



**Health & safety incident reporting system
users' guide, 2010 data**

Report No. 444

May 2011





Publications

Global experience

The International Association of Oil & Gas Producers has access to a wealth of technical knowledge and experience with its members operating around the world in many different terrains. We collate and distil this valuable knowledge for the industry to use as guidelines for good practice by individual members.

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Document revisions

1.0 Initial release

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1 Summary

The International Association of Oil & Gas Producers, OGP has been collecting global safety incident data from member companies since 1985. The data collected are input directly to the OGP safety database, which is the largest database of health & safety incident statistics in the industry.

The principal purpose of the data collection is to record and analyse the global occupational illness and injury statistics of the OGP member companies in the areas of occupational health and safety, asset integrity including process safety, and motor vehicle safety. The annual report produced provides the information required to analyse industry incident trends, benchmark performance and identify subject areas and activities where focused efforts can be made to effect the greatest improvements.

The scope of OGP's incident reporting system includes worldwide exploration and production (E&P) activities, onshore and offshore, for both member companies and their associated contractor work hours, as defined in section 4.1. The data reported by member companies are consolidated and analysed in order to compute the frequency and severity of incidents and illnesses occurring in E&P operations by region, country, function and company. A code is used to preserve company anonymity.

The main changes to the 2010 data request are:

- 'Pressure release' and 'Water-related, drowning' have been added to the list of causes.
- "Decommissioning" has been added to the activity "Construction, Commissioning".
- The term "event" has been introduced to encompass both "incidents" i.e. when there has been a resulting injury or fatality, and "near misses" i.e. where there has been no harm but which in other circumstances could have resulted in an incident. See Glossary.
- Report 3 has been changed from "Significant Incidents" to "High Potential Events" to capture more detailed information situations which had the potential to cause fatalities.
- Report 6 broadens the scope of the reporting system to include events related to Asset Integrity (AI). Two indicators have been introduced to track "Process Safety Events" (PSE), which can also be referred to as Asset Integrity Events. PSE result from Loss of Primary Containment (LOPC), these are measured at two consequence levels, Tier 1 and Tier 2, which are only reportable to OGP for both onshore and offshore production and drilling activities. The data will be normalized using combined company and contractor work hours for production and drilling activities, as provided in Report 1. It should be noted that:
 - For the first, and probably second, year of reporting, results will be subject to independent validation (maintaining anonymity of companies, as per normal practice). The aim of validation will be to assess whether the reported data is consistent with the scope, definitions and instructions in this guide. Public reporting by OGP, initially limited to industry level data, will only proceed when the validation demonstrates that enough member companies have reported data that is sufficiently reliable to provide statistically representative aggregate data.
 - Results will be reported back to Member companies submitting data (using the normal practice of codes to preserve anonymity of companies).
 - The reporting requirements may need to be revised depending on feedback from Member companies and the Asset Integrity Subcommittee, who will review the data in conjunction with the Safety Data Subcommittee.

This guide has been developed to assist Member companies in accurately completing their annual health and safety data report to OGP, this document supersedes OGP Report N° 433.

2 Structure of the reporting system

Organisations are requested to provide their health and safety incident data using the standardised forms which are reproduced in the relevant sections of this guide with a completed example of Report 2, for reference, available in Appendix 1. Where available, a separate Report 1, 4 and 5 should be completed for each country in which the reporting Company has E&P operations and for each category (company personnel onshore and offshore and for Contractor personnel onshore and offshore). A glossary of terms is provided in Appendix 3 and Frequently Asked Questions are listed in Appendix 4.

Report 1: Occupational Injuries is to be used for reporting all recordable work-related injuries. Recordable incidents are those which result in:

- a fatality
- an injury requiring time off work (lost work day case)
- a restriction in the work performed (restricted duty case)
- an injury requiring medical treatment

Note: Work-related 3rd party fatalities shall be entered in Section E of Report 1, using the 3rd party onshore or offshore category as appropriate, with details of each fatal incident provided in Report 2. For Report 6, 3rd party fatalities are included in the consequence criteria for reporting the Process Safety Event indicator at the Tier 1 level.

Report 1A: Lost Workday Case Breakdown – Cause – is used to provide additional information on the injury causes associated with lost workday cases.

Report 1B: Lost Workday Case Breakdown – Activity – is used to provide additional information on the activities associated with lost workday cases.

The intent of gathering the detailed information in both reports 1A and 1B is to provide industry with focus areas for the development of guidance and recommended practice.

Report 2: Fatal Incidents is used to provide additional information on work-related fatalities as a result of an injury, rather than an illness (Details of occupational illness related fatalities should be reported in Report 4). Wherever a fatality is indicated in Report 1, details of the incident should be provided in Report 2, i.e. one completed Report 2 for every incident involving one or more fatalities. When a fatal incident results from an Asset Integrity/Process Safety Event, this should be indicated on Report 2, as well as including the relevant data in Report 6.

Report 3: Significant Incidents are defined to be incidents (excluding fatalities) which cause or have the potential to cause serious injury and/or fatality, or significant structural damage (which may place personnel at risk); these need not even be recordable incidents.

The intent of gathering the detailed information in both reports 2 and 3 is to maximise learning from incidents which did or may have resulted in a fatality. The learning from these incidents is not necessarily dependent on the actual outcome, therefore it is very important to provide sufficient detail on learning, to be able to provide the industry with recommendations and guidance to prevent recurrence.

Report 4: Occupational Illness is used for reporting of work-related occupational illnesses. The reporting of occupational illness data to OGP is generally not as comprehensive as injury reporting, often due to regulatory or legal constraints. It is important for the analysis of the reported data that it is indicated whether or not the requested information is being reported. If not, please enter N/A in the excel spreadsheet or use the 'NO' checkbox in the online data entry system to indicate that occupational illness data is not being reported. Only enter work hours associated with the operations where occupational illness data is being reported, as this allows rates/frequencies to be representatively calculated.

Report 5: Motor Vehicle Crashes is used for reporting the number and severity of Motor Vehicle Crashes. This data is used for industry performance benchmarking in line with the OGP Land Transportation Recommended Practice.

