

Incident, Near Miss and Unsafe Condition Reporting and Investigation

Short description

This section defines the systematic process and reporting structure for the investigation of incidents, near misses and unsafe conditions including the methods used to determine the root causes of incidents and near misses that create the opportunity for potential and real loss creating events.

Contact person

Andrew Richardson

Name

770-613-2999

Phone number

HSEQ

Functional Department

arichardson@cce-inc.com

Email address

Responsible

Brent LeVander

Name

HSEQ

Functional Department

Approval

Geoff Preisman

Name

President and CEO

Title

Content

1	Objective and area of application	3
2	Superior and additional applicable documents	4
3	Definitions.....	4
4	Incident investigation and reporting process	5
4.1	Incident reporting	5
4.1.1	Incident description and details.....	6
4.1.2	Contributing factors for incidents.....	6
4.2	Root cause analysis	7
4.2.1	RCA comprehensive.....	8
4.2.2	RCA light.....	8
4.3	Active	8
4.3.1	Accessing the Active system	9
4.3.2	Opening a new case in Active.....	9
4.3.3	Where and what section	10
4.3.4	General classifications.....	10
4.3.5	Consequences	11
4.3.6	Loss potential	12
4.3.7	Causes.....	12
4.3.8	Actions	12
4.3.9	Save case	13
4.3.10	Case review	13
4.3.11	Near Miss and Unsafe Condition Reporting	13
5	Personnel conducting incident investigations	13
6	Lessons Learned.....	14
7	Safety Alerts.....	14
8	Amendment history.....	15
9	Appendix.....	15

1 Objective and area of application

HSEQ incident, near miss and unsafe condition investigation is necessary to identify the root cause(s) of incidents that have potential to create loss or produce negative impact to HSEQ operations. The term incident is inclusive of accidents, near misses, environmental release or negative impact, and quality defects including the degradation of reputation and will be referred to as “incident” throughout this section. Removal of causal factors in the chain or sequence of events will often eliminate an incident. An effective incident investigation of these causal factors can establish the mechanism or management change process to prevent future incidents, thus increasing productivity, improving morale, and reducing the direct and indirect cost of HSEQ incidents. This procedure outlines the framework and process for investigating HSEQ incidents.

The investigation of incidents is an essential procedure that may drive the implementation of process changes, behavioral changes, or other systematic HSEQ changes that can prevent recurrence of incidents from similar causes. The surface causes of an incident may only be a symptom of an underlying problem or latent failure (root cause) in the HSEQ management system which needs to be evaluated as part of the systematic process of continuous improvement.

Once the underlying or root cause(s) of an incident have been investigated and identified, a corrective action plan will be established to correct any behavior or HSEQ management system failures or gaps. Traditionally, incidents that resulted in recordable injuries, restricted duty, lost time, significant impact to the environment, cost related warranty issues/rework or high value property damage have been investigated. However, incidents are preceded by warning signs or indicators and should be investigated to prevent a more severe consequence and potential future incidents. Therefore, it is imperative that causal factors and behaviors are properly identified and effectively investigated in order to examine if changes to process, behaviors or the HSEQ management system are necessary. An incident investigation should be initiated immediately after an incident is identified.

Incident investigations apply to all Centennial projects and operations and are grouped into the following categories:

- Personal injury (first aid only)
- Personal injury (medical treatment)
- Property damage
- Motor vehicle incident
- Near miss
- Quality
- Environmental
- Unsafe Condition

2 Superior and additional applicable documents

1000_GP_11_01_en_7.0 Group Policy on Health, Safety, Environment and Quality (HSEQ)

This section of the HSEQ Manual applies to all Centennial employees and subcontractors who are performing work in Centennial facilities and project sites. There may be more stringent requirements than this section as defined by specific State, local or contract specific incident or near miss requirements. If there is a conflict between this section and other applicable regulations, the more stringent will apply.

3 Definitions

The following definitions of terms are important for an understanding of this section.

Term	Definition
Centennial	All Centennial employees, joint venture employees, subcontractors, and business partners
Incident	HSEQ event with negative or potential negative (direct or indirect) impact. An incident can lead to numerous consequences.
HSEQ	Health, Safety, Environment and Quality
Near miss	An event (incident) which had the potential to cause injury and/or damage and/or loss, but which was avoided by circumstances.
Consequence	Impact of an incident
Corrective action	An action implemented to correct the hazard or other undesirable condition in order to prevent recurrence.
MVI	Motor vehicle incident
PDCA	The plan, do, check, act process for continuous improvement.
Active	Web-based HSEQ management software for reporting incidents
PSO	Project Safety Officer
Severity	Each consequence of an incident will be divided into 5 severity levels. Severity level "1" is the highest severity level. The most serious single consequence determines the severity level of the entire incident.
SSR	Senior Site Representative
RCA	Root Cause Analysis

Root cause analysis	Standardized method/process of investigation to determine the underlying causes of an incident.
PEX	Project Executive
HSEQ Director	Leads the HSEQ Team
Unsafe Condition	Something exists that varies from the normal safe condition and can result in injury, death, property damage or environmental discharge.

