



# Lusail Real Estate Development Company

## Health, Safety, Security, Environment, Logistics & Quality Department

### Lusail Construction Safety Forms/Checklists – Incident Event Investigation Report

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## LUSAIL INCIDENT EVENT CLASSIFICATION REPORT

### Part - A

Complete the information required for the Incident. (As stipulated in LUS-HSE-SP2-453-001.03 - Incident Investigation Reporting)

Reported Date:		Reported Time:		Reported By Contact details:	
Incident Date:		Incident Time:		Incident #	
Business Type	<input type="checkbox"/> Construction Package <input type="checkbox"/> Developer <input type="checkbox"/> Building Package <input type="checkbox"/> Operations <input type="checkbox"/> Other _____ <input type="checkbox"/> Mega Project <input type="checkbox"/> QD / Lusail Facilities				
Project Name	(e.g. CP15A2)		Company Name: (Main Contractor)		
Location of Incident:					
Job Classification of Injured Person			Length of Service:		
Injured Person's Name:			Supervisor Name Contact details :		
Summary: (Brief)					
Detailed Description:					
Immediate Actions Taken:					
Project Manager (LREDC):			Project Manager (Contractor)		
Safety Manager (Contractor):			LCCC Notified – Time & Date:		
<b>Incident Classification</b> (Multiple classifications can be selected)					
<input type="checkbox"/> Dangerous Occurrence	<input type="checkbox"/> Major Environmental	<input type="checkbox"/> Minor Environment	<input type="checkbox"/> Road Accident / MVA		
<input type="checkbox"/> Occupational Exposure (Not Heat related illness)	<input type="checkbox"/> Major Property / Equipment Damage or loss	<input type="checkbox"/> Minor Property / Equipment Damage or loss	<input type="checkbox"/> Fire Event		
<input type="checkbox"/> Workplace Injury	<input type="checkbox"/> Heat Related Illness	<input type="checkbox"/> Other _____			

LREDC Risk Matrix						
Likelihood	Consequence/ Severity	1 Minor First Aid Injury 1 < Qr.10k	2 Medium Medically Treated Injury Qr.10K – Qr.20k	3 Serious Restricted Work Injury Qr.20K – Qr.50K	4 Major Lost Time Injury Qr.50k – Qr.100k	5 Catastrophic Fatality >Qr.100k
	A: Almost Certain > 1 per week >25%	Moderate 11	High 16	Extreme 20	Extreme 23	Extreme 25
	B: Likely 1/week – 1/month 10% - 25%	Moderate 7	High 12	High 17	Extreme 21	Extreme 24
	C: Possible 1/month – 1/year 1% - 10%	Low 4	Moderate 8	High 13	High 18	Extreme 22
	D: Unlikely 1/year – 1/10 years 0.1% - 1%	Low 2	Low 5	Moderate 9	High 14	High 19
	E: Rare < 1/10 years 0.1%	Low 1	Low 3	Low 6	Moderate 10	High 15
Final Risk Rating: <small>Note: use the Matrix</small>		Consequence:		Likelihood:		Total:

Note –

- Incidents initially rated as a Level 1 Risk (Low 1 to Low 6) may only require minimal analysis dependent on the circumstances of the incident and potential for reoccurrence.
- Incidents initially rated as a Level 2 Risk (Moderate 7 to Moderate 11) will require a more detailed incident analysis.
- Incidents rated as a 'Significant Incident' / Level 3 & 4 Risk (High 12 to Extreme 25) a detailed analysis including a **Formal Root Cause Analysis is required Part D**

### Part B - Incident Classification Details

Complete the information required for the Incident Classification/s

PROPERTY / EQUIPMENT DAMAGE OR LOSS			
Equipment Damage or Loss Classification:	Damage <input type="checkbox"/>	Loss <input type="checkbox"/>	Theft <input type="checkbox"/>
Description:			
Model:		Year:	
Serial Number		Owner Details:	
Estimated Cost of Equipment Damage (Labor and Parts Only):	QAR.		

