



PROCEDURE

Incident Investigation and Reporting

QATAR STEEL COMPANY (QPSC)

Procedure	2.32.2.1.02.01
Established	01-Jan-2002
Effective date	01-Mar-2021
Revision	1.03

REVISION HISTORY

Revision No.	Issue Date	Amendment Description	Date Effective	Date to be Revalidated
00	01-Jan-2002	First Issue	01-Jan-2002	14-Oct-2003
01	14-Oct-2003	Re-Issue	14-Oct-2003	01-Nov-2005
02	01-Nov-2005	Re-Issue	01-Nov-2005	01-Apr-2008
03	01-Apr-2008	Qatar Steel Logo change	01-Apr-2008	01-Apr-2011
	01-Apr-2011	Checked & found OK	01-Apr-2011	10-Sep-2013
04	10-Sep-2013	Revised as per OHSAS 18001 & Online incident-tracking system included.	10-Sep-2013	28-Jun-2015
05	28-Jun-2015	Section 4.2.13 & 4.2.14 added in Employees responsibilities.	28-Jun-2015	17-Aug-2016
1.00	17-Aug-2016	Section 4.2.2.3a added in Area In-Charge responsibilities	17-Aug-2016	16-Aug-2019
1.01	16-Jan-2018	Full revision of procedure	16-Jan-2018	11-Nov-2019
1.02	01-Jan-2020	Update of template and company acronym Full revision of the procedure	01-Jan-2020	31-Dec-2022
1.03	01-Mar-2021	Section 7.2 Requirements of a Team leader. Section 7.8 Mothballing plant - Incidents reports status categorized as 'Closed' due to mothballing	01-Mar-2021	28-Feb-2024

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1 INTERNAL CONTROLS

1.1. Review of Procedure

To assure Managements, Shareholders and External agencies confidence in the company's policies & practices, QATAR STEEL Internal Audit may verify compliance with this procedure. [Department Owner] shall review this procedure every three years to ensure that it continues to serve the purpose intended.

1.2. Employee Responsibilities

All employees of the company are required to observe and abide with this procedure.

1.3. Approval

This procedure and any amendments made thereto; require the following approvals.

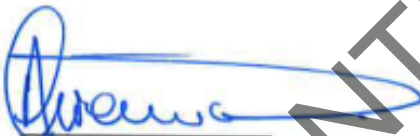
AUTHORITY



Approved by
Mr. Abdulrahman Ali Al-Abdulla,
Managing Director & Chief Executive Officer (MD&CEO)

DATE

03/03/2021



Checked by
Mr. Alexander Stramrood,
Manager, HSE

28/02/2021



Drafted by
Hemesh Dhulab
HSE Engineer

28-FEB-2021

This document has been reviewed by Document Controller. It complies with the requirements of policy 1.12.0.1.01.01 and it is considered ready for issue.

Signed by  Date 28 FEB 2021

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2 PURPOSE

The purpose of this procedure is to describe the reporting and investigation of incidents in Qatar Steel with the aim of preventing incidents occurring and continuous improvement of HSE systems by:

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

3 SCOPE

This procedure outlines the process for investigating, reporting and communicating incidents for Qatar Steel employees, contractors and visitors. It is applicable to all incidents occurring at Qatar Steel facilities and Doha offices, including:

- a) Personal Injury (Occupational Health and Safety injuries and illnesses to Qatar Steel employees, contractors and visitors at Qatar Steel premises)
- b) Environmental release
- c) Near miss
- d) Unsafe conditions
- e) Explosion / Fire
- f) Property Damage
- g) Unsafe act
- h) Vehicle incidents (Employee / visitor transportation provided by Qatar Steel i.e. Qatar Steel Buses, Qatar Steel contractor vehicles within Qatar Steel premises)
- i) Other violations (e.g. security incidents)

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4 PROCEDURE

4.1 Introduction

Incident investigation is the process of identifying the underlying causes of incidents and remedial steps to be taken to prevent similar events from occurring again. The objective of an incident investigation is for employees to learn from experiences and thus avoid repeating past mistakes.

4.2 Abbreviations

COD	Change of Design
ERP	Emergency Response Plan
HSE	Health Safety & Environment
ITS	Incident Tracking System
LTI	Loss Time Injury
MD & CEO	Managing Director & Chief Executive Officer
MIC	Mesaieed Industrial City
MME	Ministry of Municipality and Environment
MTC	Medical Treatment Case
CO	Chief Officer
PHA	Process Hazard Analysis
PPE	Personal Protective Equipment
PSSR	Pre-startup Safety Reviews
PSM	Process Safety Management
QAR	Qatari Riyal
RCA	Root Cause Analysis
RWC	Restricted Workday Case
TA	Test Authorization
YTD	Year to Date

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4.3 Definitions

Table 1: Definitions of terms used throughout the procedure

Term	Definition
Incident	<p>An unplanned or unusual event and circumstances that result in, or have the potential to result in, an undesirable consequence</p> <p>An incident may be categorized as either an “accident” or a “near miss”.</p>
Accident	<p>Any event that has resulted in injury or damage to a person, property or equipment such as the following that result in undesirable consequences:</p> <ul style="list-style-type: none"> • Injuries/illnesses that have a serious adverse effect on employee health or safety • Significant environmental impact • Unfavorable impact on the public • Significant property damage including all fires/explosions
Near Miss	<p>An unplanned or uncontrolled event or chain of events that has not resulted in recordable injury, illness, asset damage or environmental damage but had the potential to do so in other circumstances (incident has occurred).</p> <ul style="list-style-type: none"> • A person trips over an object and falls to the ground but did not get injured • A person has to dive or jump out of the way to avoid a collision with a motorized vehicle, a moving object like a suspended part on a conveyor or from an uncontrolled suspended load • A person has to jump from a falling ladder • Any emergency equipment (fire extinguisher, Air Pack, Oxygen sensor, eye wash, etc.) fails to operate properly when called on in an emergency.
Unsafe Act	<p>Any act or omission by an individual that poses a risk of injury or damage, such as breaching a safety procedure, or the failure to act upon an unsafe condition. Examples may include:</p> <ul style="list-style-type: none"> • Not reporting an unsafe condition and leaving a hazard for someone else, • Failure to follow health and safety procedures or failure to wear the specified PPE.
Unsafe	Any situation that could result in injury or damage to people,

