

1. Objective

This procedure defines the requirements for the reporting, classification and investigation of HSSE events in QAPCO. The objective is to ensure that:

- Investigations are carried out in a consistent manner, and that the investigation methodology is appropriate to the severity of the consequences.
- Investigations correctly identify the contributing factors and root causes associated with HSSE events.
- Actions are identified and implemented in order to eliminate, or reduce the frequency of, similar undesirable events; and
- The lessons learnt from investigations are effectively communicated to drive a process of continuous improvement

2. Scope

This procedure applies to all HSSE events associated with QAPCO managed facilities and includes the following categories:

- Process Safety
- Occupation Health and Safety (OHS)
- Environmental Releases
- Vehicle Accidents
- Security Breaches

Unsafe acts and conditions (i.e., safety observations) are best addressed as part of an 'action-orientated' safety observation program and will not be investigated unless specifically requested by the Asset Owner or Safety Manager. There is a separate Root Cause Failure Analysis procedure (PR-PSS-48) that addresses the investigation of equipment reliability incidents that do not have any safety implications.

3. Procedure Summary

There are nine basic steps associated with the investigation of any HSSE event.

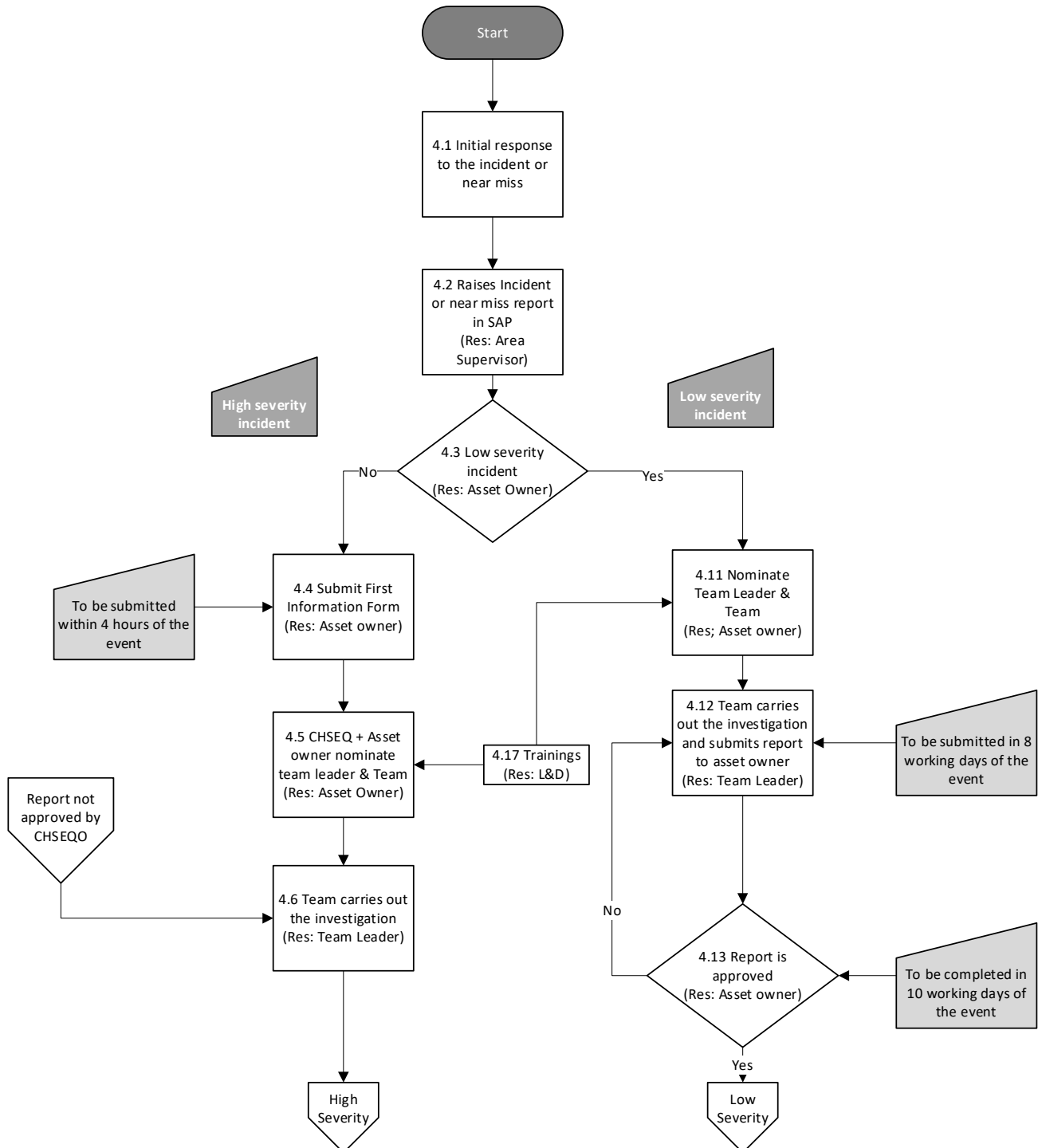
1. Initial Response and Reporting
2. Nominate the Investigation Team and Team Leader
3. Determining the Facts
4. Determining the Contributory Factors and Root Causes
5. Determining the Management Systems to be Strengthened
6. Recommending Corrective Actions to Prevent Reoccurrence
7. Documenting and Communicating the Findings
8. Sharing the Lessons Learnt
9. Following-up and Closing-out the Actions