Report 6: Asset Integrity/Process Safety Events is used for reporting Tier 1 and Tier 2 Process Safety Events (PSE) according to the OGP guide “*Asset Integrity – Key Performance Indicators*” that is due to be published in early 2011, which is consistent with API Recommended Practice No. 754 on “*Process Safety Performance Indicators for the Refining and Petrochemical Industries*”.

3 Reporting process and timescales

Member companies shall nominate a representative, who will have responsibility for submitting the required health and safety incident data to OGP by the deadline date of 1st March 2011.

The preferred means of submitting data to OGP is through the use of the web-based data entry system. Alternatively, organisations can submit data by completing pre-prepared Excel forms. Finally data will be accepted in hardcopy format. Additional guidance can be provided for each available reporting option by contacting Wendy Poore at OGP.

ALL HEALTH AND SAFETY INCIDENT DATA SHOULD BE SUBMITTED AS EARLY AS POSSIBLE AFTER THE END OF THE REPORTING YEAR, IF POSSIBLE BY 14TH FEBRUARY STRETCH TARGET, BUT BY 1ST MARCH 2011 AT THE VERY LATEST.

For any issues please contact Wendy Poore immediately:

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Company data received by the Secretariat will be logged and reviewed for completeness. The Secretariat will contact the Company nominee if any questions arise.

A consolidated Safety Performance Report will be produced as early as possible after all data returns are received from reporting Members, and in normal circumstances by mid year.

4 Scope of reporting & key definitions

Data are to be reported on a country-by-country basis for all operations by the member company. In the case of joint ventures where the Member company has operational control, data should be included as part of the overall company reporting, unless the joint venture company is an OGP member in its own right.

The following definitions provide the scope of reporting for incidents and events that should be included within the data submission to OGP.

4.1 Work-relatedness definition

An injury or illness must be considered work-related if an event or exposure in the work environment caused or contributed to the resulting condition or significantly aggravated a pre-existing injury or illness. Work-relatedness is presumed for injuries and illnesses resulting from events or exposures occurring in the work environment unless one of the following exceptions applies in its entirety:

- Occurs when an employee or contractor is present in the work environment as a member of the general public. In case of a fatality, it will be included in the 3rd party statistics;
- Results solely from voluntary participation in a wellness program or in a medical, fitness, or recreational activity, such as blood donation, physical examination, flu vaccination, exercise class, racquetball, or baseball etc. Where the activity is company-sponsored the participation must be perceived by the employee as voluntary for this exception to apply;
- Involves signs or symptoms that surface at work but result solely from a non work-related event or exposure;
- Is solely the result of eating, drinking, or preparing food or drink for personal consumption (whether bought on the employer's premises or brought in). For example, if the employee is injured by choking on a sandwich while in the employer's establishment, the case would not be considered work-related. Note: If the employee is made ill by ingesting food contaminated by workplace contaminants (such as lead), or gets food poisoning from food supplied by the employer, the case would be considered work-related;
- Is solely the result of doing personal tasks in the work environment outside of the employee's assigned working hours;
- Is solely the result of personal grooming, self medication for a non-work-related condition or is intentionally self-inflicted;
- Is the common cold or flu (Note: contagious diseases such as tuberculosis, brucellosis, hepatitis A, or plague are considered work-related if the employee is infected at work); and
- Occurs during a commute from the home to the normal place of work or first stop unless it is company-mandated transport.

4.2 Occupational injury definition

An occupational injury is any injury such as a cut, fracture, sprain, amputation etc., 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, insect or snake bite. Report Forms 1, 1A and 2 should be used to report occupational injuries and fatalities.

4.3 Occupational illness definition

An occupational illness is any abnormal condition or disorder of an employee, other than one resulting from an occupational injury, caused by exposure to environmental factors associated with employment. This includes both acute and chronic illnesses or diseases. They may be caused by inhalation, absorption, ingestion of or direct contact with the hazard, as well as exposure to physical and psychological hazards. For additional information refer to OGP/IPIECA Report no. 393 “*Health Performance Indicators*”, published 2007.

4.4 Process safety event definition

A ‘process safety event’, which can also be referred to as an ‘asset integrity event’, is a Loss of Primary Containment (LOPC) and is recordable if:

- the consequence was a reportable employee or contractor injury or fatality, a third party hospital admission or fatality, a community or site evacuation or a fire/explosion; or
- a pressure relief device discharge or material release occurs which exceeded defined thresholds (even if none of the consequences above occurred)

as specified within the OGP Guide “*Asset integrity - key performance indicators*” (expected early 2011), which provides consequence and threshold definitions consistent with API Recommended Practice No. 754. The definitions and thresholds are also provided within this guide as part of Report 6. It should be noted that work relatedness is not generally a factor when determining whether an asset integrity/process safety event is recordable.

4.5 Company/contractor activity definitions

Company work-related activities

All work by Company personnel, including attendance at courses, conferences and Company-organised events where participation is perceived by the employee as mandatory, business travel, field visits or any other activity or presence expected by the employer. Refer to the section on work-relatedness for the exemptions that apply.

Contractor work-related activities

Reporting is required for all work performed by Contractor personnel under the following contractual Modes 1 and 2, as will be defined in the updated version of OGP Report 423 “*HSE management – guidelines for working together in a contract environment*” published in 2010:

Mode 1 - The contractor provides people, processes and tools for the execution of the contract under the supervision, instructions and HSE-MS of the client. The contractor has a management system to provide assurance that the personnel for whom it is responsible are qualified and fit for the work and that the processes, tools, materials and equipment they provide are properly maintained and suitable.

Mode 2 - The contractor executes all aspects of the contract under its own HSE-MS, providing the necessary instructions and supervision and verifying the proper functioning of its HSE-MS. The client is responsible for verifying the overall effectiveness of the HSE management controls

put in place by the contractor, including its interface with subcontractors, and assuring that both the client's and the contractor's HSE-MS are compatible.

Note: For reporting purposes, Sub-Contractor personnel are to be treated as if they were Contractor personnel and work hours and work-related events reported as Contractor events.

4.6 Personnel definitions

Company employee

A person employed by and on the payroll of the reporting Company, including corporate and management personnel specifically involved in E&P activities. Persons employed under short-service contracts are included as Company employees provided they are paid directly by the Company.

Contractor employee

A person employed by a Contractor or Contractor's Sub-Contractor(s) who is directly involved in execution of prescribed work under a contract with the reporting Company.