4 Incident investigation and reporting process

The Centennial incident investigation and reporting process is designed to determine root causes and the chain of events leading to an incident. This process is managed by implementing the PDCA process for continuous improvement.

The Centennial procedure for incident investigation includes processes for:

- Obtaining medical treatment if necessary
- Securing the work area/suspend operation
- Reporting incidents to relevant organizational parties and structure
- Organizing and preserving the incident scene
- Documenting and recording details regarding the incident
- Investigating the incident or near miss to determine root causes
- Analyzing the impact(s) and the potential risk of future incidents
- Managing corrective action process to prevent recurrence
- Following up to ensure that corrective action is sufficient for preventing recurrence
- Completing all action items

4.1 Incident reporting

The Centennial internal process and structure for reporting an HSEQ incident shall be followed in accordance with the Administrative Manual section 1.6 Reporting Policy and the Centennial Incident Reporting Procedure (Appendix 3). All Centennial or subcontractor incidents must be reported to Centennial project site personnel and the following personnel in accordance with the Centennial Incident Reporting Procedure and include:

- Regional HSEQ Manager and SSR
- PEX, HSEQ Director, Legal and Executive Management
- Customer and Regulatory agencies (if required)

The Incident investigation Report (Appendix 1) shall be reviewed by the HSEQ team and legal prior to being finalized. Once finalized, the HSEQ team and legal will have approval authority on the final version of the Incident Investigation Report. Final, approved reports shall be stored

confidentially. Each incident shall have a Case Manager assigned and in most cases this will be the Regional HSEQ Manager.

Motor vehicle incidents shall follow the incident reporting procedure as described above but shall be documented on the Motor Vehicle Incident Report (Appendix 2). If an employee is involved in a motor vehicle incident while operating a rented vehicle or a Centennial owned/leased vehicle, the employee is responsible to notify either the Corporate Rental Liaison or Fleet Manager as appropriate.

4.1.1 Incident description and details

The details of the incident should be factual and relevant. These should include the exact time and location of the incident, the circumstances which preceded the incident, the sequence or chain of events of the incident itself, the numbers, names and contact details of personnel involved including the supervisor, and the names and contact information of any witnesses present. Incident investigators will gather all pertinent information of the incident that is relevant and will assist in determining the root cause of the incident.

Items that should be included with the completed incident report include:

- Photographs (multiple angles)
 - Panoramic view(s)
 - Close up shots of specific relevant items or to demonstrate scale
- Witness statements and interviews
- Sketch or diagram of the work area
- Police report (if a motor vehicle incident)

If additional support or clarification is needed regarding the incident report process or procedure, contact the Regional HSEQ Manager.

4.1.2 Contributing factors to the incident

When determining corrective actions to prevent recurrence, it is helpful to analyze the contributing factors that led to the incident occurring. Contributing factors are separated into the categories listed below:

- Work procedures: were actual work procedure(s) at the time of the incident investigated to answer questions such as:
 - Were work-procedures used which are consistent with Centennial HSEQ policies and procedures, or federal, state, or local regulations?
 - Had conditions or methods changed to make the procedure inconsistent with Centennial HSEQ policies and procedures or federal, state, or local regulations?
 - Were changes to conditions or procedures assessed for increased or new risk? If so, was a revised AHA completed?
 - Were procedures adequate and consistent to ensure product or work integrity and limit defects?
 - Were work procedures adequate to limit environmental impact?

- **Materials:** were possible causes of the incident a result of equipment and/or materials used? Incident investigators may ask:
 - Was there an equipment or tool failure?
 - Were hazardous substances or chemicals involved?
 - Was the material substandard or non-compliant?
 - Should personal protective equipment (PPE) have been used?
 - Was adequate PPE used?
 - Were users of PPE adequately trained?
 - Were materials chosen and used to limit environmental impacts?
- **Environment:** The physical environment is a factor that must be considered during the incident investigation. For example, incident investigators may want to know:
 - What were the weather conditions?
 - Was poor housekeeping a problem?
 - Was it too hot or too cold?
 - Was noise a problem?
 - Was there adequate light?
 - Were toxic or hazardous gases, dusts, or fumes present?
- **Human Factors:** The physical and mental condition of those individuals directly involved in the incident must be investigated. Incident investigators should determine:
 - Were workers experienced in the work being done?
 - Had they been adequately trained?
 - Can they physically do the work?
 - Was fatigue a factor?
 - Were they under stress (work or personal)?

