1.0 PURPOSE

Takla Nation shall implement processes to determine and manage the consequences of incidents including notification, investigating, reviewing, and reporting. The purpose of this policy is to:

- prevent similar incidents in the future
- fulfill legal requirements
- determine the costs of an incident
- support continuous improvement.

2.0 SCOPE

Takla Nation shall conduct investigations of all incidents occurring at appropriate jobs and work activities which are authorized by the Organization at their various business locations. They shall seek to determine the root causes of each incident and make recommendation to remediate each root cause.

3.0 RESPONSIBILITY

Leadership (Managers and Supervisors) have the prime legal imperative to investigate incidents and remedy their causes.
Safety Representatives are not accountable for this process. However, they are required to attend, and expected to be a qualified resource for the identification of root cause during the review of incidents. They are responsible for reporting on trends, and making recommendations for OHS program improvement.

The Department Manager is accountable to ensure that:

- all incidents are investigated,
- the correct root cause is identified, and
- effective recommendations for improvement are implemented,

The Supervisor is responsible to:

- investigate all incidents in the field,
- conduct a root cause analysis and
- submit reports to the Department Manager.

The Safety Representative is responsible to:

- participate in all field investigations and make observations, interview witnesses, collect and store all data, evidence, etc.
- participate in all formal incident reviews and assist in the identification of root cause.
- assist the Supervisor in developing reports for submission to Management.
- maintain a database of all incidents and their associated factors and results.

The JHSC Representative is responsible to:

- participate in all field investigations and make observations.
- participate in all incident reviews and assist in the identification of root cause

4.0 DEFINITIONS

The term “incident” can be defined as an occurrence (unplanned event) arising in the course of work that resulted in - or could have resulted in - injuries, illnesses, damage to property, or damage to the environment.

5.0 RELATED DOCUMENTATION

Health & Hygiene – Injury Management

6.0 INCIDENT INVESTIGATION PROCEDURE

6.1 Incident Notification

a. Incident notification is the act of physically contacting the Organization leadership positions who are accountable to be informed, and to investigate, any incident. This will normally be done by mobile phone or radio.
b. Notification within the Organization is expected to occur within five minutes of the incident, taking into account any emergency response actions which must be done first.
c. All incidents will be reported immediately to the direct Supervisor or designated Organization Representative. The Supervisor shall then notify the site OHS Representative and appropriate levels of Management as per the protocol.

NOTE: Notification of an incident - and leadership of the investigation - is based on severity.
Example: A worker falls from height, appears seriously injured, and an ambulance is called to transport them to the hospital. It is quickly determined that it is most likely going to be a Lost Time Injury. The severity is high; therefore, the Supervisor immediately calls and reports the injury to the Department Manager, and requests their attendance at the field investigation.

d. The following table is used to determine the appropriate Organization position that should be informed, relative to the severity of the incident. That position is also responsible to lead the investigation.

Table 9-1

Protocol for Incident Notification and Investigation Team Lead	
Incident Level	**Investigation Lead**
Fatality (FT)	Senior Manager and selected team
Lost-time injury/illness (LT)	Department Manager and selected team
Restricted Work injury/illness (RW)	Supervisor/Foreman
Medical Treatment Injury/illness (MT)	Supervisor/Foreman
First Aid Injury/illness (FA)	Supervisor/Foreman
Occupational disease (OD)	Health Director and Safety Officer
Fire, Property damage less than $5K	Supervisor + Fire Chief/ Emergency Services Manager
Fire, Property damage $5K – $100K	Senior Manager + Department Manager + Fire Chief

Fire, Property damage greater than $100K	Senior Manager and selected team + Fire Chief
Near Miss (NM+) with major potential (FT, LT)	Department Manager
Near-miss (NM) serious potential (RW/MT)	Department Manager
Environmental incident (ENV)	Environmental Representative (Environmental Monitor?)
Exposure to biological, chemical or physical agent (OCC)	Health Director and Safety Officer
NOTES: The Safety Officer shall attend all Incident Investigations NOTE: A member of the JHSC shall be invited to attend where possible NOTE: Contractor Supervisors shall attend if a contractor is involved	

e. WorkSafeBC shall be notified immediately (using the Prevention Information Line) in the event that the following significant incidents should occur:
   - Any incident that kills or seriously injures a worker
   - A major leak or release of a dangerous substance
   - A major structural failure or collapse of a structure, equipment, construction support system, or excavation
   - A fire or explosion that had a potential for causing serious injury to a worker

f. Communication of significant incidents to WorkSafeBC shall only be issued by the Senior Manager of the Organization.