Third Party

A person with no business relationship with the company or contractor. Incidents in which there are third party fatalities should be reported on Report 1, with details provided in Report 2. This third party information will be used internally within OGP to identify learning opportunities.

4.7 Location definitions

Onshore

Refers to all activities and operations that take place within a landmass, including those on swamps, rivers and lakes. Land-to-land aircraft operations are counted as onshore, even though flights may be over water.

Offshore

Refers to all activities and operations that take place at sea, including activities in bays, in major inland seas, such as the Caspian Sea, or other inland seas directly connected to oceans. Incidents including transportation of people and equipment from shore to the offshore location, either by vessel or helicopter, should be recorded as "offshore".

Note: Strictly speaking, the categorisation under onshore or offshore refers to the physical location of the incident, and not to an individual's normal place of work. However, where this is administratively difficult, it is acceptable to record an incident as happening at the location where the work hours are recorded, even though the incident physically happened elsewhere. For example, a mechanic who normally works onshore is called offshore for a repair job lasting 2 days. Whilst offshore, the mechanic suffers an injury resulting in a lost workday. If the mechanic's work hours are counted as onshore hours, even though he was physically offshore, then the LWDC should be counted as an onshore incident. The same principle applies for personnel who

travel internationally, the incident should be assigned to the geographic location where their work hours are allocated.

4.8 Functions definitions

Exploration

Covers geophysical, seismographic and geological activities, inclusive of administrative and engineering aspects, maintenance, materials supply, and transportation of personnel and equipment. Exploration drilling is to be included under “drilling”. Exploration activities fall outside the scope of Report 6 for Asset Integrity/Process Safety Events.

Drilling

Includes all exploration, appraisal and production drilling, wireline, completion and workover as well as their administrative, engineering, construction, materials supply and transportation aspects. It includes site preparation, rigging up and down and restoration of the drilling site upon work completion.

Production

Covers petroleum and natural gas production operations, including administrative and engineering aspects, repairs, maintenance and servicing, materials supply and transportation of personnel and equipment. It covers all mainstream production operations including:

- Work on production wells under pressure;
- Oil (including condensates) and gas extraction and separation (primary production);
- Heavy oil production where it is inseparable from upstream (i.e. steam assisted gravity drainage) production;
- Primary oil processing (water separation, stabilisation);
- Primary gas processing (dehydration, liquids separation, sweetening, CO₂ removal);
- Floating Storage Units (FSUs) and subsea storage units;
- Gas processing activities with the primary intent of producing gas liquids for sale;
- Secondary liquid separation (i.e., Natural Gas Liquids [NGL] extraction using refrigeration processing);
- Liquefied Natural Gas (LNG) and Gas to Liquids (GTL) operations;
- Flow-lines between wells, and pipelines between facilities associated with field production operations;
- Oil and gas loading facilities, including land or marine vessels (trucks and ships) when connected to an oil or gas production process;
- Pipeline operations (including booster stations) operated by company E&P business.

Production excludes:

- Production drilling or workover;
- Mining processes associated with the extraction of heavy oil tar sands;
- Heavy oil when separable from upstream operations;
- Secondary heavy oil processing (upgrader);

- Refineries.

Construction

All construction, fabrication activities and also disassembly, removal and disposal (decommissioning) at the end of the facility life. Construction activities under contracting Modes 1 and 2 shall be reported, as defined in the contractor work activities below. Construction of process plant, fabrication yard construction of structures, offshore installation, hook-up and commissioning, and removal of redundant process facilities are all examples to be included. Construction activities fall outside the scope of Report 6 on Asset Integrity/Process Safety Events.

Unspecified

Should be used for the entry of data associated with office personnel whose work hours and incident data cannot be reasonably assigned to the administrative support of one of the function groupings of exploration, drilling, production or construction. Corporate overhead support function personnel such as finance or human resources staff may be examples where work hours cannot be specifically assigned to a particular function.

4.9 Incident/event classification definitions

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. In some cases, a delayed fatality occurs in the next calendar year after the incident. For example, if the above fire occurred on December 21, the second death from it might occur in January of the next year. All fatalities from an incident should be included in the report for the year incident occurred.

Lost Work Day Case (LWDC)

When reporting occupational injury data (report forms 1, 1A and 1B): non-fatal cases that involve a person being unfit to perform any work on any day after the occurrence of the occupational injury. “Any day” includes rest days, weekend days, leave days, public holidays or days after ceasing employment.

When reporting occupational illness data (report form 4): non-fatal cases that involve a person being unfit to perform any work on any day after the occurrence of the occupational illness. “Any day” includes rest days, weekend days, leave days, public holidays or days after ceasing employment.

Restricted Work Day Case (RWDC)

When reporting occupational injury data (report form 1): cases that do not result in a fatality or a lost work day case but do result in a person being unfit for full performance of the regular job on any day after the occupational injury.

When reporting occupational illness data (report form 4): cases that do not result in a fatality or a lost work day case but do result in a person being unfit for full performance of the regular job on any day after the occupational illness.

For both illness and injury RWDC definitions work performed might be:

- an 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 Cases (MTC)

Are those cases not severe enough to be reported as fatalities, lost work day cases or restricted work day cases but are more severe than requiring simple first aid treatment. Further guidance on cases that qualify as medical treatment rather than first aid cases is given in Appendix 2.

Asset Integrity/Process Safety Event (PSE)

Recordable PSE are classified into Tier 1 or 2 based on whether an LOPC event meets or exceeds defined consequences or release thresholds (see Report 6 for detail of PSE data to be recorded). Companies may wish to internally classify other LOPC events which do not meet Tier 1 or 2 thresholds as a "Tier 3 PSE" (effectively a near miss). The new OGP Report, "Asset Integrity - Key Performance Indicators" (expected early 2011), also recommends indicators at "Tier 4" to assess performance of barriers which prevent LOPC. The general concept of using Tiers is analogous to the reporting hierarchy for occupational incidents, often referred to as the "personal safety triangle". Companies are encouraged to consider implementation of indicators in Tiers 3 and 4 for internal performance management, as well as the Tier 1 and 2 indicators included here for industry wide reporting.