4.2 Root cause analysis

A root cause analysis (RCA) shall be carried out for all incidents according to the following description. The objective of the RCA is the identification of appropriate and necessary corrective and preventive measures. Thereafter, updates/adjustments of the risk assessment and implementation of measures shall be carried out.

In addition to an Incident Investigation Report, a Root Cause Analysis shall be completed for any incident greater than a level 5 (levels 1-4) incident in accordance with this section. Root cause analysis shall be conducted by a member of the HSEQ team and may include the following team members:

- PSO
- Regional HSEQ Manager
- HSEQ Director

Depending on the severity level or the potential risk, the responsibility for conducting a root cause analysis (RCA) is assigned as follows:

Responsible for RCA	Severity Level	Investigation Timeframe	Potential Risk
HSEQ Director	1 & 2	Immediate	Red
Regional HSEQ Manager	3	<24 hours	Yellow
Regional HSEQ Manager/PSO	4 & 5*	<24 hours	Green

*RCA not mandatory for level 5 incidents.

Root cause analysis shall be completed according to the severity level shown below:

	1	2	3	4	5
RCA Comprehensive	x	x	x		
RCA Light				x	

4.2.1 RCA Comprehensive

For significant (level 1-3) HSE incidents it is mandatory that the RCA is carried out using the following methods:

- TapRoot

For quality incidents, the RCA is carried out using one of the following methods:

- Tripod
- Kepner
- Tregoe
- 5 Why
- 8D
- Ishikawa
- Failure Mode Effect Analysis (FMEA)

The results of the RCA are then documented in ACTIVE with the key words of the “causes” section. The document of methods used is to be added to ACTIVE.

4.2.2 RCA Light

The Root Cause Analysis (RCA) Light (Appendix 4) shall be used for level 4 and 5 (RCA not mandatory for level 5 incidents but may be investigated as desired) incidents to document this procedure.

4.3 Active

All incidents will be reported according to the process of section 4.1 of this section and subsequently input into the Active HSEQ risk management software program by an authorized Active user. Personal sensitive information (such as name with specific information on injuries) shall not be entered into Active. Centennial employees who are authorized and may have been trained and authorized to input incidents into the Active system may include Centennial:

- Regional HSEQ Manager
- HSEQ Director
- Chief Information Officer
- HSEQ Executive

All Active actions, processes and user responsibilities will be conducted in accordance with the Bilfinger Global Standard on Administration and Utilization of the HSEQ Management Software ACTIVE. The specific topics covered by this section include:

- Administrator and user responsibilities
- Administration of users and cases in Active
- Required and optional documentation
- Communication and training

The Active HSEQ management software assists with many features of incident management and is designed to report, record and track incidents while providing risk measurement and assessment based on the actual consequences of the incident.

The specific functions of Active assist in:

- Reporting of incidents by category, near misses, unsafe conditions etc.
- Providing a risk matrix with “traffic light” style indicators of red-high, yellow-medium, and green-low risk cases
- Documentation of the impact of loss and consequence details
- Identifying preventive, corrective, and temporary actions – due dates and assignment of responsible parties
- Providing the ability to attach investigation documents – statements, pictures, videos, and any kind of document
- Email distribution of notifications, alerts, reminders, and key lessons learned

The timeframes for registration of cases in Active are as follows:

- Level One < 3 hours
- Level Two < 12 hours
- Level Three < 24 hours
- Level Four < 48 hours
- Level Five < 48 hours

4.3.1 Accessing the Active system

Active can be accessed from any office or through the corporate server. Access is granted by the Active Administrator on the Bilfinger HSEQ team and can be requested with permission by the Centennial HSEQ Director. The Centennial IT Department can assist once access is obtained.