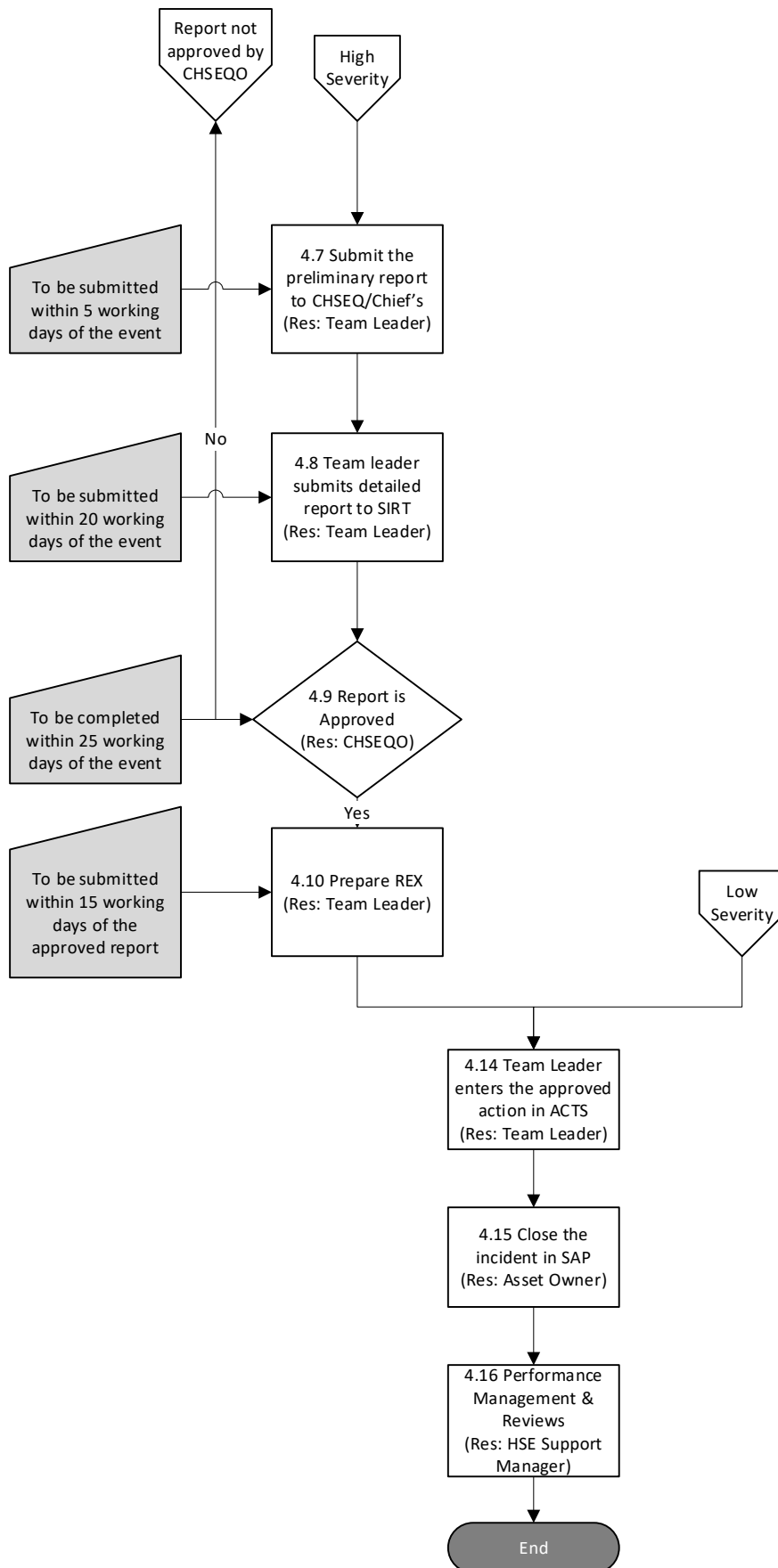
The level of response, and the investigation methodology to be applied, are based on the severity of the event. The actual severity shall be used for the classification of incidents and the potential severity for near misses. However, it is also important to capture incidents that, while they may have only had relatively minor consequences, the potential consequences could have been much higher. High Severity events require a detailed investigation and shall be reviewed and approved by the QAPCO Serious Incident Review Team (SIRT). Details of the composition of the SIRT are given in PR-SO-001-AP06 (Appendix 06). Low Severity events require a simplified investigation and shall be reviewed and approved by the Asset Owner. Further details on the classification of HSSE events are given in Section 4.3 of this procedure.