g. If a worker gets medical treatment from a doctor or other qualified practitioner, due to a work-related injury or disease, it must be reported to WorkSafeBC using a Form 7.

h. If a Prime Contractor has been declared at an Organization site, then the Prime Contractor is accountable to notify the Organization immediately, investigate all incidents and submit a report as per Organization procedure.

6.2 Incident Field Investigation

a) After notification, designated Organization leadership personnel must immediately proceed to the field location of the incident and investigate all reported occurrences. Persons attending should include:
   - Representatives from the department responsible for supervising the activity.
   - The Safety Officer must attend all incident investigations.
   - A member of the Joint Health and Safety Committee from the Workers representatives.
   - Applicable representatives from health, environment, hygiene and security, as required by the nature of the incident.
   - Other trade and/or discipline specialists such as engineer, fireman, electrician, instrumentation, lifting superintendent, maintenance, operations, etc. as required by the nature of the incident.

b) Leadership of the investigation will be based on the severity of the incident as per Table 9-1 Incident Notification and Investigation Team Lead.

c) The incident field investigation must begin as soon as possible after the scene has been secured and a determination has been made that it is safe to proceed with the investigation.

d) Organization personnel who are responsible for the field investigation shall proceed immediately to the scene.

NOTE: A field investigation of an incident is considered a priority over any other normal work.

e) The Supervisor will assess the scene and control potential secondary incidents as well as evaluate the area for any other potential loss.

f) Whenever appropriate, the Supervisor will suspend all activity in the area and the incident area will be preserved until it is determined that all evidence has been documented and there are no regulatory requirements for further preservation.

g) Methods to be used to gather information and data for the Formal incident review may include:

- Interviewing victims, workers, supervisors, and other witnesses. Statements of interviewed witnesses shall be recorded and signed by them.
- On-site observations, measurements and assessments;
- Taking of photographs, videos, tape recordings,
- Copies of documents associated with the work such as Tool Box Talks, Job Hazard Assessments, work permits, training certificates, licenses, drawings, injury reports, etc.

h) In the event that the incident is reportable to WorkSafeBC, the conditions of the incident scene shall not be disturbed unless:

- you have to attend to someone who has been injured or killed;
- you have to take some action to prevent further injuries;
- you have to protect property that is endangered as a result of the incident;
- you have been given permission to do so by a WorkSafeBC officer or a peace officer.

6.3 Interim Report of Incident

a) An interim report shall be completed by the Investigation Team Leader, with the assistance of the Safety Officer, and issued by the end of the day of the occurrence.

b) The Interim Incident Report form (Form 9-2) shall be used.

NOTE: The information recorded on the Interim Report Form is not final and shall be considered "best opinion" until the formal review is held.

c) The Safety Officer shall assist the Supervisor to complete the report and shall then draft an interim site communication for distribution to the workplace.

6.4 Incident Formal Review

a) The investigation Leader (as per Table 9-1) Incident Notification and Investigation Team Lead) is responsible to schedule a Formal Review within 3 working days of the incident occurrence. This includes booking a conference room and sending invitations to all participants.
b) All field investigating personnel shall attend the formal review and they shall bring along any material information and data gathered from the field.
c) The Review Team should invite any experts or specialists that may be needed to clarify the facts, and should engage in consultations with suppliers, constructors, contractors, subcontractors, manufacturers, outside experts and other third parties as required.
d) The Review Team shall fairly and objectively consider the facts surrounding the occurrence of the event and determine:
    - An analysis of emergency response actions (if applicable)
    - the true sequence of events
    - the immediate causes
    - the root causes
    - corrective actions to remediate the root cause
    - the person responsible for the corrective action and its expected completion date.
e) The Review Team shall use the Systematic Causal Analysis Technique to determine Root Cause.
f) In the event of a Fatality, the SCAT analysis shall be supplemented with the use of a TapRoot system.