FIRE EVENT			
Description:			
Materials Involved:			
Source of Fuel:			
Type of Fuel:	<input type="checkbox"/> Flammable gas – Acetylene	<input type="checkbox"/> Flammable gas – LPG	<input type="checkbox"/> Paper
	<input type="checkbox"/> Flammable gas – Nitrogen	<input type="checkbox"/> Flammable gas – Oxygen	<input type="checkbox"/> Plastic
	<input type="checkbox"/> Flammable gas – Propane	<input type="checkbox"/> Flammable metal	<input type="checkbox"/> Rubber
	<input type="checkbox"/> Flammable liquid – Diesel	<input type="checkbox"/> Flammable liquid – Petrol	<input type="checkbox"/> Hessian Clothes
	<input type="checkbox"/> Flammable liquid - Paints		<input type="checkbox"/> Wood
	<input type="checkbox"/> Flammable liquid – Solvents		<input type="checkbox"/> Other _____
Source of Ignition:	<input type="checkbox"/> Auto-ignition	<input type="checkbox"/> Cutting	<input type="checkbox"/> Electrical
	<input type="checkbox"/> Exothermic reaction	<input type="checkbox"/> Friction	<input type="checkbox"/> Hot surfaces
	<input type="checkbox"/> Instrumentation	<input type="checkbox"/> Static electricity	<input type="checkbox"/> Other _____
Source of Oxygen:	<input type="checkbox"/> Air		

<b>Method of Extinguishment:</b>	<input type="checkbox"/> Extinguisher - CO2	<input type="checkbox"/> Extinguisher – DCP	<input type="checkbox"/> Extinguisher – Foam
	<input type="checkbox"/> Extinguisher – Water	<input type="checkbox"/> Fire blanket	<input type="checkbox"/> Civil Defense
	<input type="checkbox"/> Fire tender	<input type="checkbox"/> Water truck	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Sprinkler reticulation	<input type="checkbox"/> Mobile Equipment	

**WORK PLACE INJURY / ILLNESS** (Details to be enter by treating medical professional)

<b>Date:</b>		<b>Information entered by:</b>	
<b>Injured / Ill Person's Name:</b>		<b>Employer:</b>	
<b>Gender:</b>		<b>Date of Birth:</b>	
<b>Nationality:</b>			
<b>Employee Type:</b>	<input type="checkbox"/> Contractor	<input type="checkbox"/> Sub-contractor	<input type="checkbox"/> Visitor
	<input type="checkbox"/> Member of the public	<input type="checkbox"/> Other	
<b>Brief Summary of Injury:</b>			
<b>Medical Assessment, Treatment and Management</b>			
<b>Was the injury work-related?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Was outside agencies required?</b>	<input type="checkbox"/> Ambulance <input type="checkbox"/> Police <input type="checkbox"/> Other _____	<b>If other Specify</b>	
<b>Work-related classifications:</b>	<input type="checkbox"/> First Aid Injury - FAI		<input type="checkbox"/> Fatality
	<input type="checkbox"/> Medically Treated Injury beyond FAI - MTI		<input type="checkbox"/> Occupational Exposure (Not Heat related illness)
	<input type="checkbox"/> Restricted Work Injury - RTI		<input type="checkbox"/> Heat Stress
	<input type="checkbox"/> Lost Time Injury - LTI		<input type="checkbox"/> Other _____
	<input type="checkbox"/> Pending Classification		

<b>Body Location</b>		<p>Utilize the red ring below and drag to demonstrate where the IP sustained injuries (multiple locations can be shown)</p>
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Mechanism	Type of Contact	Contact With
	<input type="checkbox"/> Struck Against	<input type="checkbox"/> Electricity
	<input type="checkbox"/> Struck By	<input type="checkbox"/> Heat/Climate Related Stress
	<input type="checkbox"/> Caught In	<input type="checkbox"/> Cold
	<input type="checkbox"/> Caught On	<input type="checkbox"/> Radiation
	<input type="checkbox"/> Caught Between	<input type="checkbox"/> Caustics
	<input type="checkbox"/> Falls from a Height	<input type="checkbox"/> Toxic or Noxious Substances
	<input type="checkbox"/> Slips / Trips	<input type="checkbox"/> Machinery
	<input type="checkbox"/> Fall on Same Level	<input type="checkbox"/> Welding Flash
	<input type="checkbox"/> Falls on Level Ground	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Vehicle accident	
	<input type="checkbox"/> Fall to Below Ground Level	
	<input type="checkbox"/> Striking Fixed Object	
	<input type="checkbox"/> Trapped	
	<input type="checkbox"/> Falling Objects or Materials	
	<input type="checkbox"/> Sting Bite- Insect, Spider, Snake, etc.	
	<input type="checkbox"/> Stepping On	
	<input type="checkbox"/> Other _____	