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4. Incident Investigation & Reporting Process Workflow





Procedure Clarifications

Ref.	Clarifications details
4.1	<p><u>Initial Response</u></p> <p>The witness (i.e., QAPCO Employee, Contractor or Visitor) to a HSSE incident shall immediately call:</p> <ul style="list-style-type: none"> • The Fire and Emergency Control Centre in case of a fire, an injury or illness requiring medical attention, or a release of hazardous material • The Supervisor for the area where the incident occurred. <p>The Fire and Emergency Control Centre shall initiate an appropriate response in accordance with the Emergency Response Plan (PR-PSS-139). They shall immediately contact the Asset Owner and, if the incident occurs in a plant area, the relevant Central Control Room (CCR). The Medical Centre shall keep the Asset Owner updated on the status and severity of any work-related injuries or illnesses.</p> <p>The Area Supervisor shall immediately notify their Manager (his nominated delegate, or the Duty On-Call) and the On-Call Safety Representative and, where safe to do so, take the necessary actions to eliminate or control the hazards associated with the incident and make the area safe. Reference shall be made to the Emergency Operation Instructions for the relevant facility. The Area Supervisor shall ensure an incident or near miss is raised in the SAP HSSE module. Details of High Severity events are to be cascaded up the line management chain by the Asset Owner to the COO and the CHSEQO.</p> <p>Safety must always be the first consideration. However, the area Supervisor and the area Safety Representative must also arrange to preserve and collect any evidence associated with the incident before it is contaminated or lost. This is especially critical if the event is serious enough to warrant investigation by external agencies. As appropriate to the incident, this could include:</p> <ul style="list-style-type: none"> • Barricading and securing the scene, including protecting it from the weather. • Taking photographs of the scene and any relevant equipment (QAPCO protocols on the use of cameras must be followed) • Noting the location of people and the timing of events. • Collecting, storing and preserving any physical items (e.g., equipment and tools) • Collecting any relevant data and information (i.e., electronic or hard copy) • Documenting preliminary interviews with key witnesses
4.2	<p><u>SAP HSSE Module</u></p> <p>The SAP HSSE module shall be used for the management of all data and information related to HSSE events.</p>

4.3

The Classification of HSSE Events

To ensure a consistent approach, facilitate the analysis of data, and drive continuous improvement HSSE events shall be classified by Type, Category and Severity:

Type

- Incident
- Near Miss

Category¹

- Process Safety
- Occupational Health and Safety
- Environmental Releases
- Vehicle Accidents
- Security Issues

Severity

- High Severity
- Low Severity

For Process Safety Events the severity is based on the definitions of the leading and lagging indicators (T-1 PSE to T-4 PSE) given in API RP 754 (Process Safety Performance Indicators for the Refining and Petrochemical Industries). **Note: For the purposes of this procedure the Direct Cost elements of the T-1 and T-2 PSE indicators shall not be applied.** Further guidance on the application of API RP 754 is given in PR-SO-001-AP07 (Appendix 07).

For all other events the severity is based on the consequence assessment criteria given in the QAPCO ERM Instruction (IN-RC-001)². This defines five severity levels ranging from Minor to Catastrophic. In the case of work-related injuries or illnesses additional data shall be captured on the type of injury or illness:

- Fatalities
- Lost Time Injury
 - Permanent Disabilities
 - Lost Workday Cases
- Restricted Workday Case
- Medical Treatment Case
- First Aid Case

When deciding on the classification of events the actual severity is to be used for incidents and the potential severity for near misses. However, it is also important to capture incidents that, while they may have only had relatively minor consequences, the potential consequences could have

¹ Fires has not been added as a separate category as they may be related to Process Safety, Occupational Safety, Vehicle Accidents or Security Breaches.