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Term	Definition
Condition	property or equipment. Examples may include: <ul style="list-style-type: none"> Dangerous item left as an obstruction or a confusing or misleading procedure/works instruction.
Recordable injury	All work-related incidents resulting in a fatality, an injury requiring time off work (LTI), a restriction in the work performed (RWC), or an injury requiring medical treatment (MTC) or a First Aid Case.
Personal Injury	Any injury such as a cut, fracture, sprain, amputation, which results from a work-related activity or from an exposure involving a single incident in the work environment, such as deafness from explosion, one-time chemical exposure, back disorder from a slip/trip.
Fatality	Cases that involve one or more people who died as a result of a work-related incident or occupational illness. 'Delayed' deaths that occur after the incident are to be included if the deaths were a direct result of the incident. For example, if a fire killed one person outright, and a second died three weeks later from lung damage caused by the fire, both shall be reported.
Lost Time Injury (LTI)	Non-fatal cases that involve a person being unfit to perform any work on any day after the occurrence of the injury or occupational illness. 'Any day' includes rest days, weekend days, leave days, public holidays or days after ceasing employment.
Restricted Workday Case (RWC)	Cases that do not result in a fatality or a LTI but do result in a person being unfit for full performance of the regular job on any day after the injury or occupational illness e.g. punctured ear drums, fractured ribs or toes. Work performed might be: <ul style="list-style-type: none"> Assignment to a temporary job Part-time work at the regular job Working full-time in the regular job but not performing all the usual duties of the job.
Medical Treatment Case (MTC)	Cases not severe enough to be reported as fatalities, LTI or RWC but when the management and care of the patient to address the injury or illness is above and beyond first aid treatment. MTC includes treatment of injuries administered by physicians, registered professional personnel, or lay persons (i.e. non-medical personnel). Examples of MTC: <ul style="list-style-type: none"> Any loss of consciousness

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Term	Definition
	<ul style="list-style-type: none"> Needle stick injuries and cuts from sharp objects that are contaminated with another person's blood or other potentially infectious material <p>Examples of non-MTC:</p> <ul style="list-style-type: none"> First aid treatment (one-time treatment and subsequent observation of minor scratches, cuts, bumps, splinters, and so forth, which do not ordinarily require medical care) even though provided by a physician or registered professional personnel.
First Aid Accident	<p>Cases not sufficiently serious to be reported as MTC or more serious, but nevertheless requiring first aid treatment, including the following:</p> <ul style="list-style-type: none"> Using a non-prescription medication at non-prescription strength Cleaning, flushing or soaking wounds on the surface of the skin Using wound coverings such as bandages, Band-Aids, gauze pads (other wound closing devices such as sutures, staples, surgical glue, are considered medical treatment) Using hot or cold therapy Using any non-rigid means of support, such as elastic bandages, wraps, non-rigid back belts (devices with rigid stays or other systems designed to immobilize parts of the body are considered medical treatment for recordkeeping purposes) Using temporary immobilization devices while transporting an accident victim (e.g. splints, slings, neck collars, back boards) Drilling of a fingernail or toenail to relieve pressure, or draining fluid from a blister Using eye patches Removing foreign bodies from the eye using only irrigation or a cotton swab Removing splinters or foreign material from areas other than the eye by irrigation, tweezers, cotton swabs or other simple means (needles, pins or small tools to extract splinters would generally be included) Using finger guards Using massages (physical therapy or chiropractic treatment are considered medical treatment for recordkeeping purposes) Drinking fluids for relief of heat stress.

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Explosion/ 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 that are uncontrolled and not part of the process.
Security Incidents	<p>Any event that threatens or actually impacts the security of Qatar Steel staff, assets, confidential information or business continuity arising from sabotage, political or social upset, organized crime.</p> <p>Examples include:</p> <ul style="list-style-type: none"> • Unauthorized access or intruder on a Qatar Steel site • Theft from a Qatar Steel site or personnel engaged in controlled activities • Criminal damage to Company property • Physical harm / Receipt of threats (verbal or written) • Significant protest or demonstration at a controlled or monitored site
Environmental Release	<p>Any unplanned event that has an adverse impact upon the quality of air, land, water, wildlife for example:</p> <ul style="list-style-type: none"> • Sudden and uncontrolled liquid / gaseous release • Exceedance / breach of permit or external reporting requirement • Waste management (escape or improper storage/disposal). <p>Controlled release of gases or liquid through maintenance shall not be considered incidents, and are thus not reportable provided they are within regulatory permit conditions. If outside regulations, the release shall be recorded as an environmental incident.</p>
Property Damage	An event which results in damage to equipment, building, structures, vehicles etc.
Vehicle Incidents	Any crash involving a Qatar Steel Employee or visitor transportation provided by Qatar Steel i.e. Qatar Steel Buses, Qatar Steel Contractor vehicles within Qatar Steel premises.
Other Violations	Other events not covered by the definitions provided above e.g. Process Safety incidents
Non-industrial Incident	Any potential or actual harm or damage (including death) to the body resulting from external causes that does not arise on Qatar Steel premises.
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Term	Definition
Risk Assessment Matrix	The Risk Assessment Matrix is a tool that standardizes qualitative risk assessment, facilitates the Qualitative categorization of HSE risks and, where appropriate, used for prioritization of activities and resources. The matrix axes, consistent with definition of risk, are Consequences (Impacts) and Probability (Likelihood).
Root Cause	The most basic causes that can reasonably be identified, for which effective corrective actions for preventing recurrence can be generated. These causes are most often imbedded in the systems of the organization.
Repeat Incidents	<p>Repeat incidents are defined as events that meet the following criteria:</p> <ul style="list-style-type: none"> • Previously occurred at the same site/operation and was investigated and, • Involved the same activity and, • Occurred as a result of exposure to a similar hazard and, • Occurred as a result of a similar immediate or root cause. <p>Note that all 4 criteria must be satisfied for a repeat incident classification.</p>