ROAD ACCIDENT / MOTOR VEHICLE ACCIDENT					
Driver Name:					
Time of Day:	<input type="checkbox"/> Dawn	<input type="checkbox"/> Daylight	<input type="checkbox"/> Dusk	<input type="checkbox"/> Night	
Weather Conditions:	<input type="checkbox"/> Clear	<input type="checkbox"/> Wet	<input type="checkbox"/> Cold	<input type="checkbox"/> Dry	<input type="checkbox"/> Foggy
	<input type="checkbox"/> Hot	<input type="checkbox"/> Humid	<input type="checkbox"/> Sunny	<input type="checkbox"/> Raining	<input type="checkbox"/> Windy
	<input type="checkbox"/> Cloudy / Overcast				
Road Type:	<input type="checkbox"/> Bend	<input type="checkbox"/> Intersection	<input type="checkbox"/> Parking Area	<input type="checkbox"/> Straight	
Road Surface Conditions:	<input type="checkbox"/> Asphalt	<input type="checkbox"/> Gravel-Loose or Potholed	<input type="checkbox"/> Gravel-Good	<input type="checkbox"/> Gravel-Muddy	
Vehicle Type:				Vehicle Make:	
Vehicle Model:				Vehicle Year:	
Company Vehicle:	<input type="checkbox"/> YES <input type="checkbox"/> NO			Registration Plate Number:	

DANGEROUS OCCURRENCE			
Possible Classification of the Incident:			
<input type="checkbox"/> Major Environmental	<input type="checkbox"/> Minor Environment	<input type="checkbox"/> Road Accident / MVA	<input type="checkbox"/> Fire Event
<input type="checkbox"/> Major Property / Equipment Damage or loss	<input type="checkbox"/> Minor Property / Equipment Damage or loss	<input type="checkbox"/> Other _____	
Comments:			

OCCUPATIONAL EXPOSURE (Not Heat Related Illness)		
Person Exposed:		
Employee Type:	<input type="checkbox"/> Employee	<input type="checkbox"/> Contractor <input type="checkbox"/> Visitor
Employer :		
Gender:	Date of Birth:	
Nationality:		
Summary:		
Detailed Description :		

<b>Method of Exposure:</b>	<input type="checkbox"/> Ingestion	<input type="checkbox"/> Inhalation	<input type="checkbox"/> Absorption	<input type="checkbox"/> Skin Contact	<input type="checkbox"/> Injection
<b>Agency:</b>	<input type="checkbox"/> Asbestos	<input type="checkbox"/> Diesel Particulate	<input type="checkbox"/> Blood	<input type="checkbox"/> Bodily Fluids	<input type="checkbox"/> Vibration
	<input type="checkbox"/> Viruses	<input type="checkbox"/> Dust	<input type="checkbox"/> Silica	<input type="checkbox"/> Heavy Metals	<input type="checkbox"/> Other_____
	<input type="checkbox"/> Radiation	<input type="checkbox"/> Noise	<input type="checkbox"/> Thermal		

### Part C – Incident Analysis

<b>Analysis Team Leader:</b>				
<b>Analysis Team:</b>				
<b>Start Date:</b>				<b>End Date</b>
<b>Detailed Description of Analysis Findings:</b>				
	<p><b>Note:</b> All supporting documents (which incl. pictures and statements) must be appendix to this report and referenced</p>			
<b>Witnesses Names and Contact Details:</b>				

