- Safety enhancements based on root cause analysis.
- Training needs and improvements in safety procedures.
- Corrective actions to prevent similar incidents in the future.

**9. Implementation Status:**

- Summary of actions taken to address recommendations.
- Status of the implementation of corrective actions.

**10. Summary and Conclusion:**

- Key takeaways from the annual incident analysis.
- Overall safety performance and improvements achieved.

**11. Action Plan for the Following Year:**

- Identified focus areas and objectives for safety improvement.
- Planned initiatives and training programs.

**12. Acknowledgements and Appreciation:**

- Recognize and appreciate the efforts of the safety team and employees in reporting incidents and promoting safety.

**13. Signatures:**

- [Your Company/ Organization Representatives]

[Your Company/ Organization Contact Information]



## Annexure E One Slider Summary (OSS)

PTCL - Internal

### Work-related (Add incident category) – (Add function name)

### (Add incident main detail)

Insert picture

Insert picture

Insert picture

Insert picture

**Location**

---

(Add customer premises), Location ABC/XYZ.

**What happened?**

---

On MM/DD/YYYY,  
(Add what happened?)  
(When it happened?)  
(How did it happen?)  
(What went wrong?), etc.

**Immediate actions taken**

---

(Add the immediate actions that were taken).

**#ReadyToRise #TayyarHo #ExpressYourTalent**

## Annexure F

### Fact finding report template

ACCIDENT INVESTIGATION REPORT

**ACCIDENT INVESTIGATION REPORT**

**EXECUTIVE SUMMARY**

**TABLE OF CONTENTS**

1. Appointment and formation of Investigation Team
2. Abbreviations / Definitions
3. Staff / Officers Interviewed
4. Description of Site
5. Activity Prior To Incident
6. Description of Accident
7. Incident Direct Cost
8. Emergency Response
9. Investigation Team Findings
10. Root Cause Analysis
11. Recommendations

**1. INVESTIGATION TEAM MEMBERS**

SR. NO.	NAME	DESIGNATION	DEPARTMENT

**2. STAFF / OFFICERS INTERVIEWED**

**3. ABBREVIATIONS / DEFINITIONS**

ABBREVIATION	DEFINITION	ABBREVIATION	DEFINITION

**4. DESCRIPTION OF SITE FACILITY**

Page 1 of 3

ACCIDENT INVESTIGATION REPORT




FIGURE 2-1 INCIDENT LOCATION

**5. ACTIVITY PRIOR TO INCIDENT**

**6. DESCRIPTION OF INCIDENT**

**7. SEQUENCE / TIMELINE OF EVENTS**

Time in Hours	Sequence of Events on DD/MM/YYYY

**8. INCIDENT/DIRECT COST**

**9. EMERGENCY RESPONSE**

**10. INVESTIGATION TEAM'S FINDINGS**

**11. ROOT CAUSE ANALYSIS**

**BEHAVIORAL NOTE**

**OVERALL COMMENTS**

**12. CONCLUSION**

Page 2 of 3

**13. RECOMMENDATIONS**

SR. NO.	RECOMMENDATIONS	RESPONSIBILITY	TIMELINE
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**SIGNATURES OF INVESTIGATION TEAM**

**ANNEXURES**

ANNEXURE	DESCRIPTION
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**DISCLAIMER**

"Contents of this report are privileged and confidential and may not be disclosed in evidence or otherwise outside PTCL Group. Any misuse of this report will be actionable at law by PTCL Group."

**Annexure G**  
**Learning from Incident template**

## Lesson Learned – Fatal Incident

### What Happened- description and facts

*(What happened?)*

*(How did it happen?)*

*(When did it happen?)*

*(Where did it take place?)*

*(Describe the sequence of events)*

### Key Action for the function/department

1. *Ensure effective communication/training and implementation of HSE instruction and guidelines on "Aerial and Buried Network".*
2. *Ensure that only authorized and skilled individuals are involved in PTCL tasks.*

### Why Did it happen

#### **Underlying Causes**

*(Mention the root causes)*

#### **Root Causes**

*(Mention the root causes)*

### Key Learnings

*(Please list down the key learnings)*