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5 CLASSIFICATION

Accidents and near misses are classified according to the following criteria.

5.1 Type of Event / Observation

- 1) Accident
- 2) Near Miss
- 3) Unsafe Act
- 4) Unsafe Condition

5.2 Type of Outcome

- a. Personal Injury
- b. Environmental Release
- c. Explosion / Fire
- d. Property Damage
- e. Vehicle Incident
- f. Other (e.g. Security)

5.3 Severity of Event

The actual and potential severity of each accident and near miss is classified in alignment with the level of consequence to People, Assets and Production, Environment and Reputation as outlined in the Qatar Steel Risk Matrix.

The severity level determines the level of response with respect to the investigation methodology, who investigates and reports, who is informed, and who reviews/approves investigations.

In instances where an accident/near miss has multiple potential effects, the most severe shall prevail and injury to personnel has priority over other effects when other severities are equal.

5.3.1 Actual Severity Level

Assess the actual severity in each of the categories in Tables 2 - 5 and record the highest level. For near miss events, potential severity is used.

5.3.2 Potential Severity Level

The potential severity level is classified by determining the most realistic outcome had the circumstances been different.

Where a change in circumstances or removal/absence of barriers could have led to a different outcome, it is necessary to look at the actual circumstances and consider “what might have been”. In determining the most realistic outcome, effective barriers and protective measures in place should be considered. Discounting the effectiveness of reliable barriers could cause an over-estimation of the potential consequence of an incident.

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5.4 Risk Ranking

Table 2: People

Potential Severity	People	Description
0	No injury	No injury or health effect.
1	Slight injury or health effect	First Aid cases or minor discomfort cases e.g. Headache, dust / fumes / gases having irritation in the nose when inhaled - a person can return back to work after a rest.
2	Minor injury or health effect	Reversible injuries or illnesses requiring Medical Treatment (MTC) or Restricted Workday Cases (RWC) for 5 days or less but not LTI's. E.g. loss of consciousness from medical reasons only (e.g. diabetes, epilepsy, narcolepsy etc.), needle stick injuries and cuts from sharp objects.
3	Major injury or health effect	Reversible injuries or illnesses resulting in RWCs for more than 5 days or LTIs e.g. punctured ear drums, fractured ribs or toes, chronic back injuries, loss of consciousness from work-related activities e.g. blow to the head, heat induced.
4	Single Fatality or permanent total disability	Single fatality, permanent disability or irreversible illness such as corrosive burns, amputation.
5	Multiple fatalities	Multiple fatalities or multiple irreversible illnesses. A near miss with potential for multiple fatalities.

Table 3: Asset damage, Loss of Production

Potential Severity	Asset damage, Loss of Production	Description
0	No damage	No financial impact.
1	Slight damage, (< QAR 50,000)	No disruption to operation, estimated cost less than QAR 50,000.
2	Minor damage (QAR 50,000 to 500,000)	Brief disruption to operation, estimated cost of QAR 50,000 to 500,000
3	Local damage (QAR 0.5M to 5,000,000)	Partial shutdown of operation, estimated cost of QAR 500,000 to 5,000,000.
4	Major damage (QAR 5M to 25,000,000)	Partial loss of operation; estimated cost between QAR 5M to 25,000,000.
5	Extensive damage (>QAR 25,000,000)	Substantial or total loss of operation with estimated cost in excess of QAR 25,000,000.

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Table 4: Environment

Potential Severity	Environment	Description
0	No effect	No impact to the environment.
1	Slight effect	No lasting effect. Low-level impacts on biological or physical environment, local environmental risk within the fence and within the system. Clean up within days.
2	Minor effect	Minor short-medium term damage to small area of limited significance. Single exceeding of statutory or prescribed limits; single complaint; no permanent effect on the environment. Clean up within weeks.
3	Local effect	Moderate short-medium term widespread impacts; repeated exceeding of statutory or prescribed limits and beyond fence or neighborhood. Clean up within months.
4	Major effect	Severe environmental damage; Qatar Steel is required to take extensive measures to restore the contaminated environment to its original state; extended exceeding of statutory or prescribed limits. Clean up within months – years.
5	Massive effect	Persistent severe environmental damage or severe nuisance extending over a large area; in terms of commercial or recreational use or nature conservancy, a major economic loss for Qatar Steel; constant high exceeding of statutory or prescribed limits. Long term clean up required.

Table 5: Reputation

Potential Severity	Reputation	Description
0	No impact	No reputational impact.
1	Slight impact	Public awareness may exist but there is no public concern.
2	Limited impact	Some local public concern; some local media or local political attention with potentially adverse aspects for Qatar Steel operations.
3	National impact	National public concern; extensive adverse attention in the national media. Significant difficulties in gaining approvals.
4	Regional impact	Extensive adverse attention in the regional media; regional public and political concern. May lose consent to operate or not gain approval. Management credentials are significantly tarnished.
5	International impact	Extensive adverse attention in international media; international public attention. Consent to operate threatened. Reputation severely tarnished.