² API RP 754 and IN-RC-001 may be subject to amendment, in which case, the consequence assessment criteria given in the latest versions of both documents shall apply.

	<p>been much higher. This leads to the definition of a High Potential Incident (HIPO) as an incident, or near miss, that under slightly different circumstances could have resulted in a T-1 PSE or T-2 PSE Process Safety incident, or an incident with Major or Catastrophic consequences.</p> <p>A detailed investigation is required for High Severity events that meet the following criteria:</p> <ul style="list-style-type: none"> • A T-1 PSE or T-2 PSE process safety incident • An incident with Serious, Major or Catastrophic consequences • An incident that resulted in a Medical Treatment or Restricted Workday Case • A High Potential Incident. <p>For all other Low Severity events a simplified investigation is required. However, the Asset Owner may still request that a detailed investigation is carried out if warranted by the circumstances. For example, for recurring, chronic problems.</p> <p>The HSEQ Group, with input from the subject matter expert where required, shall finalize the classification of High Severity events:</p> <ul style="list-style-type: none"> • HSSE Support Manager for Process Safety Events • Safety Manager for work related injuries and illnesses. <p>The Asset Owner, or his nominated delegate, shall finalize the classification of Low Severity events with support from the Safety Representative where required.</p> <p>It is important that HSSE events are consistently and accurately classified to ensure that resources are utilized where they can add the most value to QAPCO.</p>
<p>4.4</p>	<p><u>First Information Form</u></p> <p>For High Severity events the Asset Owner (his nominated delegate, or the Duty On-Call) shall provide details of what happened, when and where it happened, and the immediate actions taken by email within 4 hours of the event occurring. This shall focus on the facts available and not speculate on potential causes. A First Information Form and the associated distribution list is given in PR-SO-001-AP08 (Appendix 08).</p>
<p>4.5</p>	<p><u>Investigation Team for High Severity Events</u></p> <p>High Severity events require the formal notification of an investigation team. The investigation Team Leader and the investigation Team Members shall be nominated by the CHSEQO after consultation with the Asset Owner. The investigation Team Leader shall be independent of the area where the event occurred. An external Team Leader may be appointed by the CEO, if considered necessary based on the severity and complexity of the event.</p> <p>Investigation Team Leader</p> <p>The Team Leader shall be trained and competent in the investigation and reporting of HSSE events, including:</p>

	<ul style="list-style-type: none"> • Collecting and preserving evidence • Conducting effective interviews • Sequencing events and establishing timelines • Root Cause Analysis (RCA) techniques • Writing recommendations • Producing investigation reports. <p>The Team Leader shall have previously participated in several investigations before leading an investigation for the first time. If the Team Leader is not experienced in the application of RCA techniques, then a QAPCO approved RCA facilitator shall be included as part of the investigation team.</p> <p>Investigation Team Members</p> <p>Team members shall include personnel selected from functions and departments that can contribute, and add value, to the investigation based on the type and category of the event. As a minimum, this shall include personnel from the area where the event occurred (e.g. engineers, supervisors, operators and safety representatives). Where necessary, additional team members may include subject matter experts and representatives drawn from:</p> <ul style="list-style-type: none"> • Maintenance • Reliability • Engineering • Fire fighting • Environmental services • Security • Contractors (i.e., if the event involved contractors) <p>To ensure the investigation process is efficient investigation teams for High Severity events shall, typically, comprise three (3) to seven (7) people. All persons that either contributed to, witnessed, or were affected by an event, have a responsibility to provide accurate, factual information to the investigation team to support the investigation process.</p>
<p>4.6 and 4.12³</p>	<p><u>Investigation and Reporting</u></p> <p>The investigation of all events shall be initiated as soon as possible after the nomination of the investigation Team Leader and the Team Members, and within a maximum of forty-eight (48) hours of the event occurring. This will minimize the risk that evidence deteriorates, is lost or corrupted. This applies to both peoples' memories and physical evidence.</p> <p>The following basic steps applies to all investigations, but the level of detail required, the RCA methodology to be applied, and the reporting requirements are different for Low and High Severity events as defined in the relevant sections.</p>

³ Applies to low severity incident

A. Onboarding the Investigation Team

The Team Leader shall arrange a kick-off meeting to brief the Team Members on the background to the event, the scope and objectives of the investigation, the method of working, and the plan of action.