4.10 Incident/event categories

The following list should be used for Reports 1A, 2 and 3:

- *Assault or Violent Act*
- *Caught In, Under or Between* includes injuries where the injured person(s) is crushed or similarly injured in non-impact cases e.g. between machinery moving parts or other objects, caught between rolling tubulars, crushed between a ship and a dock, or similar incidents.
- *Confined Space*
- *Cut, Puncture, Scrape*
- *Explosions or Burns* are injuries caused by the effects of fire and explosion such as burns, toxic gases, asphyxiation. 'Explosion' means a rapid combustion, not an overpressure. For example, a person hit by flying debris from a vessel explosion is classed in the category 'struck by'.
- *Exposure Electrical* includes incidents other than fatalities that involve electrical shock or electrical burns etc.
- *Exposure: Noise, Chemical, Biological, Vibration*
- *Falls from height* are injuries caused by incidents where a person falls off, over or onto something.
- *Overexertion/Strain*

- *Pressure release*
- *Slips and Trips (at the same height)*
- *Struck By* describes incidents where injury results from being impacted by moving equipment and machinery, or by flying or falling objects. Water related, drowning Incidents where water played a significant role.
- *Water related, drowning*
- *Other* is the category to specify where the injury cannot be logically classed under other headings.

4.11 Type of activity

The following list should be used for Reports 1B, 2 and 3:

- *Construction, Commissioning, Decommissioning*
- *Diving, Subsea, ROV*
- *Drilling, Workover, Well Services*
- *Lifting, Crane, Rigging, Deck Operations*
- *Maintenance, Inspection, Testing*
- *Office, Warehouse, Accommodation, Catering*
- *Production Operations* –includes normal, start-up or shut-down operations
- *Seismic/Survey Operations*
- *Transport – Air* incidents involving aircraft, either fixed wing or helicopters. Injuries caused by accidents on the ground at airports are classified in one of the other categories.
- *Transport – Land* incidents involving motorized vehicles designed for transporting people and goods over land, e.g. cars, buses, trucks. Pedestrians struck by a vehicle are classified as land transport incidents. Incidents from a mobile crane would only be land transport incidents if the crane were being moved between locations.
- *Transport - Water, including Marine Activity*
- *Unspecified – Other* is the category to specify where the injury cannot be logically classed under other headings.

4.12 Causal factors

The following list of causal factors should be used for Reports 2 and 3:

Further guidance has been provided in Appendix 3A – Glossary of Causal Factors to assist the user of the OGP list of causal factors, to further define and explain the classifications. Since the causal factors selected will be used for trend analysis, accuracy in selecting the appropriate cause is important. Users are encouraged to use this glossary to ensure proper understanding of each cause category.

People (Acts)

The “People (Acts)” causal factors involve either the actions of a person or actions which were required but not carried out or were incorrectly performed. There are four main categories, with an additional level of detail under each.

Following Procedures:

- *Violation intentional (by individual or group)*
- *Violation unintentional (by individual or group)*
- *Improper position (in the line of fire)*
- *Overexertion or improper position/posture for task*
- *Work or motion at improper speed*
- *Improper lifting or loading*

Use of Tools, Equipment, Materials and Products:

- *Improper use/position of tools/equipment/materials/products*
- *Servicing of energized equipment/inadequate energy isolation*

Use of Protective Methods:

- *Failure to warn of hazard*
- *Inadequate use of safety systems*
- *Personal Protective Equipment not used or used improperly*
- *Equipment or materials not secured*
- *Disabled or removed guards, warning systems or safety devices*

Inattention/Lack of Awareness:

- *Improper decision making or lack of judgement*
- *Lack of attention/distracted by other concerns/stress*
- *Acts of violence*
- *Use of drugs or alcohol*
- *Fatigue*

Process (Conditions) Classifications

Process (Conditions) classifications usually involve some type of physical hazard or organisational aspect out with the control of the individual. There are five major classification categories, with an additional level of detail under each of the major categories.

Protective Systems

- *Inadequate/defective guards or protective barriers*
- *Inadequate/defective Personal Protective Equipment*
- *Inadequate/defective warning systems/safety devices*
- *Inadequate security provisions or systems*

Tools, Equipment, Materials, Products:

- *Inadequate design/specification/management of change*
- *Inadequate/defective tools/equipment/materials/products*

- *Inadequate maintenance/inspection/testing*

Work Place Hazards:

- *Congestion, clutter or restricted motion*
- *Inadequate surfaces, floors, walkways or roads*
- *Hazardous atmosphere (explosive/toxic/asphyxiant)*
- *Storms or acts of nature*

Organisational:

- *Inadequate training/competence*
- *Inadequate work standards/procedures*
- *Inadequate hazard identification or risk assessment*
- *Inadequate communication*
- *Inadequate supervision*
- *Poor leadership/organisational culture*
- *Failure to report/learn from events*

5 Instructions for completion of report forms

The following section provides detailed descriptions of the report form and specific requirements for each of the reports.

The following information is required on all reports:

Contact Name/Title: Company nominated contact.

Year: Year to which the data relate.

Company: Parent member company submitting data.

Country: Country to which the data relate.

5.1 Report 1 – Occupational injuries

Separate submissions of Report 1 are to be completed for each country in which the reporting company operate under the following categories:

- A Company personnel Onshore
- B Company personnel Offshore
- C Contractor personnel Onshore
- D Contractor Personnel Offshore
- E 3rd Party Onshore (Fatalities only), 3rd Party Offshore (Fatalities only)

Data field descriptions

Nº Fatal Incidents: Enter the number of fatal incidents in the reporting year for the selected category. For each fatal incident, details should be entered in Report 2: Fatal Incidents.

Note: A fatal incident that involved only 3rd Party fatalities should be entered here with details given in Report 2.

Incident Category Reporting: Indicate whether the following data are being reported as separate categories i.e. indicate "yes" even if the number of incidents to report is zero (if "yes" is not indicated and the entry is left blank the data will not be included in the normalised results):

- Lost Workday Case (LWDC) Days
- Restricted Workday Cases (RWDCs)
- RWDC Days
- Medical Treatment Cases

Function: Separate entries should be made for each function, see section 4.8 for definitions. Injuries occurring in seismic and drilling camps or on offshore platforms during off-duty hours need not be included unless they are work-related, i.e. they are caused by other personnel who are at work.