6 ROLES AND RESPONSIBILITIES

All Qatar Steel employees are responsible for obeying the incident reporting guidelines contained

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within this procedure. A failure to obey and practice these responsibilities could lead to disciplinary action. Functional responsibilities are assigned to key personnel as follows:

HSE Manager

- Provides appropriate notification of incidents to external stakeholders (MIC) in the timing defined in this procedure (after consultation with MD & CEO)
- Reviews Initial Incident Report form for the sufficiency and quality of the information provided and decides whether a Detailed Incident Investigation with Root-Cause Analysis is required for incidents, based on the guidelines provided in this procedure.
- Informs the MD & CEO and CO of any serious incident (as identified in the notification flow).
- Approves the Incident investigation task team composition
- Reviews all Detailed investigation reports for the sufficiency and quality of the information provided and provides feedback to incident investigation team leader as necessary
- Provides any kind of assistance / expertise throughout incident investigations, as requested by the Incident Investigation Team Leader
- Support communication of Lessons Learned across Qatar Steel
- Issues bi-monthly reports to Department Managers and MD & CEO for summary of all incidents, including bimonthly progress status reports of open action items. Reports are issued to the owning Department Manager.
- Reviews the justification for a proposed new action / deadline
- Ensures that all incidents and corrective actions are maintained in the central database (ITS system)
- Supports Line Management in communication of learnings and findings from incidents with a severity (actual or potential) classified as S3, S4 or S5 as per this procedure
- In case of personal injury, HSE Manager / Dept. shall follow up that necessary reports to Insurance & Human Capital Department have been sent and received by responsible personnel.
- Frequently inspects the incidents corrective actions across different departments for effectiveness (utilizing the inspection checklist provided in this procedure)
- Formally appoints the Incident Investigation Team Leader and defines the deadline, when a Detailed Investigation and Root Cause Analysis is to be performed
- Supports the arrangement of adequate resources to support investigations of S4 or S5 severity. This can be in the form of 3rd party support if required.
- Reviews and approves the Detailed Incident Investigation Reports.

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HSE Coordinator

- Ensure the shift supervisor secures the incident scene.
- Initiate evidence collection process (statements, measurements, document collection and photos).
- Receives notification and supports Shift Supervisor in the initial classification of the incidents
- Coordinates the initial response based on the initial classification of the Incident
- Review initial incident form for the quality/sufficiency of the information and data provided.
- Issue the initial incident form through ITS system (if the actual and potential severity is S1 or S2)
- Participate in incident investigations, providing any kind of assistance / expertise and ensure that they are completed within the prescribed time limits.
- Ensure that the incident procedure is adhered to
- Follow-up on implementation of corrective and/or preventive actions.
- Compile a Safety Alert regarding the incident and distribute to Department Managers, as per instruction.
- Provides support to HSE Manager in preparation of periodic reports
- Notifies HSE Manager immediately of any serious incidents (classified as actual S3 or actual & potential S4 or S5)

Chief Officer

- Reviews and validates a proposed new action / deadline
- Arranges a routine meeting with all involved parties at regular intervals to discuss the progress of incidents action plans and status.

Managing Director & Chief Executive Officer

- Notifies the Board of Directors of incidents resulting in a fatality / multiple fatalities.
- Provides support in the form of reviews and resources in the case that there is an actual S4 or S5.

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Department Manager

- Encourages employees and contractors working under him to promptly notify all incidents and near misses
- Ensures availability of department personnel and appropriate resources for investigations, as required (is also consulted for alignment on task team membership within his department)
- Contributes to the detailed incident investigation process if/when required by the Incident Investigation Team Leader
- Reviews Detailed Incident Reports for the sufficiency and quality of the information provided and provide feedback to Incident Investigation Team Leader, as necessary.
- Ensures implementation of all actions related to his area of responsibility and routinely monitors and follow up to ensure timely completion as per defined deadlines
- Shares incident reports with all the personnel in his area of responsibilities and actively communicate key findings and learnings
- Ensures incidents corrective actions in his area of responsibility are periodically inspected for effectiveness
- Reviews the justification for a proposed new action / deadline

Shift Supervisor

- Upon receipt of initial notification by the Incident Notifier, evaluates and classifies the incident, according to the requirements set in this procedure
- Encourages employees and contractors working under him to promptly notify all incidents and near misses.
- Secures the incident scene and prevent potential escalation of hazards (e.g. barricaded) and preserve the scene to avoid destruction of evidence / reoccurrence of incident and potential escalation of hazard.
- Identify initial action to be implemented and assigns actioners
- Shares incident reports with all the personnel in his area of responsibilities and actively communicate key findings and learnings.
- Contributes to the detailed incident investigation process if/when required by the Incident Investigation Team Leader

Incident Investigation Team

- Actively participate and contribute to the incident investigation process by completing the tasks assigned by the Incident Investigation Team Leader. For example:
- Attend the meetings and participate to all investigation activities
- Support collection of evidence / facts as agreed with the Team Leader
- Contribute to and/or write the incident investigation report as agreed with the Team Leader

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- Complete all actions arising from the investigation that are required to move the investigation forward as requested by the team leader.
- Ensure confidentiality is maintained during the course of the investigation
- Each Team Member formally represents his function/department in the course of the investigation process

Incident Investigation Team Leader

- Identifies, together with HSE Manager and in alignment with relevant department/functions, the necessary Incident Investigation Team Members
- Plan and lead the detailed incident investigation (and Root-Cause Analysis) as per the present procedure
- Ensures systematic identification of root-causes through application of suitable root-cause analysis methodologies
- Ensure that appropriate corrective / preventative actions (recommendations) are identified and agreed with respective functions / departments
- Ensures that the Detailed Incident Investigation Report is completed within defined timeline and meets the minimum requirements as specified in current procedure
- Present the result of the Detailed Incident Investigation to Qatar Steel Management, when required

Note - Investigation Team Leader is normally a Qatar Steel employee. In specific circumstances, the CO may indicate the need to appoint an external Team Leader to facilitate and lead the investigation.