B. Determining the Facts

The objective is not to allocate blame, but to learn as much as possible about the facts associated with the event by considering people, conditions, data and information. The team shall aim to document all relevant, factual information to facilitate further review and investigation as necessary, including:

- Creating a list of the people involved and conducting interviews
- Developing a timeline for the event
- Inspecting the location, and any photographs or drawings of the scene
- Identifying any changes made to the scene because of mitigation activities;
- Details of any injuries, asset damage, environmental releases or other impacts;
- Obtaining physical evidence;
- Collecting relevant process or equipment data, information and documentation;
- Collecting operating procedures, method statements, risk assessments and training records etc.

Once all the information is collected, it may be necessary for the Investigation Team to review and agree on the significance, and weighting, of any conflicting evidence.

C. Determining Contributory Factors and Root Causes

Identifying the root causes of a HSSE event is key to preventing reoccurrence. While there may be associated physical or human causes, identifying the underlying management system failings allows for a broader and more sustainable impact:

- Identifying only the physical cause will impact one item of equipment;
- Identifying only the human cause will correct one person's mistake or behavior;
- Identifying management system failings has the potential to impact the whole organization.

To drill down past the physical and human causes of events to the underlying root causes requires the application of a methodical and consistent approach.

For the majority of Low Severity events the application of the 'Five Whys' technique is sufficient. This is an iterative technique used to explore the cause-and-effect relationships associated with an event by repeatedly asking the question 'Why?'. Each answer forms the basis for the next question. The 'Five' in the name derives from the observation of the typical number of times the question has to be asked to arrive at the root cause of a problem.

The analysis of High Severity events, which tend to be more complex and where there may be multiple root causes, must be supported by the development of a 'Why Tree'. Why Trees (also called logic trees, fault trees or cause and effect charts) are routinely used to conduct root cause

	<p>analysis. They are built by defining the undesirable event at the top and then branching off with the facts associated with the event. Theories are proposed to explain the relationship between the facts and the event, and then they are proven or disproven. For proven theories the steps are repeated. Branches lead to physical causes then human causes and finally the underlying root causes.</p> <p>Further guidance on the application of the Five Whys technique and the development of Why Trees is given in PR-SO-001-AP09 (Appendix 09).</p> <p>D. Determining the Management Systems to be Strengthened</p> <p>In order to prevent reoccurrence of events, extract the maximum benefit from investigations and drive continuous improvement it is important to ensure any management system failings are correctly identified. These opportunities for improvement should flow from the root cause analysis and may be related to:</p> <ul style="list-style-type: none"> • Risk Assessment • Process Hazard Analysis • Instructions / Task Based instructions • Safe Work Practices • Management of Changes (Technology, Facility, Personnel) • Training and Competency • Contractor Safety • Learning from Previous Investigations • Emergency Planning and Response • Audits • Mechanical Integrity • Quality Assurance • Pre-startup Safety Reviews • Site or Area Management <p>E. Recommending Corrective Actions to Prevent Reoccurrence</p> <p>The reason for investigating HSSE events is not just to identify root causes, but also to recommend and implement effective corrective actions in order to eliminate, or reduce the frequency of, similar undesirable events. Finding root causes merely removes doubt about the circumstances that allowed something to happen.</p> <p>There shall be at least one action for each root cause identified as part of the investigation. Teams should also consider assigning actions to contributory factors, but only where they believe it will have a significant impact on reoccurrence. Proposed actions must be agreed, and prioritized, by the investigation team and specify the action owner and the expected completion date. Actions must be agreed with the action owner and the department or organization responsible for carrying out the work before they can be considered valid actions.</p>
4.8	<p><u>Investigation Reports for High Severity Events</u></p> <p>For High Severity events the Team Leader shall complete the Investigation Report Form, including any associated attachments, as shown in PR-SO-001-AP10 (Appendix 10). The Form shall be sent</p>