Number employees: Enter the average number of full-time and part-time employees involved in E&P, calculated on a full-time basis, during the reporting year. Two part-time employees can be treated as one full-time employee. If data are not available, it is acceptable to divide the recorded worked hours by 2000 to derive the average number of employees.

Hours worked (000's): Hours must be reported in multiples of one thousand and should be rounded to the nearest thousand. An entry is required for hours for each row of data entered. If the whole row is empty or populated with '0' (zeros) the entry will be accepted.

- For onshore activities, actual hours worked, including overtime hours, should be recorded. The hours worked by an individual will generally be about 2000 per year.
- For offshore activities, hours worked should be calculated on the basis of a 12-hour workday. Average hours worked in a year will generally lie between 1600 and 2300 per person and will depend upon the on/off shift ratio.
- A person whose normal place of work is onshore but who occasionally visits offshore may have all working hours allocated to ‘onshore’, but then any injury occurring whilst offshore should be recorded as an onshore incident, i.e. in the same location as working hours are counted.

Nº Company/Contractor/Third Party Fatalities: Enter the number of company/ contractor/ third party fatalities that resulted from incidents in the reporting year. Where the date of death of a fatally injured person is in the calendar year after the incident occurs, the death should nevertheless be included as a fatality for the year of the incident. For each fatality, details should be entered in Report 2: Fatal Incidents. Provision is made in Report 2 for the reporting of related 3rd Party fatalities.

Nº Medical Treatment Cases: If medical treatment cases (MTC) are collected and reported, enter the number of MTCs in the reporting year. Further guidance on cases that qualify as medical treatment cases is given in Appendix 2.

Nº Lost Work Day Cases: The number of lost work day cases (LWDC) is the number of non-fatal cases that involve a person being unfit to perform any work on any day after the occurrence of the occupational injury. “Any day” includes rest days, weekend days, leave days, public holidays or days after ceasing employment.

Nº of Lost Work Days: If the number of days unfit for work (LWDC Days) is collected and reported, enter the sum total of calendar days (consecutive or otherwise) after the days on which the occupational injuries occurred, where persons reported under LWDC (above) were unfit for work and did not work.

- If LWDC days are reported at least one day must be reported for each lost workday case (LWDC).
- Where absence from work extends beyond the year end, the actual or estimated days unfit for work in the following year should be added to those for the reporting year in computing the number of lost work days i.e. days unfit for work.
- Do not include days unfit for work between a fatal incident and the date of death.

Example

Three employees were severely injured and unfit for work after their respective incidents. Employee A was unfit for 2 working days, a weekend and 2 further days. Employee B was unfit for 3 weeks, and Employee C was fit for work the day after the injury but thereafter not fit for the three following days.

A was unfit for work for 2+2+2 days	=	6 days
B was unfit for work for 3x7 days	=	21 days
C was unfit for work for		3 days
Number of days unfit for work	=	30 days

This example should be reported as 3 Lost Work Day Cases and 30 Lost Work Days.

Nº Restricted Workday Cases: The number of restricted work day cases (RWDC) is the number of cases that do not result in a fatality or a lost work day case but do result in a person being unfit

for full performance of the regular job on any day after the occupational injury. Restricted work performed might be:

- an 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.

Nº Days Restricted Work: Days counting as restricted work are defined as for a lost work day case (LWDC above).

- If a value has been given for RWDC and data are collected and reported by your company for the number of days of restricted work (RWDC Days), enter the sum total number of days of restricted work (RWDC Days). These should be calculated in the same manner as for lost work day cases (LWDC above).
- If RWDC days are reported at least one day must be reported for each restricted workday case (RWDC). If this is not the case a validation error will occur and the entry will not be accepted.

OGP Health & Safety Data Report

CONTACT NAME/TITLE

REPORT 1 - OCCUPATIONAL INJURIES - 2010 data

Year

Company

Country

Total number of fatal incidents involving employee, contractor or 3rd party fatalities:

(This should tally with the number of report 2 worksheets.)

COMPANY EMPLOYEES

The following data are collected (enter yes/no in appropriate box):

	Yes	No		Yes	No
Lost Workday Case (LWDC) Days	<input type="text"/>	<input type="text"/>	RWDC Days	<input type="text"/>	<input type="text"/>
Restricted Workday Cases (RWDCs)	<input type="text"/>	<input type="text"/>	Medical Treatment Cases	<input type="text"/>	<input type="text"/>

A		ONSHORE							
FUNCTION	Employees	Hours (thousands)	Employee Fatalities	MTC	LWDC	LWDC Days	RWDC	RWDC Days	
Exploration									
Production									
Drilling									
Construction									
Unspecified									
Total	0	0	0	0	0	0	0	0	0

Note: 'Hours Worked' are based on actual hours. The average 'Hours Worked' are about 2000 per man year.

B		OFFSHORE							
FUNCTION	Employees	Hours (thousands)	Employee Fatalities	MTC	LWDC	LWDC Days	RWDC	RWDC Days	
Exploration									
Production									
Drilling									
Construction									
Unspecified									
Total	0	0	0	0	0	0	0	0	0

Note: 'Hours Worked' to be based on 12 hours day/shift. Thus, depending upon on/off ratio, hours worked vary between 1600 and 2300 per man year.

CONTRACTOR EMPLOYEES

	Yes	No		Yes	No
Lost Workday Case (LWDC) Days	<input type="text"/>	<input type="text"/>	RWDC Days	<input type="text"/>	<input type="text"/>
Restricted Workday Cases (RWDCs)	<input type="text"/>	<input type="text"/>	Medical Treatment Cases	<input type="text"/>	<input type="text"/>

C		ONSHORE							
FUNCTION	Employees	Hours (thousands)	Employee Fatalities	MTC	LWDC	LWDC Days	RWDC	RWDC Days	
Exploration									
Production									
Drilling									
Construction									
Unspecified									
Total	0	0	0	0	0	0	0	0	0

Note: 'Hours Worked' are based on actual hours. The average 'Hours Worked' are about 2000 per man year.

D		OFFSHORE							
FUNCTION	Employees	Hours (thousands)	Employee Fatalities	MTC	LWDC	LWDC Days	RWDC	RWDC Days	
Exploration									
Production									
Drilling									
Construction									
Unspecified									
Total	0	0	0	0	0	0	0	0	0

Note: 'Hours Worked' to be based on 12 hours day/shift. Thus, depending upon on/off ratio, hours worked vary between 1600 and 2300 per man year.