Action Owner

- Ensure that the action is completed and implemented by the due date.
- Inform the Department Manager and HSE Manager when an action is completed and provide evidence and a full description of exactly what was done to fulfil the requirements of the recommendation. Evidence could be minutes of a meeting an updated procedure, a work order for some engineering work, etc.
- Define the action as completed and attach or reference the relevant evidence wherever possible.

Medic / Nurse

- To provide medical care in the case of personal injuries
- Support and advise with incident investigation, including classification of injuries / medical conditions
- Monitor status of injured persons and liaise with outside hospitals

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7 INCIDENT INVESTIGATION AND REPORTING PROCESS FLOW

The steps in the process of incident investigation are described as follows:



Figure 1: 8 Step Incident Investigation Process

7.1 Step 1 – Initial Response

7.1.1 Initial Response

- When an incident occurs, it is the responsibility of either an eyewitness, the affected person, or any other appropriate person with adequate information to notify the Shift Supervisor so that an appropriate and timely response is made.
- An initial evaluation is conducted, and classification is made. The initial notification shall also be provided to the HSE Co-ordinator who will assist the Shift Supervisor in the initial classification of the incident.
- Immediate actions shall be taken to eliminate or control hazards when an incident occurs. Depending on the incident, the Emergency Response Plan might be activated, if necessary, following specific guidelines provided in Qatar Steel ERP procedure.
- The safety of personnel and the surrounding community is the first consideration; however, in addition to activating the appropriate emergency response to the event, area supervision must take steps to preserve physical items, computer data, and other relevant information until the investigation begins.

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- Preservation of the scene and all potentially relevant physical items, computer data, and other information is especially critical if the event is serious enough to warrant investigation by external agencies or the local country authority having legal jurisdiction.
- Steps that should be taken to prevent the disturbance of or tampering with potential evidence include the following:
 - Barricading and securing of the scene, including protecting it from the weather
 - Collecting, identifying, and properly storing (i.e., preserving) physical items and data records
 - Photographing the incident scene and equipment, as necessary
 - Documenting interviews of key personnel

7.1.2 Notification

- Actual S3, actual and potential S4 & S5 incidents are immediately communicated to the HSE Manager, affected Department Managers, MD & CEO and Chief Officers via phone (SMS or call).
- A short email (which generates also an SMS) within two (2) hours from the incident occurrence. Shift supervisor & HSE coordinator outline the nature and severity of the incident, including the number of personnel/ contractors injured, extent of injuries and whether hospitalization was required.
- Actual S1, S2 and potential S3 incidents are notified within 24 hrs. to HSE Manager and Department Manager via email/ SMS
- All incidents are investigated and documented via ITS.
- Once the Initial Incident Report is generated in ITS, in the case of actual and potential S1 and S2, then the report is formally issued
- Initial Incident Report is issued within 48 hours from the time of the incident occurrence.
- HSE Manager shall review the report to ensure completeness, accuracy and quality of reported information.
- If the severity of the incident is potentially S3, then the Initial Incident Report is reviewed by the HSE Manager and the decision to undertake a detailed investigation is at the discretion of the HSE Manager, with consultation from relevant Department managers (decision to be made within 48 hours of the incident occurrence).
- External notification of incidents is aimed to share substantial information with the Board of Directors of Qatar Steel, concerning HSE incidents resulting in a fatality / multiple fatalities.
- HSE Manager will notify the relevant authority for any HSE incidents with actual severity classified as S3, S4 or S5 incidents.
- The notification will be in the form of fax or email and should take place within 24hrs from the incident occurrence. This notification excludes emergency case incidents, which are handled under the "Emergency Response Procedure.

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HSE Department

Issued by:
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7.1.3 Communication of learnings

- Communicating the learnings from an initial investigation is a vital component in the effort to prevent recurrence and to leverage learning more broadly.
- HSE Manager & Department Managers shall ensure an active and timely communication and review of relevant learnings to appropriate personnel, including employees and contractors from the affected area, and those whose job tasks are related to the incident findings.
- HSE Department may assist Department Managers in the preparation of a support document to facilitate the communication of the learnings across the organization.

7.1.4 Classification of Incident

- A detailed (formal) investigation - with Root Cause Analysis - might be required, depending on the classification of the incident severity, considering both actual or potential consequence of the incident (see *Risk Ranking Section 7.4*).
- Incidents with an actual S3 or actual and potential S4 or S5 require a formal and detailed investigation. The investigation of incidents with potential S3 consequences are at the discretion of the HSE Manager (in consultation with relevant Department Managers). See Table 6 below.
- Incidents with an actual or potential consequence classified as S1 or S2 are not subject to a mandatory Detailed Investigation (Management can request a detailed investigation).
- HSE Manager provides the Chief Officer with written indication on the need to conduct a detailed incident investigation, based on the criteria outlined in table below.
- Any deviation from these requirements will need formal justification from the Management.

Table 6: Detailed Incident investigation requirements

S1 or S2	Potential S3	Actual S3 & Actual & Potential S4 or S5
Detailed Investigation / RCA requirements		
Detailed Investigation / RCA is not required	A detailed RCA may be conducted for potential S3 or if there is recurrence of accident / near miss. This is at the discretion of the HSE Manager (in consultation with relevant Department Managers)	Detailed Investigation / RCA is required

Note - Disciplinary action would be taken against any employee who conceals an injury or incident and/or evidence.