6.5 Incident Final Report

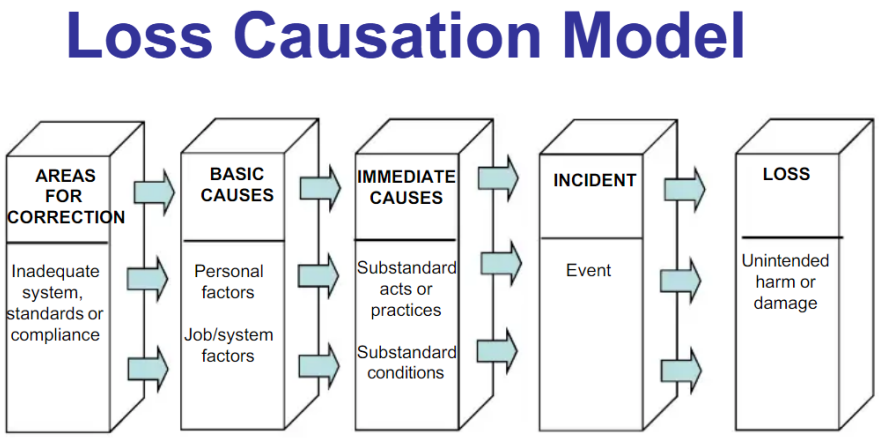
a) A Final Report shall be constructed which summarizes all the findings of the incident including the emergency response, field investigation, sequence of events, formal review and action log.
b) The Team Lead of the incident is responsible to sign and issue the Final Report of Incident within one week of the Formal Review. The Final Report must be co-signed by an OHS representative.
c) The OHS representative shall construct a Lessons Learned Bulletin, based on the findings, which shall be approved by Management and distributed to all stakeholders.
d) All actions arising from the Final Report shall be tracked for completion and the results reported to Management on a monthly basis.
e) OHS shall construct trend reports and summarize monthly and annually in order to support continuous improvement.

7.0 ROOT CAUSE ANALYSIS

7.1 Definition of Terms

a. Accident – An undesired event that results in harm to people, damage to property or loss to process.
b. Type of Contact – Various categories for the mechanism of an incident/injury
c. Near Miss– An undesired event that, under slightly different circumstances, could have resulted in harm to people, damage to property or loss to process.
d. Immediate Cause – The circumstances that immediately precede the accident.
   - Immediate causes may be broken down into two categories - substandard practices and substandard conditions.
e. Basic Cause/Root Cause – The management system that allows the substandard practice to be committed, or the substandard condition to exist.
   - Root Causes may be broken down into two categories – personal factors and job factors.
f. Corrective Action – An activity that is conducted to prevent the existence of a substandard condition or prevent the substandard act from being committed.

7.2 Loss Causation Model



7.3 Systematic Cause Analysis Technique

a. Evaluate the loss potential if the event is not controlled
b. Categorize the type of contact
c. Identify the immediate causes – substandard acts and/or conditions
d. Identify the basic (root) causes – personal factors and/or job factors
e. Establish corrective actions that will directly remediate each of the root causes. Assign a specific person to be responsible for completion, and a specific date for completion.

8.0 INCIDENT INVESTIGATION FORMS

8.1 Form 9-2 Interim Incident Investigation Report

Interim Incident Investigation Report

1. (check one) Actual Incident ☐ Near Miss Incident ☐

Leader Investigator name	Leader Position/Department	Phone
Safety Representative Name:	Safety Area/Department	Phone

2. Injured person(s) (if applicable)

Name	Position/Department	Organization	Description of Injury

3. Short Description of the Incident

4. Place, date, and time of incident

Location where incident occurred

Date of Report: (yyyy-m-dd) Date of incident (yyyy-mm-dd) Time ☐ a.m. ☐ p.m.

8. Known (or potential) Consequences

Injury to person(s)	Damage to Property	Damage to Environment	Chemical/Biological Exposure

9. Emergency Response Actions taken (if applicable)

10. Unsafe acts or conditions that contributed to the incident (estimated, best guess)

Substandard Acts	Substandard Conditions

12. Actions Taken at the Scene

Action	Action by (Name/Position)
1.	