3RD PARTY

E		Fatalities	
FUNCTION	Onshore	Offshore	
Exploration			
Production			
Drilling			
Construction			
Unspecified			
Total	0	0	

Reports IA & IB

Reports 1A and 1B are to be completed after Report 1. Enter only the number of Lost Work Day Cases (LWDCs) reported, related to each of the functions presented for the relevant country, and by category (Report 1A) and activity (Report 1B), refer to section 4.1 for definitions. The number of LWDCs reported here in 1A and 1B should be equal and the same as in Report 1.

5.1.a Report IA - LWDCs by category

OGP Health & Safety Data Report		CONTACT NAME/TITLE													
REPORT 1A - LOST WORKDAY CASE BREAKDOWN BY CATEGORY - 2010 data															
Year		Company				Country									
COMPANY EMPLOYEES															
A ONSHORE		LWDCs only													
FUNCTION	Assault or Violent Act	Caught In, Under or Between	Confined Space	Cut, Puncture, Scrape	Explosion/ burn	Exposure: Electrical	Exposure: Noise, Chemical, Biological, Vibration	Falls from height	Overexertion/ Strain	Pressure release	Slips and Trips (at the same height)	Struck by	Water related, drowning	Other	Total
Exploration															0
Production															0
Drilling															0
Construction															0
Unspecified															0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
B OFFSHORE		LWDCs only													
FUNCTION	Assault or Violent Act	Caught In, Under or Between	Confined Space	Cut, Puncture, Scrape	Explosion/ burn	Exposure: Electrical	Exposure: Noise, Chemical, Biological, Vibration	Falls from height	Overexertion/ Strain	Pressure release	Slips and Trips (at the same height)	Struck by	Water related, drowning	Other	Total
Exploration															0
Production															0
Drilling															0
Construction															0
Unspecified															0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CONTRACTOR EMPLOYEES															
C ONSHORE		LWDCs only													
FUNCTION	Assault or Violent Act	Caught In, Under or Between	Confined Space	Cut, Puncture, Scrape	Explosion/ burn	Exposure: Electrical	Exposure: Noise, Chemical, Biological, Vibration	Falls from height	Overexertion/ Strain	Pressure release	Slips and Trips (at the same height)	Struck by	Water related, drowning	Other	Total
Exploration															0
Production															0
Drilling															0
Construction															0
Unspecified															0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
D OFFSHORE		LWDCs only													
FUNCTION	Assault or Violent Act	Caught In, Under or Between	Confined Space	Cut, Puncture, Scrape	Explosion/ burn	Exposure: Electrical	Exposure: Noise, Chemical, Biological, Vibration	Falls from height	Overexertion/ Strain	Pressure release	Slips and Trips (at the same height)	Struck by	Water related, drowning	Other	Total
Exploration															0
Production															0
Drilling															0
Construction															0
Unspecified															0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

5.1.b Report 1B - LWDCs by activity

OGP Health & Safety Data Report

CONTACT NAME/TITLE

REPORT 1B - LOST WORKDAY CASE BREAKDOWN BY ACTIVITY - 2010 data

Year

Company

Country

COMPANY EMPLOYEES

A ONSHORE		LWDCs only											
FUNCTION	Construction, Commissioning, Decommissioning	Diving, Subsea, ROV	Drilling, Workover, Well Services	Lifting, Crane, Rigging, Deck Operations	Maintenance, Inspection, Testing	Office, Warehouse, Accommodation, Catering	Production Operations	Seismic/ Survey Operations	Transport - Air	Transport - Land	Transport - Water, incl. Marine Activity	Unspecified - Other	Total
Exploration													0
Production													0
Drilling													0
Construction													0
Unspecified													0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0

B OFFSHORE		LWDCs only											
FUNCTION	Construction, Commissioning, Decommissioning	Diving, Subsea, ROV	Drilling, Workover, Well Services	Lifting, Crane, Rigging, Deck Operations	Maintenance, Inspection, Testing	Office, Warehouse, Accommodation, Catering	Production Operations	Seismic/ Survey Operations	Transport - Air	Transport - Land	Transport - Water, incl. Marine Activity	Unspecified - Other	Total
Exploration													0
Production													0
Drilling													0
Construction													0
Unspecified													0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0

CONTRACTOR EMPLOYEES

C ONSHORE		LWDCs only											
FUNCTION	Construction, Commissioning, Decommissioning	Diving, Subsea, ROV	Drilling, Workover, Well Services	Lifting, Crane, Rigging, Deck Operations	Maintenance, Inspection, Testing	Office, Warehouse, Accommodation, Catering	Production Operations	Seismic/ Survey Operations	Transport - Air	Transport - Land	Transport - Water, incl. Marine Activity	Unspecified - Other	Total
Exploration													0
Production													0
Drilling													0
Construction													0
Unspecified													0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0

D OFFSHORE		LWDCs only											
FUNCTION	Construction, Commissioning, Decommissioning	Diving, Subsea, ROV	Drilling, Workover, Well Services	Lifting, Crane, Rigging, Deck Operations	Maintenance, Inspection, Testing	Office, Warehouse, Accommodation, Catering	Production Operations	Seismic/ Survey Operations	Transport - Air	Transport - Land	Transport - Water, incl. Marine Activity	Unspecified - Other	Total
Exploration													0
Production													0
Drilling													0
Construction													0
Unspecified													0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0

5.2 Report 2 - Fatal incidents

Report 2 is to be completed after Report 1 for any incident resulting in one or more fatalities of company employees, contractor employees or third parties. The intent of gathering detailed information in Report 2 is to maximise learning from fatal incidents, therefore, it is very important to provide sufficient detail with recommendations and guidance to prevent recurrence. Incidents solely involving third party fatalities will not be published but will only be used for member company learning.

Data field descriptions

Date of incident: Record the date the incident occurred.

Place of incident: Select “Onshore” or “Offshore”, see section 4.7 for location definitions.

Time incident occurred: Record the time or the time of day the incident occurred.

Narrative description of event: Please provide a short description of what happened.