### Part D – Formal Root Cause Analysis

Risk Rating 12 and above and or classified as high potential

Conditions	
<b>Were Conditions a factor?</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO If Yes Select one of the Following
<input type="checkbox"/> C1 - Guards or protective systems (including warning systems)	<input type="checkbox"/> C2 - Tools/equipment/materials - conditions
<input type="checkbox"/> C3 - Tools/equipment/materials – availability	<input type="checkbox"/> C4 - Tools/equipment/materials - suitability
<input type="checkbox"/> C5 - Tools/equipment/materials - failure/mechanical failure	<input type="checkbox"/> C6 - Congestion
<input type="checkbox"/> C7 - Access/egress	<input type="checkbox"/> C8 - Routine Tasks
<input type="checkbox"/> C9 - Non-routine Task	<input type="checkbox"/> C10 - Hazardous Substance and Materials
<input type="checkbox"/> C11 - Inadequate or Improper PPE	<input type="checkbox"/> C12 - Flora and Fauna
<input type="checkbox"/> C13 - Instruction	<input type="checkbox"/> C14 - Communication Systems
<input type="checkbox"/> C15 - Time Constraints	<input type="checkbox"/> C16 - Supervision
<input type="checkbox"/> C17 - Lighting	<input type="checkbox"/> C18 - Ventilation
<input type="checkbox"/> C19 - Housekeeping	<input type="checkbox"/> C20 - Weather
<input type="checkbox"/> C21 - Noise	<input type="checkbox"/> C22 - Surface Conditions
<input type="checkbox"/> C23 - Task/planning	<input type="checkbox"/> Other _____
Actions	
<b>Were Actions a factor?</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO If Yes Select one of the Following
<input type="checkbox"/> A1 - Use of equipment - Incorrectly	<input type="checkbox"/> A2 - Use of Equipment - Without Authority
<input type="checkbox"/> A3 - Failure to communicate	<input type="checkbox"/> A4 - Inadequate Communication
<input type="checkbox"/> A5 - Fitness for Work issue	<input type="checkbox"/> A6 - Poor Time Management
<input type="checkbox"/> A7 - Misconduct	<input type="checkbox"/> A8 - Bypassed safety device/system

<input type="checkbox"/> A9 - Incorrect selection or use of PPE	<input type="checkbox"/> A10 - Inadequate equipment maintenance
<input type="checkbox"/> A11 - Improper work methods	<input type="checkbox"/> A12 - Manual Tasks
<input type="checkbox"/> A13 - Inadequate risk identification/management	<input type="checkbox"/> A14 - Failure to secure
<input type="checkbox"/> A15 - Operating Speed	<input type="checkbox"/> A16 - Occupational Hygiene Practices
<input type="checkbox"/> A17 - Task Planning	<input type="checkbox"/> Other _____

**Human Factors**

**Were Humans a factor?**  YES  NO If Yes Select one of the Following

<input type="checkbox"/> H1 - Complacency	<input type="checkbox"/> H2 - Motivation
<input type="checkbox"/> H3 - Attitude	<input type="checkbox"/> H4 - Task Stress
<input type="checkbox"/> H5 - Time Pressures	<input type="checkbox"/> H6 - Slip (attention failure)
<input type="checkbox"/> H7 - Lapse (memory failure)	<input type="checkbox"/> H8 - Mistake (knowledge of rule base)/ Lack of competence
<input type="checkbox"/> H9 - Violation - Routine (deliberate action breaking rules - norm)	<input type="checkbox"/> H10 - Violation - Exceptional (deliberate action breaking rules - challenged, not norm)
<input type="checkbox"/> H11 - Drugs/alcohol influence	<input type="checkbox"/> H12 - Fatigue
<input type="checkbox"/> H13 - Hazard recognition or perception	<input type="checkbox"/> H14 - Personal Stress/Distraction
<input type="checkbox"/> Other _____	

**Organisational Factors**

**Were there Organisational Factors?**  YES  NO If Yes Select one of the Following

<input type="checkbox"/> OF1 - Leadership / supervision	<input type="checkbox"/> OF2 - Design/construction/commissioning
<input type="checkbox"/> OF3 - Work procedures/SMS	<input type="checkbox"/> OF4 - Tools or Equipment
<input type="checkbox"/> OF5 - Risk Management	<input type="checkbox"/> OF6 - Supplier/Contractor Management
<input type="checkbox"/> OF7 - Maintenance Management	<input type="checkbox"/> OF8 - Operational practices
<input type="checkbox"/> OF9 - Change Management	<input type="checkbox"/> OF10 - Crisis and emergency management
<input type="checkbox"/> OF11 - Planning/operational constraints	<input type="checkbox"/> OF12 - Communication
<input type="checkbox"/> OF13 - Training and Development	<input type="checkbox"/> OF14 - Selection and recruitment
<input type="checkbox"/> OF15 - Organizational culture	<input type="checkbox"/> OF16 - Purchasing/procurement
<input type="checkbox"/> OF17 - Organizational Learning	<input type="checkbox"/> Other _____

**Formal Root Cause Analysis – Further Details**

**Note:** All supporting documents must be appendix to this report and referenced

Tick boxes that have been checked above must be expanded and explicated within the Analysis



## Part E – Corrective Actions

Corrective Actions - Tables can be duplicated if required.