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7.2 Step 2 – Form Investigation Team

The composition of the investigation team is critical as it could affect quality of investigation. The incident investigation team leader shall be appointed by the HSE Manager.

In determining the composition of the investigating team, the following guidelines need to be considered depending on the nature, severity and complexity of the incident:

- The HSE Manager shall sponsor the investigation and shall nominate the incident investigation team leader:

Investigation Team Leader

- The Investigation Team Leader will always be the highest position in terms of the companies hierarchy, e.g. Department manager will not be a member of the investigation team but rather the Team Leader of the investigation team,
- The Investigation Team Leader shall be trained and competent in the Incident Investigation and Reporting process, including Root-Cause Analysis techniques. He must have successfully completed Incident Investigation training and be competent, as a minimum, in the following:
 - Collecting and preserving evidence
 - Conducting effective interviews
 - Establishing event chronologies
 - Application of root cause analysis (RCA) techniques
 - Writing recommendations
 - Creating incident investigation report
- The Investigation Team Leader should also have participated in several investigations before leading the Investigation Team for the first time.
- Investigation team leader shall be independent of the affected area
- Investigation team leader shall assign one of the team members as a scribe for duration the investigation
- Selection of Investigation team leader shall be as follows:
 - In the case of Actual & Potential S3, the chair shall be at Section Head level and above.
 - In the case of Actual & potential S4 or S5, the chair shall be at Manager level

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Team Members

- Incident investigation team should consist a minimum of five and maximum seven core members
 - HSE Manager / HSE Engineer / Department Manager
 - Subject Matter Experts from different disciplines as required e.g.
 - Operations,
 - Maintenance,
 - Medical / Nurse, in case of injuries or illnesses
 - Representative from the affected department
 - Learning and Development / HSE Trainer
 - Incident controller in case the incident was handled as an emergency
 - As appropriate, and where the incident involved contract work, contractor management and employees
 - At least one member of the investigation team shall be knowledgeable of the process, where the incident occurred.
 - For security related incidents, security personnel must be consulted and be part of investigation team member.

The following people may NOT form part of the investigation team

- Injured employee(s)
- Witnesses to the incident.
- Direct supervisor

Initial on boarding of the Incident Investigation Team members represents a key step to ensure adequate alignment of the different members. Soon after the identification of the team members by the Incident Investigation Team Leader, the Team Leader shall:

- Formally notify the Team Members of the inclusion within the Incident Investigation Team
- Organize a formal onboarding meeting with all team members to align on objectives, scope, working method, plan of activities

7.3 Step 3 – Determine the Facts

All information and evidence relating to the incident, as well as to the events and conditions leading up to the incident, should be gathered.

In order to determine what happened to cause the incident and how it happened, the Incident Investigation Team needs to establish answers to the following: WHO, WHAT, WHEN, WHERE and WHY. When questioning people, be aware of comments like “that area isn’t important” or “don’t go there” and these may lead to important aspects of the contributing factors.

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Effective evidence preservation is the key to answering these questions and achieving a successful investigation. The four types of evidence, known as the Four P's, are Position, People, Parts and Paper.

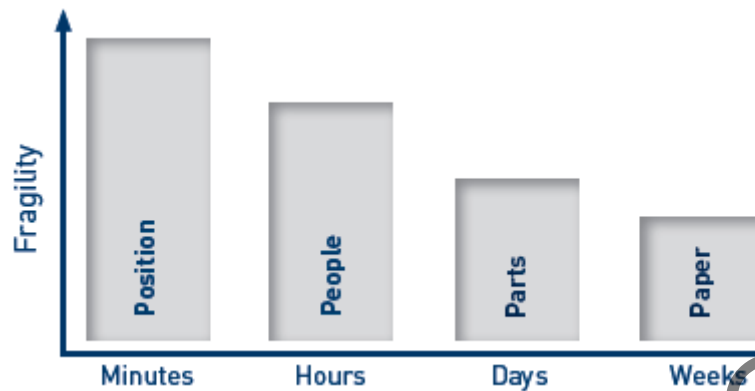


Figure 2: Four types of evidence (Position, People, Parts and Paper)

Position

This is the most fragile form of evidence so should be gathered as soon as possible after the incident has occurred.

Conduct a physical examination of the area around the incident location. Sketches, diagrams, position maps and photographs all assist in determining where people and equipment were before, during and after the incident. Look for evidence of movement e.g. scrapes, skid marks, etc. In the event of a fatality, take photographs tactfully showing the position of the body, and if the body can be removed, photograph the area again after removal.

Note: Due to the fragile nature of the 'position' evidence, there is local responsibility of first responders to capture this information.

People

The primary method to be used for gathering people evidence, the second most fragile type of evidence, is personal interviews. As people's recollection of details will be affected over time, it is imperative that witnesses are interviewed as quickly as possible. Relevant information is not restricted to the incident itself, but includes standards and practices of the work group, normal operating conditions and any past incident of a similar nature. Interviews and witness statements need to be taken from those people both directly and indirectly involved in the incident.

Best practice is to undertake the interview, then have the interviewer complete the witness statement afterwards, then review with the interviewee who should then sign as correct. Collecting witness statements without an interview can lead to omission of important information.

The willingness of witnesses to disclose information can be affected by the way they are questioned. When interviewing witnesses the following points should be used where appropriate:

Interviews Questioning techniques to use:

- Ensure that while one person makes his/her statement, other witnesses are not present
- Interview at an appropriate place

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- Use an interpreter if necessary
- Put the person at ease
- Get the individual's version
- Use the questioning technique of starting with open questions. Further clarity must then be obtained by general questions followed by specific (yes/no) questions
 - Use CLOSED questions only to establish facts
 - Avoid hypothetical questions e.g. "So what do you think happened?"
 - Avoid leading questions e.g. "So in your opinion he did it?"
- Ask necessary questions at the right time
- Statements must be read back to the persons to ensure they reflect the true events and only once agreed to, should be signed by the person who gave the statement
- Give the witness some feedback
- Record critical information quickly
- Use visual aids
- End on a positive note
- Give the witness the opportunity to come back to the investigation team if they remember further information.