4.3.2 Opening a new case in Active

Select the appropriate option from the “Register a New Case” frame in the upper left of the screen and select from the following options:

- HSE Incident - Accident
- HSE Incident - Near Miss
- HSE - Unsafe Condition
- Quality Management - Non-conformance
- Exposure hours - work hours

Enter the following information in the “new case” section:

- In charge of case (click on the add link, then in the pop-up screen enter):
 - Unit in charge- Use the pick list to expand Centennial Contractors and then expand to the applicable region, office, and contract
 - Person in charge- Use the pick list to select the Active user who is responsible for the case
 - Press the “OK” button
 - Select “Registered” as the case status
 - Click on “Continue Editing Case After Save” link and proceed to the “Where and What” section

4.3.3 Where and what section

Enter the following information into the “Where and what” section:

- Date: select the date that the incident occurred by clicking on the icon to the right of the “date and time” field
- Time: manually enter the time that the incident occurred in the following format
 - Two-digit hour
 - Two-digit minute
 - AM or PM
 - Example: 02:45 PM
- Location: Use the pick list to expand “America” and select USA
- Title of the Active case
 - identify the parties involved in the incident
 - Centennial employee or asset
 - Subcontractor employee or asset
 - Client or customer employee or asset
 - Type of incident (in accordance with section 4.2.2 of this section)
 - Brief description of the incident
- Case description: provide an expanded description of the incident
- Select whether the authorities have been notified and/or the incident was investigated by the authorities having jurisdiction
- Responsible unit: Use the pick list to expand and select the Centennial unit that is responsible for the incident
- Reported by unit: Use the pick list to expand and select the Centennial unit that is reported the incident
- Reported by company: leave blank
- External customer: Click box at right to view pre-entered External Customers and select appropriate customer from list. If the External Customer is not found in the list, then select “not in list” and manually enter the customer’s name in the text box if applicable

- Contact person: manually enter the Centennial employee responsible for the Active case and their contact number

4.3.4 General classifications

Enter the following information into the “General classifications” section:

- Work processes: use the pick list to select the work process or processes that contributed or were taking place at the time of the incident
- Rules and regulations: use the pick list to select what types of rules and/or regulations were violated potentially leading to the incident (these may be internal, external or project specific)
- Equipment involved: use the pick list to select the type(s) of equipment that was involved or possibly contributed to the incident
- Hazard category of substance involved: use the pick list to select a substance that may have exposed personnel to a potential health hazard if applicable
- Company/companies involved: use the pick list to select the name of the company or companies involved in the incident
 - If the company or companies are not on the pick list, select the letter “N” and then select “Not in list” and manually enter the name of the company or companies in the text box

4.3.5 Consequences

Enter the following information into the “Consequences” section:

- Select “Add actual consequences” and choose the appropriate consequence and severity from the options in the table on the following page
 - The majority of consequence severities resulting from Centennial and subcontractor incidents will be level 4 or 5 categories
 - Any consequence severity resulting from a Centennial or subcontractor incident that is believed to be a level 1, 2 or 3 will be coordinated with the HSEQ Director prior to entry into Active
- Consequences cover accidents, property damage, environmental incidents, force majeure, actions taken by the client or authorities and impact on reputation. It is important to understand the different levels as some are quantitative (medical treatment received or dollar amount of damage) while others can be more subjective (impact on performance or dispute). The following chart depicts the different consequence categories and a brief explanation for each level.

Consequence and severity	Level-1	Level-2	Level-3	Level-4	Level-5
Personal injury	Fatal	Serious with possible permanent injury	Serious personal injury (includes lost time & restricted work cases)	Injury requiring medical treatment	First aid injury
Defects on equipment or products	>1 million (euro)	>500,000 (euro)	>100,000 (euro)	>10,000 (euro)	<10,000 (euro)
Discharge to the environment	With major impact to environment or public health	With minor impact to environment or public health	Into open secondary containment	Into closed secondary containment	With no impact to environment or public health
Force majeure classification	Major impact on performance /business (sabotage, crime, natural disaster, or strike)	Middle impact on performance/ business (sabotage, crime, natural disaster, or strike)	Minimal impact on performance/ business (sabotage, crime, natural disaster, or strike)	Local impact on performance/ business (sabotage, crime, natural disaster, or strike)	No impact on performance /business (sabotage, crime, natural disaster, or strike)
Action by client	Termination of all business	Project shut down	Work shut down	Equipment or work not approved	Persons stopped from working
Action by authorities	Termination of all business	Project shut down	Work shut down	Equipment or work not approved	Persons stopped from working
Impact on reputation	Media interest	Top client/authority dispute	Client/authority impact	Stakeholder (except client or authority) dispute	Local minor issue

4.3.6 Loss potential

Use the “Possible further consequence” matrix provided to express the appropriate severity and frequency of the incident.