<b>Action Assigned To:</b>		<b>Date Raised:</b>		<b>Due Date:</b>	
<b>Action Category:</b>	<input type="checkbox"/> 1 Elimination	<input type="checkbox"/> 2 Substitution	<input type="checkbox"/> 3 Engineering		
	<input type="checkbox"/> 4 Administration	<input type="checkbox"/> 5 PPE			
<b>Priority:</b>	<input type="checkbox"/> Urgent (Within 24-48 hours)	<input type="checkbox"/> High (Within the week)	<input type="checkbox"/> Medium (Within the month)		
	<input type="checkbox"/> Low (Due Date Greater than one month)				
<b>Action Title:</b>					
<b>Action Description:</b>					

<b>Action Assigned To:</b>		<b>Date Raised:</b>		<b>Due Date:</b>	
<b>Action Category:</b>	<input type="checkbox"/> 1 Elimination	<input type="checkbox"/> 2 Substitution	<input type="checkbox"/> 3 Engineering		
	<input type="checkbox"/> 4 Administration	<input type="checkbox"/> 5 PPE			
<b>Priority:</b>	<input type="checkbox"/> Urgent (Within 24-48 hours)	<input type="checkbox"/> High (Within the week)	<input type="checkbox"/> Medium (Within the month)		
	<input type="checkbox"/> Low (Due Date Greater than one month)				
<b>Action Title:</b>					
<b>Action Description:</b>					

<b>Action Assigned To:</b>		<b>Date Raised:</b>		<b>Due Date:</b>	
<b>Action Category:</b>	<input type="checkbox"/> 1 Elimination	<input type="checkbox"/> 2 Substitution	<input type="checkbox"/> 3 Engineering		
	<input type="checkbox"/> 4 Administration	<input type="checkbox"/> 5 PPE			
<b>Priority:</b>	<input type="checkbox"/> Urgent (Within 24-48 hours)	<input type="checkbox"/> High (Within the week)	<input type="checkbox"/> Medium (Within the month)		
	<input type="checkbox"/> Low (Due Date Greater than one month)				
<b>Action Title:</b>					
<b>Action Description:</b>					

<b>Action Assigned To:</b>		<b>Date Raised:</b>		<b>Due Date:</b>	
<b>Action Category:</b>	<input type="checkbox"/> 1 Elimination	<input type="checkbox"/> 2 Substitution	<input type="checkbox"/> 3 Engineering		
	<input type="checkbox"/> 4 Administration	<input type="checkbox"/> 5 PPE			
<b>Priority:</b>	<input type="checkbox"/> Urgent (Within 24-48 hours)	<input type="checkbox"/> High (Within the week)	<input type="checkbox"/> Medium (Within the month)		
	<input type="checkbox"/> Low (Due Date Greater than one month)				
<b>Action Title:</b>					
<b>Action Description:</b>					

<b>Action Assigned To:</b>		<b>Date Raised:</b>		<b>Due Date:</b>	
<b>Action Category:</b>	<input type="checkbox"/> 1 Elimination	<input type="checkbox"/> 2 Substitution	<input type="checkbox"/> 3 Engineering		
	<input type="checkbox"/> 4 Administration	<input type="checkbox"/> 5 PPE			
<b>Priority:</b>	<input type="checkbox"/> Urgent (Within 24-48 hours)	<input type="checkbox"/> High (Within the week)	<input type="checkbox"/> Medium (Within the month)		
	<input type="checkbox"/> Low (Due Date Greater than one month)				
<b>Action Title:</b>					
<b>Action Description:</b>					

Contractor HSE Representative Approval – Printed Name

Contractor HSE Representative- Signature

Contractor Project Manager Approval – Printed Name

Contractor Project Manager- Signature

### Part F – Sign-Off

SIGN OFF	
Consultant HSE Signing Off	
Person Signing Off:	Signature
Sign Off Comments:	
Sign Off Date:	
PMCM HSE Sign Off	
Person Signing Off:	Signature
Sign Off Comments :	
Sign Off Date	
LREDC HSE Sign Off	
Person Signing Off:	Signature
Sign Off Comments :	
Sign Off Date	