A demonstration may assist to visualize the incident, but incident re-enactment should be used only:

- When the information cannot be gained in another way
- When it is vital to the development of remedial actions, or
- When it is absolutely necessary to verify critical facts about the incident.

When using re-enactments, have the witness describe each step carefully before acting the part. Stop the action before the critical (accidental) step.

After all statements have been taken and other relevant evidence collected, the investigation team must have a discussion to ensure that they have a full understanding of the sequence of events.

Parts

Parts, tools, equipment, PPE (personal protective equipment) must be retrieved, labelled (what it is and where it was found) and protected against damage for later analysis. An examination of physical items involved in the incident must be carried out to determine what role they played in the incident and to identify the possible causes of the incident.

The following questions may be asked when examining a piece of plant/equipment:

- Where is it damaged?
- What caused the part to fail?
- Was the part being used fit for purpose?
- Did the part conform to the design specification?

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- What was the extent of the wear and tear?
- Is there any evidence of “tampering” (seek expert advice)?

Paper

Paper evidence is the least fragile of all types of evidence, and will be available for analysis days or weeks after the incident. Review documents and records that are relevant e.g.:

- Equipment maintenance records,
- Procedures,
- Risk assessments,
- Permits,
- Test certificates,
- Toolbox talks,
- Registers,
- Training certificates,
- Competence certificates and qualifications.

Such documents are used to confirm facts and verify conditions which will assist with establishing the potential causes.

Develop a Chronology/Timeline

Once all sources of information and evidence have been gathered it is important to analyze it in such a way as to establish the sequence of events and conditions that led to the incident. This is most effectively done by establishing a timeline for the events and conditions which is described in the following steps.

1. Identify the main event or “incident”. This should be a single line statement usually describing the point in time when the incident occurred. The main “incident” event would not normally have associated conditions.
2. Progressing backward in time identifies the pre-incident sequence of events from the information collected through interviews and document reviews. Branches can be constructed where a parallel event sequence occurred. The branches should join the main time sequence at the appropriate point.
3. Progress forward in time from the incident and identify the post-incident event sequence.
4. For each event, detail relevant conditions at the time of that event.
5. Ensure each event and condition is discretely numbered so that the timeline can be reconstructed. An Excel spreadsheet is recommended to record the Timeline.
6. Any events or conditions that are assumed or that require further investigation should be clearly marked so this information can be acquired.

Once the Incident Investigation Team has agreed upon the timeline, those personnel directly involved

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with the incident, including contractors and temporary staff, should be consulted to verify that the timeline is correct. This step is extremely important to ensure the Team's findings are accurate and credible.

7.4 Step 4 – Determining Key Factors

Once all evidences and facts have been determined a systematic analysis of root-causes can be initiated.

Root Cause Analysis is a method whereby immediate causes are further analyzed to identify underlying causes, and underlying causes are further analyzed to identify root causes.

Identification of root causes allows identification of an effective set of preventative/ correct actions, in particular to address the systemic root-causes which have led to the incident and that could lead to future re-occurrences if not properly addressed.

Specific Root-Causes Analysis techniques may be adopted, such as those listed in the table below (list not exhaustive):

Table 7: RCA Techniques

Technique	Brief overview
5 Why Analysis	Five Whys typically refers to the practice of asking five times why the event/failure has occurred in order to get to the root cause of the problem
Fishbone / Ishikawa Diagrams	Ishikawa diagram (also known as Fishbone diagram) is simple structured graphical tool perform cause and effect analysis and identify the root causes of events/problems
Why Tree	Pre-defined logic tree is a structured/sequenced diagram tools which helps to visualize the causal relationships among different causes (from direct/immediate causes down to potential root-causes) in a logical sequence

There is no “right” or “wrong” technique. The Incident Investigation Team Leader is responsible for selecting the technique that better fits to the specific situation, taking into consideration:

- Complexity of the event and its dynamic nature
- Personal experience in application of the technique
- Competencies / confidence of the team members in the applicability of the technique

7.5 Step 5 – Determining Systems to be strengthened

Investigations shall also identify Management System elements that need to be strengthened to help prevent recurrence and enable trend analysis and continuous improvement.

These areas for improvement flow from the key factors already identified and shall be noted on the investigation report.

7.6 Step 6 – Recommending Corrective and Preventive Actions

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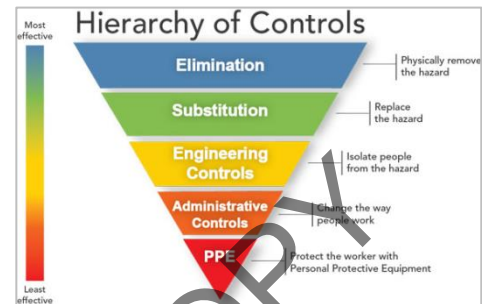
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An important step of the investigation process is to propose effective actions (preventive / corrective) to prevent recurrence. The following is vital:

- Proposed corrective and/or preventive action arising out of the Incident Investigation must address all of the identified root causes.

1. Elimination
2. Substitution
3. Engineering control
4. Procedures & Training
5. PPE



- Include identification, for each action, of responsible individual (Action Owner) and estimated completion dates
- Ensuring that proposed actions are agreed with relevant stakeholders (e.g. affected departments)

In particular, the Incident Investigation Team should identify the need to:

- Review/update any Hazard Identification & Risk Assessment studies
- Review/update any operating procedures / safe work practice
- Review/update the Emergency Response Plan
- Re-train relevant personnel

Note: Recommendations that need to be completed before operations resume should be clearly identified. Other recommendations (e.g., longer-term system- related improvements or evaluations) often require a completion date that extends beyond startup.