	<p>to the Chiefs for their information with five (5) working days of the event. For High Severity events this will be the Preliminary Report.</p> <p>For High Severity events the Team Leader shall also prepare a Detailed Investigation Report in accordance with the contents detailed in PR-SO-001-AP11 (Appendix 11). The report should be submitted within twenty (20) working days of the event to enable it to be reviewed and approved by the Serious Incident Review Team within twenty-five (25) working days of the event. QAPCO acknowledges that some specific elements of the final report may not be available within twenty days but this should not delay submission of the report based on the data and information available at the time.</p>
<p>4.10</p>	<p><u>Communicating the Findings</u></p> <p>The effective and timely communication of the findings from investigations is fundamental to preventing the reoccurrence of HSSE events. In QAPCO this is achieved through the preparation and distribution of a Return of Experience (REX) document. A template for the REX is given in PR-SO-001-AP12 (Appendix 12). This document shall include a summary of:</p> <ul style="list-style-type: none"> • What happened, and how and why it happened. • The root causes and recommendations; and • The key learnings. <p>The emphasis shall be on how to prevent similar events and any actions that need to be taken. The REX shall be used as the basis for ‘Safety Moments’ for departmental meetings and ‘Toolbox Talks’ and should be prominently displayed. The discussion of REX shall be on the agenda for PSCT, OSTF and ETF meetings. The aim is to prompt the awareness and discussion of HSSE events.</p> <p>The REX shall be prepared by the investigation Team Leader in consultation with the Asset Owner, and with input from subject matter experts where necessary. It shall be reviewed and published by the HSEQ Group.</p> <p>A REX shall be prepared for all High Severity events within fifteen (15) working days of approval of the detailed investigation report. Unless specifically requested by the Asset Owner or the Safety Manager, a REX is not required for Low Severity events.</p>
<p>4.11</p>	<p><u>Investigation Team for Low Severity Events</u></p> <p>The Asset Owner shall nominate the investigation Team Leader and Team Members for Low Severity events. The team shall be appropriate to the complexity of the event. For simple events it may be sufficient to involve the area supervisor and any persons that contributed to, witnessed, or were affected by the event. For more complex events it may be necessary to involve the responsible operations engineer, as appropriate to the location, and the safety representative</p>
<p>4.12</p>	<p><u>Investigation Reports for Low Severity Events</u></p> <p>For Low Severity events the Team Leader shall complete the Investigation Report Form, including any associated attachments, as shown in PR-SO-001-AP10 (Appendix 10). The form shall be submitted within eight (8) working days of the event to enable it to be reviewed and approved by</p>

	<p>the Asset Owner within ten (10) working days of the event. For Low Severity events this will be the Final Report.</p>
<p>4.14</p>	<p><u>Following-up and Closing-out the Actions</u></p> <p>Any agreed and outstanding actions (Reference Section 4.9 and 4.13 of this procedure) associated with high severity events shall be recorded and tracked using the centralized action tracking system (ACTS). Investigation Team Leaders shall ensure that actions are entered into ACTS within five (5) working days of the approval of final reports.</p> <p>Action owners are responsible for closing-out the actions allocated to them and for developing, and implementing plans for any overdue items. This shall be subject to verification by the Asset Owner for the area where the event occurred. Overdue actions shall be reviewed by the PSCT, OSTF and ETF as appropriate.</p>
<p>4.16</p>	<p><u>Performance Management and Review</u></p> <p>The analysis, trending and review of the leading and lagging key performance indicators associated with HSSE events is essential to drive continuous improvement. This includes the analysis of events by location, type, category and severity (Reference Section 4.3 of this procedure). The identification of recurring problems or issues enables initiatives to be taken to address common themes.</p> <p>The required data and information should be generated by the HSEQ Group and be made available for review during Departmental and Management HSSE meetings, including the PSCT, OSTF and ETF as appropriate. The objective shall be to discuss trends, highlight good and bad performance, and agree on any actions required. The information shall include:</p> <ul style="list-style-type: none"> • Number of Tier 1 (T-1 PSE) Process Safety Events • Number of Tier 2 (T-2 PSE) Process Safety Events • Number of Tier 3 (T-3 PSE) Process Safety Events • Number of High Potential Incidents (HIPO) • Process Safety Total Incident Rate (PSTIR) <ul style="list-style-type: none"> ○ Tier 1 PSE Rate ○ Tier 2 PSE Rate ○ Tier 3 PSE Rate • Number of Lost Time Injuries (LTI) <ul style="list-style-type: none"> ○ Number of Fatalities ○ Number of Lost Workday Cases (LWC) • Number of Restricted Workday Cases (RWC) • Number of Medical Treatment Cases (MTC) • Number of First Aid Cases (FAC) • Number of Vehicle Accidents • Number of Security Breaches • Total Recordable Incident Rate (TRIR) • Lost Time Incident Frequency Rate (LTIFR)

	<ul style="list-style-type: none"> • Lost Time Injury Severity Rate (LTISR) • Number of open High Severity investigations • Number of open Actions • Number of overdue Actions
4.17	<p><u>Training</u></p> <p>The successful implementation of this procedure requires that the personnel involved in the investigation of HSSE events are aware of their roles and responsibilities and have the skills and experience necessary to carry them out.</p> <p>Investigation Team Leaders and RCA Facilitators require training in the application of this procedure, including:</p> <ul style="list-style-type: none"> • Collecting and preserving evidence • Conducting effective interviews • Sequencing events and establishing timelines • Root Cause Analysis (RCA) techniques • Writing recommendations • Producing investigation reports. <p>QAPCO Supervisors and above need general awareness training in the application of this procedure which can be delivered either on-line or through classroom sessions.</p>

5. Records

The owner / executor shall maintain the following records / documents for reference.