What went wrong?: Enter the main root causes of the incident and any additional information which may be useful in learning from the incident.

Lessons learnt and recommendations to prevent recurrence: Enter details of actions being taken to prevent recurrence of this type of incident and lessons learned.

Was this incident also classified as a Tier 1 Asset Integrity/Process Safety Event?: Indicate yes or no (refer to section 4.8, data Report 6).

Function (Victim): For fatally injured company (section A) or contractor (section B) employee select from the list the best description of the function to which the employee was assigned.

Number company/contractor fatalities: Enter the total number of company or contractor employees who died as a result of the incident. Do not include 3rd Party fatalities in this box.

- ‘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 instantly, and a second died three weeks later from lung damage caused by the fire, both should be reported.
- If a delayed death occurs in the next calendar year after the incident, this should be reported. For example, if the above fire occurred on December 21, the second death from it might occur in January of the next year. All fatalities from an incident should be included in the report for the year incident occurred.

Age and Sex of Victim: The age should be reported in years. Enter the gender of the victim; Male or Female. If this information is not known, enter ‘unknown’.

Occupation of Victim: Enter the job title of the victim.

Medical cause of death: This is the cause of death given on the death certificate (if available). Where two types of causes are provided, such as ‘pulmonary oedema’ caused by ‘inhalation of hot gases from a fire’, provide both. This information should be provided if available.

Third Parties: Are those persons other than Company and Contractor employees who are fatally injured during Company’s or Contractor’s operational activities. For example, if a third party is fatally injured in company vehicle incident, this should be included, regardless of fault.

Function (incident): Select one from the list that best describes the Exploration & Production (E&P) function associated with the incident, see section 4.8 for more information.

Fatal Incident Category – required: Select from the list the category that best describes the nature of the fatal incident, see section 4.10. If a Fatality results from a Loss of Primary

Containment (LOPC) in a production or drilling activity then the incident is also likely to be classified as a Report 6 Asset Integrity/Process Safety Event with Tier 1 consequences.

Type of activity – required: Select from the list the activity that best describes the fatal incident, see section 4.11.

Causal Factors: Select as many causal factors from the list (see section 4.12 and Appendix 3A for further information) as required to accurately reflect the incident investigation findings and highlight areas for industry learning.

OGP Health & Safety **Data** Report CONTACT NAME/TITLE

Page 1 of 2

REPORT 2 - FATAL INCIDENTS - 2010 data

Year Event details Country
Company

Incident details

Date of incident: day month year

Place of incident (select one) onshore \ offshore

Time incident occurred (or time of day):

Incident description:

What went wrong? (main root causes):

Lessons learnt and recommendations to prevent reoccurrence:

	Yes	No
Was this incident also classified as a Tier 1 Asset Integrity / Process Safety Event? (see Report 6)	<input type="checkbox"/>	<input type="checkbox"/>

A COMPANY EMPLOYEES				
FUNCTION (VICTIM)	No. of Fatalities from Incident	Age & Sex of Victim	Occupation of Victim	Medical Cause of Death
Exploration				
Production				
Drilling				
Construction				
Unspecified				

B CONTRACTOR EMPLOYEES				
FUNCTION (VICTIM)	No. of Fatalities from Incident	Age & Sex of Victim	Occupation of Victim	Medical Cause of Death
Exploration				
Production				
Drilling				
Construction				
Unspecified				

C THIRD PARTIES	
No. of Fatalities from Incident	

OGP Health & Safety **Data** Report

CONTACT NAME/TITLE

REPORT 2 - FATAL INCIDENTS

Page 2 of 2

Year

Country

Company

Function (Incident): (ring one only)	Exploration	Production	Drilling	Construction:	Unspecified
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Incident category (ring one - required)	Assault and Violent act	Falls from height
	Caught In, Under or Between	Overexertion / Strain
Confined Space	Pressure release	
Cut, Puncture, Scrape	Slips and Trips (at same height)	
Explosion / Burn	Struck By	
Exposure Electrical	Water related, Drowning	
Exposure Noise, Chemical, Biological, Vibration	Other	

Type of activity: (ring one - required)	Construction, Commissioning, Decommissioning	Production Operations
	Diving, Subsea, ROV	Seismic / Survey Operations
Drilling / Workover / Well Services	Transport - Air	
Lifting, Crane, Rigging, Deck Operations	Transport - Land	
Maintenance, Inspection, Testing	Transport - Water, incl. Marine Activity	
Office, Warehouse, Accommodation, Catering	Unspecified - Other	

Causal factors (ring as many as apply See User Guide Appendix 3A	PEOPLE (ACTS) Following Procedures: <ul style="list-style-type: none"> <input type="checkbox"/> Violation intentional (by individual or group) <input type="checkbox"/> Violation unintentional (by individual or group) <input type="checkbox"/> Improper position (in the line of fire) <input type="checkbox"/> Overexertion or improper position/posture for task <input type="checkbox"/> Work or motion at improper speed <input type="checkbox"/> Improper lifting or loading Use of Tools, Equipment, Materials and Products: <ul style="list-style-type: none"> <input type="checkbox"/> Improper use/position of tools/equipment/materials/products <input type="checkbox"/> Servicing of energized equipment/inadequate energy isolation Use of Protective Methods: <ul style="list-style-type: none"> <input type="checkbox"/> Failure to warn of hazard <input type="checkbox"/> Inadequate use of safety systems <input type="checkbox"/> Personal Protective Equipment not used or used improperly <input type="checkbox"/> Equipment or materials not secured <input type="checkbox"/> Disabled or remove guards, warning systems or safety devices Inattention/Lack of Awareness: <ul style="list-style-type: none"> <input type="checkbox"/> Improper decision making or lack of judgment <input type="checkbox"/> Lack of attention/distracted by other concerns/stress <input type="checkbox"/> Acts of violence <input type="checkbox"/> Use of drugs or alcohol <input type="checkbox"/> Fatigue 	PROCESS (CONDITIONS) Protective Systems: <ul style="list-style-type: none"> <input type="checkbox"/> Inadequate/defective guards or protective barriers <input type="checkbox"/> Inadequate/defective Personal Protective Equipment <input type="checkbox"/> Inadequate/defective warning systems/safety devices <input type="checkbox"/> Inadequate security provisions or systems Tools, Equipment, Materials, Products: <ul style="list-style-type: none"> <input type="checkbox"/> Inadequate design/specification or management of change <input type="checkbox"/> Inadequate/defective tools/equipment/materials/ products <input type="checkbox"/> Inadequate maintenance/inspection/testing Work Place Hazards: <ul style="list-style-type: none"> <input type="checkbox"/> Congestion, clutter or restricted motion <input type="checkbox"/> Inadequate surfaces, floors, walkways or roads <input type="checkbox"/> Hazardous atmosphere (explosive/toxic/asphyxiant) <input type="checkbox"/> Storms or acts of nature Organisational: <ul style="list-style-type: none"> <input type="checkbox"/> Inadequate training/competence <input type="checkbox"/> Inadequate work standards/procedures <input type="checkbox"/> Inadequate hazard identification or risk assessment <input type="checkbox"/> Inadequate communication <input type="checkbox"/> Inadequate supervision <input type="checkbox"/> Poor leadership/organisational culture <input type="checkbox"/> Failure to report/learn from incidents
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5.2 Report 3 - High potential events