7.7 Step 7 – Document & Communicate Findings

Communicating the results of incident investigations is a vital component in the effort to prevent recurrence and to leverage learning's more broadly.

A Safety Report should be distributed as soon as possible after an incident occurred, the following need to be communicated to all employees:

- What happened (do not communicate the name(s) of any injured or parties involved)
- In which area
- Immediate actions taken to prevent recurrence
- Immediate and contributing causes

A Detailed Incident Investigation report should be written so that personnel not directly involved in the affected area can understand them - Site or area specific terminology should be minimized.

Once the draft of the Detailed Incident Investigation report is generated by the investigation team, line

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management and HSE Manager shall review the draft report for completeness and quality prior to approval and issuance.

Each review step shall help ensuring that the following items have been addressed and providing feedback to the investigation team concerning additional work to be done prior to finalization:

- Accuracy of incident classification
- Completeness and thoroughness of applicable facts, chronology, and root-cause analysis
- Adequacy and specificity of recommendations and timing to address all physical, human, and operating or managing system key factors (including the need for interim controls for recommendations involving long-term implementation). For any incident recommendation requiring funding, authorization at the appropriate level of the organization need to be obtained.
- Accuracy of items listed for system elements needing strengthening
- Accuracy and completeness of linkages between facts, root-causes, recommendations, and system elements needing strengthening

The Detailed Incident Investigation reports should be finally approved within maximum thirty (30) calendar days from the incident occurrence date, or within the timeframe defined by the Chief Officer.

Upon final approval, the Detailed Incident Investigation Report is shared with relevant stakeholders. In particular, copies of the Detailed Incident Investigation Report shall be sent by the HSE Manager to:

- Manager of the affected department
- Legal Department
- Environment Engineer, in the case of spills or releases and require further reporting to MME

A case study will be shared with all.

7.8 Step 8 – Follow up

To ensure prompt follow-up and closure of recommendations from an incident investigation report, a system must be developed for periodic status reports by HSE Manager until all recommendations are implemented and closed out.

Additionally, it must be ensured that the system includes a verification of the implementation and effectiveness of the corrective action.

If a recommendation is to be declined, the Action Owner shall document, in writing and obtain the approval of Department Manager and HSE Manager on adequate evidence, that one or more of the following conditions is true:

- The analysis on which the recommendation is based contains material factual errors.
- The recommendation is not necessary to protect the health and safety of the employer's own employees, the employees of contractors, or the health and safety of the community, wildlife, or environment.
- An alternative measure would prevent recurrence of a similar incident.
- The recommendation is not feasible (note that an alternative recommendation should be provided to address the key factor).

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- **Mothballing Plant: All incidents reports status categorized as ‘Closed due to mothballing’ the same incident reports will be reviewed and ensure all the recommended corrective actions are closed before the mothballing plants are planned to operate again.**

The investigation report can be finally closed only by the Chief Officer after due verification that all recommendations have been implemented.

The HSE Manager ensures periodic (weekly) report for Qatar Steel Management to support management monitoring of incident and action plans. The following leading performance indicators should be considered in the HSE Dashboard for Qatar Steel:

- Number of open detailed investigations
- Number and % of detailed investigation report finally approved within defined deadline (defined by Qatar Steel Chief Officer as per procedure)
- Number and % of open recommendations
- Number and % of overdue recommendations
- Number and % of recommendations completed within expected deadline (YTD and by year)
- Trend and analysis on system elements identified to be strengthened by investigations

Subsequent preventive/corrective action plans are reviewed on a bi-monthly basis for their progress in a meeting with participation of HSE, Production and Maintenance delegates.

Close out rate for relevant action plans is reviewed by each Department Mgr. in regular meetings and forms part of Department's performance dashboard.

A tracking system is available in Incident Tracking System to monitor the completion of the corrective actions.

Qatar Steel MD & CEO in consultation with the Chief Officers and HSE Manager shall decide which reports will be shared during Board of Directors Meetings.

8 CONTINUOUS IMPROVEMENT

This procedure must be inspected in order to ensure continuous improvement. The Audit checklist must be used when inspecting the performance of Qatar Steel against the incident investigation and reporting procedure on a quarterly basis by the HSE Dept.

9 REFERENCES

- 1) Qatar Steel, Incident Reporting, Investigation and Handling of Safety Suggestion Procedure

10 MANAGEMENT OF CHANGE

No changes shall be made to this procedure without approval from the Qatar Steel HSE Manager. Any suggestions or recommendations for updates or improvements to this procedure should be submitted in writing to the HSE Manager. Each submission should give details of the proposed amendment and the reason why it is considered necessary.

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The HSE Manager will keep a log of all change requests, prioritize them for action and, subject to his approval, schedule them for inclusion in the next relevant update of the document. The latest version of this procedure shall be made available via the QSC computer network. Earlier versions shall be retained for a minimum of three years in accordance with the Qatar Steel document management system.

11 APPENDICES

Appendix 13.1	Qatar Steel Risk Matrix
Appendix 13.2	Table of Contents for Detailed Investigation Report
Appendix 13.3	Incident Tracking System
Appendix 13.4	Overall incident investigation and reporting flow chart detailed flow
Appendix 13.5	Notification flow
Appendix 13.6	Guidance on selecting system elements to strengthen
Appendix 13.7	Illustrations of definitions
Appendix 13.8	Investigation Audit Checklist
Appendix 13.9	Incident Case Study
Appendix 13.10	World Steel Association Incident Notification Form