#	Document / Record name	Retention period	Retention policy	Retention method	Classification
1	PR-SO-001	5 Years	Current version by Safety	Soft Copy by IT	Internal
2	Implementation Plan	5 Years	Current version by Safety	Soft/Hard Copy	Internal
3	Records of User awareness	5 Years	Current version by Safety	Soft /hard copy	Internal
4	SAP HSSE Module for HSSE Event	Continuous	Backup system by I.T.	Soft copy	Internal
5	ACTS : corrective actions arising from HSSE investigations.	Continuous	Backup system by I.T.	Soft copy	Internal

6. Document References / Attachments

#	Document ID	Document name	Summary of dependency or use
6.1 Document References			
1	API RP 754	Process Safety Performance Indicators for the Refining and Petrochemical Industries	Defines the criteria for assessing the actual, and potential, severity of Process Safety related events (i.e. incidents and near misses).
2	PR-130-CE-01	QAPCO Risk Management Procedure	Defines the criteria for assessing the actual, and potential, severity of HSSE events (i.e. incidents and near misses) not covered by API RP 754.
3	PR-PSS-139	Emergency Response Plan - Mesaieed Facility	Describes the QAPCO response to incidents that could have a significant impact on safety, the environment, assets, business continuity or company reputation.
4	PR-PSS-48	Root Cause Analysis Procedure	Describes the methodology to be applied to address the investigation of equipment reliability and availability incidents.
5	PR-OE-001	Centralized Action Tracking System (ACTS)	A SharePoint application that is used to record and track the actions arising from the investigation of HSSE events.
6.2 Attachments			
6	PR-SO-001-AP01	Appendix 01: Classification and Reporting Requirements for Incidents	Describes the classification and reporting requirements for incidents.
7	PR-SO-001-AP02	Appendix 02: Classification and Reporting Requirements for Near Misses	Describes the classification and reporting requirements for near misses.
8	PR-SO-001-AP03	Appendix 03: Safety Observation Process	Process flow for the reporting and close out of safety observations.
9	PR-SO-001-AP04	Appendix 04: Roles & Responsibilities	Defines the roles and responsibilities for the different stakeholders.
10	PR-SO-001-AP05	Appendix 05: Service Level Definitions	Defines the target dates for submission of deliverables.
11	PR-SO-001-AP06	Appendix 06: Role of SIRT	Defines the objectives and composition of the SIRT.
12	PR-SO-001-AP07	Appendix 07: Guidance on application of API RP 754	Provides guidance on the application of API 754 to process safety events.
13	PR-SO-001-AP08	Appendix 08: First Information Form for High Severity Incidents	The template to be used for communicating information related to high severity incidents.
14	PR-SO-001-AP09	Appendix 09: Root Cause Analysis (RCA) Technique	Provides guidance on the application of RCA techniques.
15	PR-SO-001-AP10	Appendix 10: Investigation Report Form for low severity incident	Form to be used for the reporting of HSSE events.

16	PR-SO-001-AP11	Appendix 11: Investigation Report Template for serious incident	Provides guidance on the preparation of detailed reports for high severity events.
17	PR-SO-001-AP12	Appendix 12: Return on Experience (REX) Template	Template to be used for the development of REX.
18	PR-SO-001-AP13	Appendix 13: SIRT Review Summary Template	Template to be used for presentation to SIRT

7. IT System Requirements

#	IT system module name	Summary of IT system module use
1	SAP HSSE Module	Used to support the implementation of the HSSE investigation process and provide feedback on performance.
2	Centralized Action Tracking System (ACTS)	Used to track and close-out corrective actions arising from HSSE investigations.