2.	

Interim Lessons Learned Bulletin issued (attach)

8.2 Form 9-3 Final Incident Investigation Report (page 1)

Final Incident Investigation Report

1. (check one) Actual Incident ☐ Near Miss Incident ☐

Lead Investigator name	Leader Position & Department	Phone
Lead Investigator e-mail address		
Safety Representative name	Safety Area/Department	Phone
Safety Representative e-mail address		

2. Injured persons (if applicable)

Name	Position/Department	Organization	Description of Injury

3. Short Description of the Incident

4. Place, date, and time of incident

Location where incident occurred

Date of Report: (yyyy-mm-dd)	Date of incident (yyyy-mm-dd)	Time: ☐ a.m. ☐ p.m.

5. Type of occurrence (select all that apply)

☐ Injury Lost Time ☐ Injury Restricted Work ☐ Injury Medical Treatment ☐ Injury First Aid ☐ Occupational illness ☐ Exposure to biological, chemical or physical agent ☐ Abuse, violent behavior	☐ Fire ☐ Vehicle accident ☐ Explosion ☐ Property Damage less than $5K ☐ Property damage $5K – 100K ☐ Property damage over $100K	☐ Environment Water Release ☐ Environment Erosion ☐ Environment Vegetation ☐ Environment Emission ☐ Environment Spill ☐ Environment Wildlife

6. Witnesses

Last name	First name	Job title
a)		

b)		

h) Form 9-3 Final Incident Investigation Report (Page 2)

Final Incident Investigation Report - Page 2 (continued)

7. Sequence of events

8. Summary of Consequences

Injury to person(s)	Damage to property	Damage to Environment	Chemical/Biological Exposure

9. Review of Emergency Response Actions (if applicable)

10. Unsafe acts or conditions that contributed to the incident *(use chart)*

Substandard Acts	Substandard Conditions

11. Root Cause Analysis *(use chart)*

Factor # 1 : ☐ Personal Factor ☐ Job/System Factor

Factor explanation:

Factor explanation:

Factor # 2 : ☐ Personal Factor ☐ Job/System Factor

Factor explanation:

Factor explanation:

i) Form 9-3 Final Incident Investigation Report (Page 3)

Final Incident Investigation Report - Page 3 (continued)

12. Corrective Action Log

Action	Action by (Name/Position)	Due Date
1.		
2.		
3.		
4.		
5.		
6.		

13. Investigation Review Record of Attendance

Organization	Name	Position/Department

14. Sign for Completion

Position	Name	Signature	Date
Lead Investigator			
Safety Representative			
Department Manager			
Operations Manager			

Lessons Learned Bulletin (attach) **Issued:** ☐ YES ☐ NO

8.3 Sample - Chart Systematic Cause Analysis Technique

SCAT Chart – Systematic Cause Analysis Technique

DESCRIPTION OF ACCIDENT OR INCIDENT

EVALUATION OF LOSS POTENTIAL IF NOT CONTROLLED

Loss Severity Potential ☐ Major (A) ☐ Serious (B) ☐ Minor (C)

Probability of Occurrence ☐ High (A) ☐ Moderate (B) ☐ Rare (C)

Frequency of Exposure ☐ Extensive (A) ☐ Moderate (B) ☐ Low (C)