4.3.7 Causes

Enter the following information into the “Causes” section:

- Manually enter as complete a description of the incident causes as possible into the “Cause description” text box provided

- Selected causes: use the pick list to select the appropriate cause(s) of the incident (more than one cause may be selected). Note that the Selected Causes is a mandatory information box

4.3.8 Actions

Enter the following information into the “Actions” section

- Select “Add action” from the “Actions” section
- Select an action from the “Type” drop-down menu. Options are:
 - Immediate
 - Corrective
 - Preventative
- Deadline: select the date that the action has or will be completed by clicking on the icon to the right of the “Deadline” field
- Completed: select the date that the action was completed by clicking on the icon to the right of the “Completed” field
- Responsible unit: use the pick list to assign the responsible unit for the action
- Action description: manually enter a description of the action that will be or have been taken to ensure that the incident does not re-occur
- Comments: manually enter any additional comments regarding the action
- Description of changed or new risk: manually enter a description of any changed or new risk due to implementation of the action
- Select a status of the action from the list. Options are:
 - Proposal
 - Implementing
 - Cancelled
 - Completed
- Active user responsible for action: use the pick list to assign the Active user who is responsible for the action
- Other person responsible for action: manually enter any other person who may be responsible for overseeing implementation of action(s) in the text box provided
- Use the drop-down menu to select whether the action leads to new or increased risk
- Use the drop-down menu to select whether the action has led to the expected results

4.3.9 Save case

At this time it is appropriate to review the information entered into the Active case and select “Save case” tab in the upper right section of the screen. Once the Active case is saved, the case can not be deleted from the system.

4.3.10 Case review

The process and disposition for the review and approval of a new case that is entered into the Active software is as follows:

- Active user enters the case and saves the case in a “Registered” status
- The HSEQ Director reviews the case and the case is changed to “Processing” status

- The HSEQ Executive reviews the case and is the approval authority. Once the case is reviewed by the HSEQ Liaison and is acceptable, the case will be changed to “Approved” status
- When all activity of the case has been concluded, the HSEQ Liaison will Close the case.
- Note that if additional information or documentation about the case becomes available in the future, the case may be opened for edit, the information or documentation added, and the case closed again.

4.3.11 Near Miss and Unsafe Condition Reporting

One of the most important factors in preventing incidents is the capture of Near Misses and Unsafe Conditions. These are events that could have led to an incident but did not this time. It is extremely important that these are reported and discussed by the organization so we can prevent a potential incident from occurring in the future. The process for reporting a Near Miss or an Unsafe Condition is less involved than a standard incident and should be conducted as follows:

- Responsible Superintendent, PSO or any employee becomes aware of a Near Miss
- The Near Miss/Unsafe Condition Report (Appendix 5) shall be uploaded into Procore and distributed to the Regional HSEQ Manager and SSR
- The Regional HSEQ Manager will discuss with the PSO to ensure all necessary details are captured. Any questions will be discussed with the reporting employee
- The Regional HSEQ Manager will share the necessary details within the organization

5 Personnel conducting HSEQ incident investigations

HSEQ incident investigations will be conducted by trained Centennial employees who are knowledgeable of incident investigation processes, procedures, human factors, and environmental aspects of the incident. This may include a:

- Project Manager
- Superintendent
- Project Safety Officer
- Regional HSEQ Manager
- QC Inspector
- QC Manager
- HSEQ Director
- Any other HSEQ staff member

6 Lessons Learned

The HSEQ Director and/or Regional HSEQ Manager will create a Lessons Learned document to be shared within the company. The Lessons Learned template shall be used for all level 1-4 incidents and a copy is to be sent to the HSEQ Director. Lessons learned are to be distributed to the other Bilfinger groups for information sharing at the discretion of the HSEQ Director.

7 Safety Alerts

The Centennial HSEQ Director will compile a one-page safety alert for significant incidents Level 1-3 to be shared with other Bilfinger groups. All safety alerts will be distributed to the other groups within 24 hours of the incident for immediate review and reapplication.