8. Abbreviations / Definitions

#	Abbreviation / Keyword	Definition summary
1	Action Owner	The person responsible for ensuring that an action is completed by the agreed due date.
2	Centralized Action Tracking System (ACTS)	A QAPCO SharePoint application used to record and track actions across the organization.
3	Asset Owner	The Plant Manager for Production Plant Areas. The Project Manager for Construction Projects. The Asset Owners for Buildings is the Building Owner (i.e. the Manager responsible for the building).
4	Environmental Release	Any spilling, leaking, pumping, pouring, emitting, emptying, discharging, injecting, escaping, leaching, dumping, or disposing of pollutants into the environment.
5	ETF	QAPCO Environment and Quality Task Force.
6	Fire	Any combustion, regardless of the presence of flame. This includes electrical arcs that involve a subsequent fire or evidence of combustion. Evidence of combustion includes flames, smoke, charring or carbonizing.
7	First aid Case (FAC)	A minor work-related injury or illness that calls for only simple 'First Aid' treatment and does not call for follow-up treatment by a healthcare professional. First aid injuries do not result in lost time from work or work restrictions.
8	High Potential Incident (HIPO)	An incident, or a near miss, that under slightly different circumstances could have resulted in a T-1 PSE or T-2 PSE Process Safety incident, or an incident with Major or Catastrophic consequences.
9	High Severity Event	A T-1 PSE or T-2 PSE Process Safety incident. An incident with Serious, Major or Catastrophic consequences. An incident that resulted in a MTC or RWC. A HIPO.

10	HSSE	Health, Safety, Security and the Environment.
11	HSSE Event	An incident or near miss that had, or could have had, HSSE consequences.
12	Incident	An unplanned event, or chain of events, which had HSSE consequences.
13	Loss of Primary Containment (LOPC)	An unplanned or uncontrolled release of any material from primary containment, including non-toxic and non-flammable materials.
14	Lost Time Injury (LTI)	Any absence from work resulting from work related Fatalities, Permanent Total Disabilities, Permanent Partial Disabilities, Injuries or Illnesses.
15	Low Severity Event	A T-3 PSE Process Safety incident. An incident with Minor or Moderate consequences. A T-3 PSE near miss. A near miss with Minor, Moderate or Serious consequences.
16	Medical Treatment Case (MTC)	A work-related injury or illness that calls for medication, treatment, or medical check that is administered by a healthcare professional and that goes beyond first aid case. A medical treatment case does not result in lost time from work beyond the date of the injury.
17	Near Miss	An unplanned event, or chain of events, that did not have any HSSE consequences but had the potential to do so.
18	Occupation Health and Safety Event	An event, other than a Process Safety Event, that resulted in, or could have resulted in, a work related injury or illness.
19	OSTF	The QAPCO Occupational Safety Central Task Force.
20	PSCT	The QAPCO Process Safety Central Task Force.
21	Process Safety Event	An event that directly involves process equipment, materials, or energy that resulted in, or could have resulted in, a loss of containment and injury, environmental impact, asset damage, or major business interruption.
22	Root Cause Analysis (RCA)	A process for identifying the contributing factors and underlying causes of events leading to corrective actions and recommendations to prevent reoccurrence.
23	Restricted Workday Case (RWC)	A work-related injury or illness that results in limitations on work activity that prevents an individual from doing any part, or all, of their job for any part of the day.
24	Return of Experience (REX)	A summary of a HSSE event including details of: what happened, and how and why it happened; the root causes and recommendations; and the key learnings.
25	Security Breach	Any event that impacts the security of personnel, assets, confidential information or business continuity arising from terrorism, political or social upset, organized crime.
26	Subject Matter Expert (SME)	Individuals that are competent to provide advice and guidance in a particular field of activity (e.g. control and automation; electrical, rotating and static equipment etc.).
27	Unsafe Act	Something a person did that could have resulted in a near miss or an incident but there was no actual event.
28	Unsafe Condition	A situation which if allowed to continue, could lead to a near miss or incident but there was no actual event.
29	Vehicle Accident	Any incident involving a vehicle being driven on QAPCO premises, or business activities, by an employee, contractor or visitor.
30	Why Tree	A technique for identifying the root causes of events and the associated

		contributing factors. They are built by defining the undesirable event at the top and then branching off with the facts associated with the event.
31	QAPCO	QAPCO managed facilities which include QAPCO, Qatofin, QVC

9. Revision History

Rev #	Date	Section No.	Reason for revision / modification
01	15 th April 2022	All	<ul style="list-style-type: none"> • Complete Procedure has been changed. Title of procedure changed to "Investigation and Reporting of HSSE Events" • Changed procedure number from PR-PSS-110 to PR-SO-01. • Requirement to investigate all safety observations has been removed. • Investigation type (detailed or simplified) defined based on severity • Flowcharts added for reporting and classification of events • Events classified by type, category and the severity of the consequences • Direct Cost element of PSE Tiers excluded • Details of the SIRT composition and terms of reference updated • Requirement to investigate all safety observations has been removed. • Investigation type (detailed or simplified) defined based on severity