TYPE OF CONTACT OR NEAR CONTACT WITH ENERGY OR SUBSTANCE

1. Struck Against (Running or Bumping into) (See I.C's: 1, 2, 4, 5, 12, 14, 15, 16, 17, 18, 19, 26)
2. Struck By (Hit by moving object) (See I.C's: 1, 2, 4, 5, 6, 9, 10, 12, 13, 14, 15, 16, 20, 26)
3. Fall to Lower Level (See I.C's: 3, 5, 6, 7, 11, 12, 13, 14, 15, 16, 17, 22)
4. Fall on Same Level (Slip and Fall, Trip Over) (See I.C.'s: 4, 9, 13, 14, 15, 16, 19, 22, 26)
5. Caught In (Pinch and Nip Points) (See I.C's: 5, 6, 11, 13, 14, 15, 16, 18)
6. Caught On (Snagged, Hung((See I.C.'s: 5, 6, 11, 12, 13, 14, 15, 16, 18)
7. Caught Between or Under (Crushed or Amputated) (See I.C.'s: 1, 2, 5, 6, 9, 11, 12, 13, 14, 15, 16, 22, 28)
8. Contact With (Electricity, Heat, Cold, Radiation, Caustics, Toxic Substances, Noise) (See I.C.'s: 5, 6, 7, 11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 23, 24, 25, 27, 28)
9. Overstress; Overexertion; Overload (See I.C.'s: 8, 9, 10, 11, 13, 14, 15)

(I.C.'s) IMMEDIATE CAUSES

SUBSTANDARDS/UNSAFE ACTS

1. Operating Equipment Without Authority (See B.C's: 2, 4, 5, 7, 8, 12, 13, 15)
2. Failure to Warn (See B.C's: 1, 2, 3, 4, 5, 6, 7, 8, 9, 12, 13, 15)
3. Failure to Secure (See B.C's: 2, 3, 4, 5, 6, 7, 8, 9, 12, 13, 15)
4. Operating at Improper Speed (See B.C.'s: 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 15)
5. Making Safety Devices Inoperative (See B.C.'s: 2, 3, 4, 5, 6, 7, 8, 9, 12, 13, 15)
6. Using Defective Equipment (See B.C's: 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15)
7. Failing to Use PPE Properly (See B.C's: 2, 3, 4, 5, 7, 8, 10, 12, 13, 15)
8. Improper Loading (See B.C's: 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 15)
9. Improper Placement (See B.C's: 1, 2, 3, 4, 5, 6, 7, 8, 9, 12, 13, 15)
10. Improper Lifting (See B.C's: 1, 2, 3, 4, 5, 6, 7, 8, 9, 12, 13, 15)
11. Improper Position for Task (See B.C.'s 1, 2, 3, 4, 5, 6, 7, 8, 9, 12, 13, 15)
12. Servicing Equipment in Operation (See B.C's: 3, 4, 5, 6, 7, 8, 9, 12, 13, 15)
13. Horseplay (See B.C's: 2, 3, 4, 5, 7, 8, 13, 15)
14. Under Influence of Alcohol and/or Other Drugs (See B.C's: 2, 3, 4, 5, 7, 8, 13, 15)
15. Using Equipment Improperly (See B.C's: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 13, 15)
16. Failure to Follow Procedure

SUBSTANDARD/UNSAFE CONDITIONS

17. Inadequate Guards or Barriers (See B.C's: 5, 7, 8, 9, 10, 11, 12, 13, 15)
18. Inadequate or Improper Protective Equipment (See B.C's: 5, 7, 8, 9, 10, 12, 13)
19. Defective Tools, Equipment or Materials (See B.C's: 8, 9, 10, 11, 12, 13, 14, 15)
20. Congestion or Restricted Action (See B.C's: 8, 9, 13)
21. Inadequate Warning System (See B.C's: 8, 9, 10, 11, 12, 13)
22. Fire & Explosion Hazards (See B.C's: 5, 6, 7, 8, 9, 10, 11, 12, 13, 15)
23. Poor Housekeeping/Disorder (See B.C's: 5, 6, 7, 8, 9, 10, 11, 12, 13, 15)
24. Noise Exposure (See B.C's: 5, 6, 7, 8, 9, 10, 11, 12, 13, 14)
25. Radiation Exposure (See B.C's: 5, 6, 7, 8, 9, 10, 11, 12, 13, 14)
26. Temperature Extremes (See B.C's: 1, 2, 3, 8, 9, 11, 12)
27. Inadequate or Exoess Illumination (See B.C's: 8, 9, 10, 11, 12, 13)
28. Inadequate Ventilation (See B.C's: 8, 9, 10, 11, 12, 13)
29. Hazardous Environmental Conditions (See B.C's: 8, 9, 10, 11, 12, 13)