8 Amendment history

Date	Version	Revised content
29.01.2014	1.0	Initial Preparation
12.01.2015	1.1	Revision to paragraph 4.1 on incident reporting and Appendix 3 Centennial Incident Reporting Procedure
07.01.2016	1.2	Addition of paragraph 4.2 Root Cause Analysis
05.23.2017	1.3	Revision of RCA program in paragraph 4.2 and timeframes in paragraph 4.2.1, revision of timeframes in paragraph 4.3.5, addition of Appendix 5.1 "Lessons Learned", addition of paragraph 6 Lessons Learned, addition of paragraph 7 Safety Alerts
01.01.2018	2.0	Updates to Paragraph 2 Superior Documents (add the Group Policy and Global Standards), Paragraph 3 Definitions (Centennial and HSEQ Director), Paragraph 4.1 Incident Reporting (reporting), Paragraph 4.2 Root Cause Analysis (responsibility and requirement), Paragraph 4.3 Active (authorized), Paragraph 4.3.1 Accessing the Active system (procedure), Paragraph 4.3.5 Consequences (categories), Paragraph 4.3.10 Case review (process), Paragraph 6 Lessons Learned (removal of Appendix 5), Paragraph 7 Safety alerts (removal of Appendix 5) and Appendices 1-4 (logo)
04.01.2019	2.1	Creation of Paragraph 4.3.11 Near Miss Reporting and Appendix 5
10.01.2019	2.2	Update to Superior Documents
01.01.2020	2.3	Updates to Section Title (added Unsafe Condition), Paragraph 2 Superior Documents, Paragraph 3 Definitions (added Unsafe Condition), Paragraph 4.3.11 (added Unsafe Condition) and Appendix 5.1 (added Unsafe Condition)
11.01.2021	2.4	Updates to Paragraph 4.1 Incident Reporting (addition of Case Manager language)
04.01.2022	2.5	Update to Paragraph 2 Superior Documents (Group Policy version), Paragraph 4.1 Incident Reporting (simplified) and Appendix 3.3 Incident Reporting Procedure (updated positions)
01.02.2026	2.6	Update typo in Paragraph 4.1 Incident Reporting. Update 4.3.11 to include uploading the Near Miss/Unsafe Condition Report form into Procure. Replace references to ROMs with PEXs throughout.

9 Appendix

Appendix 1: Incident Investigation Report (0206500_CP_11_08_en_A1.1)

Appendix 2: Motor Vehicle Incident Report (0206500_CP_11_08_en_A2.1)

Appendix 3: Centennial Incident Reporting Procedure (0206500_CP_11_08_en_A3.3)

Appendix 4: Root Cause Analysis (RCA) Light (0206500_CP_11_08_en_A4.1)

Appendix 5: Near Miss/Unsafe Condition Reporting Form (0206500_CP_11_08_en_A5.1)



1. Contract Name and Number:		2. Project Name and Number:		3. Employer/Company:	
4. Incident Classification:					
5. Date of Incident:		6. Date Reported:		7. Time of Incident:	
				8. Who Was Notified?	
9. Specific Location of Incident:				10. First Report of Injury Completed:	
11. Name of Individual:		12. Regular Occupation:		13. Occupation at Time of Incident:	
14. Individual's Start Time:		15. Individual's Telephone Number: Home: Work:			16. Duration of Employment:
17. Individual's Supervisor:			Supervisor Phone Number:		18. Supervision Status at Time of Incident:
19. Was Individual trained to perform task at time of Incident:			20. Experience: Number of Years:		
21. Phase of Workday at Time of Incident:					
22. Individual was working with:					
23. Did Individual return to work:			24. Transport to Medical Facility:		
25. Type of Incident:		26. Type of Injury:		27. Part of Body Injured:	
28. Describe how the incident occurred (attach a sketch):					
29. Specify machinery, tools, substance or object connected to incident:					
30. Was Individual using the required PPE:		31. Trained for Use:		32. Has the Individual taken a Drug Test: Date Scheduled:	
33. Describe corrective plan to prevent reoccurrence or to resolve a quality issue (machine modification, mechanical guarding, environment, training):					
34. Report Date:		35. Investigated by:			
36. Additional comments on incident (This section to be completed by PSO or SSR):					
37. For Quality Incidents, what type of incident occurred (specification or code nonconformity, product failure, etc.) and who first reported the issue?					
38. PSO Signature:		39. Date:		40. CSM Signature:	
				41. Date:	

MOTOR VEHICLE INCIDENT REPORT

0206500_CP_11_08_en_A2.1

Instructions: Complete the Motor Vehicle Incident Report below in the event of a accident / incident involving vehicles. Ensure that your supervisor has been notified of the incident prior to completing this report.