(B.C's) BASIC/UNDERLYING CAUSES

PERSONAL FACTORS

1. **Inadequate Physical/Physiological Capability**
   - 1.1 Inappropriate height, weight, size, strength, reach, etc.
   - 1.2 Restricted range of body movement
   - 1.3 Limited ability to sustain body positions
   - 1.4 Substance sensitivities or allergies
   - 1.5 Sensitivities to sensory extremes (temperature, sound, etc.)
   - 1.6 Vision deficiency
   - 1.7 Hearing deficiency
   - 1.8 Other sensory deficiency (touch, taste, smell, balance)
   - 1.9 Respiratory incapacity
   - 1.10 Other permanent physical capabilities
   - 1.11 Temporary disabilities
2. **Inadequate Mental/Psychological Capability**
   - 2.1 Fears and phobias
   - 2.2 Emotional disturbance
   - 2.3 Mental illness
   - 2.4 Intelligence level
   - 2.5 Inability to comprehend
   - 2.6 Poor judgement
   - 2.7 Poor coordination
   - 2.8 Slow reaction time
   - 2.9 Low mechanical aptitude
   - 2.10 Low learning aptitude
   - 2.11 Memory failure
3. **Physical or Physiological Stress**
   - 3.1 Injury or illness
   - 3.2 Fatigue due to task load or duration
   - 3.3 Fatigue due to lack of rest
   - 3.4 Fatigue due to sensory overload
   - 3.5 Exposure to health hazards
   - 3.6 Exposure to temperature extremes
   - 3.7 Oxygen deficiency
   - 3.8 Atmospheric pressure variation
   - 3.9 Constrained movement
   - 3.10 Blood sugar insufficiency
   - 3.11 Drugs
4. **Mental or Psychological Stress**
   - 4.1 Emotional overload
   - 4.2 Fatigue due to mental task load or speed
   - 4.3 Extreme judgement/decision demands
   - 4.4 Routine, monotony, demand for uneventful vigilance
   - 4.5 Extreme concentration/perception demands
   - 4.6 "Meaningless" or "degrading" activities
   - 4.7 Confusing directions/demands
   - 4.8 Conflicting demands/directions
   - 4.9 Preoccupation with problems
   - 4.10 Frustration
   - 4.11 Mental illness
5. **Lack of Knowledge**
   - 5.1 Lack of experience
   - 5.2 Inadequate orientation
   - 5.3 Inadequate initial training
   - 5.4 Inadequate update training
   - 5.5 Misunderstood directions
6. **Lack of Skill**
   - 6.1 Inadequate initial instruction
   - 6.2 Inadequate practice
   - 6.3 Infrequent performance
   - 6.4 Lack of coaching
   - 6.5 Inadequate review instruction
7. **Improper Motivation**
   - 7.1 Improper performance is rewarding
   - 7.2 Proper performance is punishing
   - 7.3 Lack of incentive
   - 7.4 Excessive frustration
   - 7.5 Inappropriate aggression
   - 7.6 Improper attempt to save time or effort
   - 7.7 Improper attempt to avoid discomfort
   - 7.8 Improper attempt to gain attention
   - 7.9 Inadequate discipline
   - 7.10 Inappropriate peer pressure
   - 7.11 Improper supervisory example
   - 7.12 Inadequate performance feedback
   - 7.13 Inadequate reinforcement of proper behaviour
   - 7.14 Improper production incentives