 Employee Name: Date:

General Information

 Date of incident: Time of incident:

Type of incident (choose all that apply):

<input type="checkbox"/> Personal Injury	<input type="checkbox"/> Fire	<input type="checkbox"/> Other (explain below)
<input type="checkbox"/> Property Damage	<input type="checkbox"/> Fatality	<input type="text"/>
<input type="checkbox"/> Sideswipe	<input type="checkbox"/> Rear End	<input type="checkbox"/> T-bone
<input type="checkbox"/> Single Vehicle Incident	<input type="checkbox"/> Roll-Over	

Location of incident (be specific with cross streets / intersections):

 What type of traffic control devices where present: N/A

Road conditions:	Lighting conditions:	Weather conditions:	Posted speed limit:
<input type="checkbox"/> Dry	<input type="checkbox"/> Daylight	<input type="checkbox"/> Clear	<input type="text"/> mph
<input type="checkbox"/> Wet	<input type="checkbox"/> Dawn /dusk	<input type="checkbox"/> Fog	Traveling at what speed:
<input type="checkbox"/> Icy / snow	<input type="checkbox"/> Night / dark	<input type="checkbox"/> Rain / Snow	<input type="text"/> mph

Company / Employee Vehicle Information

 Year / make / model: Vehicle Color:

 VIN #: License Plate # / State:

 Owner name / address / phone #:

 Driver name / address/ phone #:

 Driver's License #: State: Driver DOB:

 Driver/occupant injured? ☐ Yes ☐ No First report filed? ☐ Yes ☐ No

 Injuries sustained (if applicable):

 Transported to hospital? ☐ Yes ☐ No Hospital name:

 Driver on a mission for employer? ☐ Yes ☐ No Seat belts used? ☐ Yes ☐ No

 Describe mission:

 Parts of vehicle damaged:

 Passenger in vehicle? ☐ Yes ☐ No Passenger Name:

 Passenger injured? ☐ Yes ☐ No Describe Injury:

Additional Vehicle(s) Involved

 Year / make / model: Vehicle Color:

 VIN #: License Plate # / State:

 Owner name / address / phone #:

Insured?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ins. Company name:		
Ins. agent name:		Ins. policy number:		
Driver name / address/ phone #:				
Driver's License #:		State:		Driver DOB:
Driver/occupant injured?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Traveling at what speed:		mph
Were individuals from the other car involved taken to the hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Parts of vehicle damaged:				
Restrictions on driver's license?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Driver in conformance to restr.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Explain if needed:				
Passenger in vehicle?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Passenger Name:		
Passenger injured?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe Injury:		

Miscellaneous Information

Witness name / phone #:	
Witness name / phone #:	

Draw sketch of vehicles at time of incident (indicate North with arrow):

Key: Label streets, show traffic controls, show/label vehicles, indicate directions.

Street name & direction you were traveling:				
Street name & direction other vehicle was traveling:				
Skid marks by Centennial employee?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Length		feet
Skid marks by other vehicle(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Length		feet
Were vehicle(s) towed from the scene? (if yes, indicate which)	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Centennial/Employee Vehicle	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Parties' Vehicle	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Location towed to:				
Were vehicle(s) drivable from the scene? (if yes, indicate which)	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Centennial/Employee Vehicle	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Parties' Vehicle	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Police Department Investigation / Report

Department:		Officer's name:	
Contact info / #:		Badge number:	
Police Report Number:		Citations Issued:	

Statement

Give a brief description of the incident:

I hereby declare that the facts as stated above are true:

Driver name:

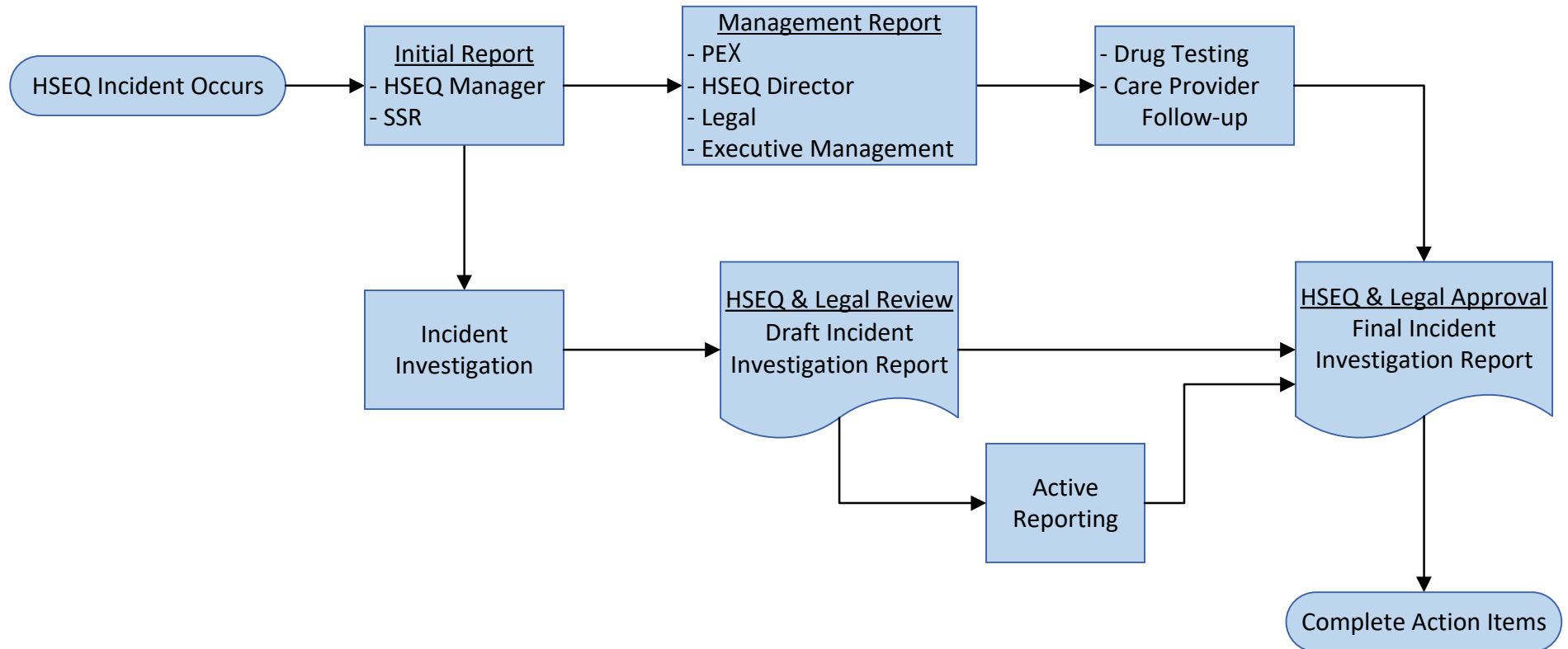
Date:

Supervisor name:

Date:

Centennial Incident Reporting Procedure

0206500_CP_11_08_en_A3.3



Root Cause Analysis (RCA) Light

0206500_CP_11_08_en_A4.1



Instructions:

Please respond to the following questions after each incident. If a question is answered with "yes", corrective and preventative measures are necessary.

1	Did a lack of clarity with regard to the task and distribution of competences contribute to the incident?	Yes	No
2	Did insufficient instruction or a lack of training contribute to the incident?	Yes	No
3	Did communication difficulties between those involved contribute to the incident?	Yes	No
4	Did missing or insufficient working instructions, safety rules or labeling contribute to the incident?	Yes	No
5	Did a failure to follow working instructions, safety rules or labeling contribute to the incident?	Yes	No
6	Did inappropriate or defective working materials (eg. Tools/equipment) contribute to the incident?	Yes	No
7	Did insufficient maintenance or repairs (eg. Structures/plants/working materials/tools) contribute to the incident?	Yes	No
8	Could the incident have been avoided if the proper personal protective equipment (eg. protective glasses/fall-protection) had been correctly worn and maintained?	Yes	No
9	Did missing, defective or insufficient protective equipment contribute to the incident?	Yes	No
10	Were the operations previously aware of the danger that led to the incident?	Yes	No
11	Did the incident occur despite the fact that measures to prevent this incident had been previously taken or mandated?	Yes	No
12	Have you found any inadequacies in the emergency organization?	Yes	No
13	If fire played a role in the incident: Have you found any inadequacies in the fire protection measures?	Yes	No
14	Did employees ever draw attention to the danger that led to the incident?	Yes	No
15	Did deficiencies in the design of the workplace and the work process contribute to the incident?	Yes	No
16	Did the condition of the injured party (eg. physical or psychological burden/fatigue/influence from medications or alcohol) contribute to the incident?	Yes	No
17	Did climatic influences (eg. Heat/cold/wet) contribute to the incident?	Yes	No
18	Did visibility conditions (eg. Darkness/glare/fog/smoke) contribute to the incident?	Yes	No
19	Did hazardous materials contribute to the incident?	Yes	No

Additional information, comments, notes or explanations (use space below):

Near Miss/Unsafe Conditions Report

0206500_CP_11_0 8_en_A5.1



☐ Near Miss ☐ Unsafe Conditions

Date: _____ Time: _____

Centennial Office: _____

Name of Contact Person: _____

Witness(es): _____

Location:

Who and/or What was involved:

Description (include Photos, if available):

Suggestion(s) for Improvement:

******Send this report to your Regional HSEQ Manageronly******