JOB FACTORS

8. **Inadequate Leadership and/or Supervision** (See CAN: 1, 2, 3, 4, 5, 6, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18)
   - 8.1 Unclear or conflicting reporting relationships
   - 8.2 Unclear or conflicting assignment of responsibility
   - 8.3 Improper or insufficient delegation
   - 8.4 Giving inadequate policy, procedure, practices or guidelines
   - 8.5 Giving objectives, goals or standards that conflict
   - 8.6 Inadequate work planning or programming
   - 8.7 Inadequate instructions, orientation and/or training
   - 8.8 Providing inadequate reference documents, directives and guidance publications
   - 8.9 Inadequate identification and evaluation of loss exposures
   - 8.10 Lack of supervisory/management job knowledge
   - 8.11 Inadequate matching of individual qualifications and job/task requirements
   - 8.12 Inadequate performance measurement and evaluation
   - 8.13 Inadequate or incorrect performance feedback
9. **Inadequate Engineering** (See CAN: 1, 3, 4, 9, 12, 13, 14)
   - 9.1 Inadequate assessment of loss exposures
   - 9.2 Inadequate consideration of human factors/ ergonomics
   - 9.3 Inadequate standards, specifications and/or design criteria
   - 9.4 Inadequate monitoring of construction
   - 9.5 Inadequate assessment of operational readiness
   - 9.6 Inadequate or improper controls
   - 9.7 Inadequate monitoring of initial operation
   - 9.8 Inadequate evaluation of charges
10. **Inadequate Purchasing**
    - 10.1 Inadequate specifications on requisitions
    - 10.2 Inadequate research on materials/equipment
    - 10.3 Inadequate specifications to vendors
    - 10.4 Inadequate mode or route of shipment
    - 10.5 Inadequate receiving inspection and acceptance
    - 10.6 Inadequate communication of safety and health data
    - 10.7 Improper handling of materials
    - 10.8 Improper storage of materials
    - 10.9 Improper transporting of materials
    - 10.10 Inadequate identification of hazardous items
    - 10.11 Improper salvage and/or waste disposal
    - 10.12 Inadequate contractor selection
11. **Inadequate Maintenance**
    - 11.1 Inadequate preventive
      - 11.1.1 Assessment of needs
      - 11.1.2 Lubrications and servicing
      - 11.1.3 Adjustment/assembly
      - 11.1.4 Cleaning or resurfacing
    - 11.2 Inadequate reparative
      - 11.2.1 Communication of needs
      - 11.2.2 Scheduling of work
      - 11.2.3 Examination of units
      - 11.2.4 Part substitution
12. **Inadequate Tools and Equipment**
    - 12.1 Inadequate assessment of needs and risks
    - 12.2 Inadequate human factors/ ergonomics considerations
    - 12.3 Inadequate standards or specifications
    - 12.4 Inadequate availability
    - 12.5 Inadequate adjustment/repair/maintenance
    - 12.6 Inadequate salvage and reclamation
    - 12.7 Inadequate removal and replacement of insuitable items
13. **Inadequate Work Standards**
    - 13.1 Inadequate development of standards for:
      - 13.1.1 Inventory and evaluation of exposures and needs
      - 13.1.2 Coordination with process design
      - 13.1.3 Employee involvement
      - 13.1.4 Procedures/practices/rules
    - 13.2 Inadequate communication of standards for:
      - 13.2.1 Publication
      - 13.2.2 Distribution
      - 13.2.3 Translation to appropriate languages
      - 13.2.4 Training
      - 13.2.5 Reinforcing with signs, colour codes and job aids
    - 13.3 Inadequate maintenance of standards for:
      - 13.3.1 Tracking of work flow
      - 13.3.2 Updating
      - 13.3.3 Monitoring use of procedures/ practices/ rules
    - 13.4 Inadequate monitoring of compliance
14. **Excessive Wear and Tear**
    - 14.1 Inadequate planning or use
    - 14.2 Improper extension of service life
    - 14.3 Inadequate inspection and/or monitoring
    - 14.4 Improper loading or rate of use
    - 14.5 Inadequate maintenance
    - 14.6 Use by unqualified or untrained people
    - 14.7 Use for wrong purpose
15. **Abuse or Misuse**
    - 15.1. Inadequate planning or use
      - 15.1.1 Intentional
      - 15.1.2 Unintentional
    - 15.2 Improper conduct that is not condoned
      - 15.2.1 Intentional
      - 15.2.2 Unintentional

9.0 RECORDS

OHS/Incident Management/Reports/North/Production/Incident #
OHS/Incident Management/Reports/North/Maintenance/Incident #
OHS/Incident Management/Reports/South/Production/Incident #
OHS/Incident Management/Reports/South/Maintenance /Incident #
OHS/Incident Management/Templates
OHS/Incident Management/Data

10.0 DOCUMENT HISTORY

Rev#	Date	State	Initials	Description of Changes
0.0	2020-06-20	Draft	GT	The document is initiated.