A high potential event is defined as any incident or near miss that could have realistically resulted in one or more fatalities. The intent of Report 3 is to maximise learning from these events, as learning is not necessarily dependant on the actual outcome.

Organisations are requested to limit the number of high potential event reports to those which have high learning value for the industry and to provide sufficient detail with recommendations and guidance to prevent recurrence.

Data field descriptions

Place of event: Select “Onshore” or “Offshore”, see section 4.7 for location definitions.

Function: Select one from the list that best describes the Exploration & Production (E&P) function associated with the event, see section 4.8 for more information.

Date of event: Record the date the event occurred.

Event category: Select from the list the category that best describes the nature of the event, see section 4.10.

Type of activity: Select from the list the activity that best describes the event, see section 4.11.

Causal Factors: Select as many causal factors from the list (see section 4.12 and Appendix 3A for further information) as required to accurately reflect the event investigation findings and highlight areas for industry learning.

Narrative description of event: Please provide a short description of what happened.

What went wrong?: Enter the main root causes of the event and any additional information which may be useful in learning from the event.

Lessons learnt and recommendations to prevent recurrence: Enter details of actions being taken to prevent recurrence of this type of event and lessons learned.

OGP Health & Safety Data Report

CONTACT NAME/TITLE

REPORT 3 - HIGH POTENTIAL EVENTS - 2010 data

Year

Company

Country

Event details

Place of event (please ring one): ONSHORE OFFSHORE

Function (please ring one): EXPLORATION DRILLING CONSTRUCTION
 PRODUCTION UNSPECIFIED

Date of event: day month year

Event description:

What went wrong? (main root causes):

Lessons learnt and recommendations to prevent reoccurrence:

Event category (ring one - required)

- Assault and Violent act
- Caught In, Under or Between
- Confined Space
- Cut, Puncture, Scrape
- Explosion / Bum
- Exposure Electrical
- Exposure Noise, Chemical, Biological, Vibration

- Falls from height
- Overexertion / Strain
- Pressure release
- Slips and Trips (at same height)
- Struck By
- Water related
- Other

Type of activity: (ring one - required)

- Construction, commissioning, decommissioning
- Diving, Subsea, ROV
- Drilling, Workover, Well Services
- Lifting, Crane, Rigging, Deck Operations
- Maintenance, Inspection, Testing
- Office, Warehouse, Accomodation, Catering

- Production operations
- Seismic / Survey Operations
- Transport - Air
- Transport - Land
- Transport - Water, incl. Marine Activity
- Unspecified - Other

Causal factors (ring as many as apply)
 See User Guide Appendix 3A

- | | |
|--|---|
| <p>PEOPLE (ACTS)</p> <p>Following</p> <ul style="list-style-type: none"> <input type="checkbox"/> Violation intentional (by individual or group) <input type="checkbox"/> Violation unintentional (by individual or group) <input type="checkbox"/> Improper position (in the line of fire) <input type="checkbox"/> Overexertion or improper position/posture for task <input type="checkbox"/> Work or motion at improper speed <input type="checkbox"/> Improper lifting or loading <p>Use of Tools, Equipment, Materials and Products:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Improper use/position of tools/equipment/materials/products <input type="checkbox"/> Servicing of energized equipment/inadequate energy isolation <p>Use of Protective Methods:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Failure to warn of hazard <input type="checkbox"/> Inadequate use of safety systems <input type="checkbox"/> Personal Protective Equipment not used or used improperly <input type="checkbox"/> Equipment or materials not secured <input type="checkbox"/> Disabled or remove guards, warning systems or safety devices <p>Inattention/Lack of Awareness:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Improper decision making or lack of judgment <input type="checkbox"/> Lack of attention/distracted by other concerns/stress <input type="checkbox"/> Acts of violence <input type="checkbox"/> Use of drugs or alcohol <input type="checkbox"/> Fatigue | <p>PROCESS (CONDITIONS)</p> <p>Protective Systems:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Inadequate/defective guards or protective barriers <input type="checkbox"/> Inadequate/defective Personal Protective Equipment <input type="checkbox"/> Inadequate/defective warning systems/safety devices <input type="checkbox"/> Inadequate security provisions or systems <p>Tools, Equipment, Materials, Products:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Inadequate design/specification or management of change <input type="checkbox"/> Inadequate/defective tools/equipment/materials/ products <input type="checkbox"/> Inadequate maintenance/inspection/testing <p>Work Place Hazards:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Congestion, clutter or restricted motion <input type="checkbox"/> Inadequate surfaces, floors, walkways or roads <input type="checkbox"/> Hazardous atmosphere (explosive/toxic/asphyxiant) <input type="checkbox"/> Storms or acts of nature <p>Organisational:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Inadequate training/competence <input type="checkbox"/> Inadequate work standards/procedures <input type="checkbox"/> Inadequate hazard identification or risk assessment <input type="checkbox"/> Inadequate communication <input type="checkbox"/> Inadequate supervision <input type="checkbox"/> Poor leadership/organisational culture <input type="checkbox"/> Failure to report/learn from incidents |
|--|---|

5.3 Report 4 – Occupational illnesses

Occupational illnesses should be submitted on the Report 4 form. Reporting will include cases which are required to be reported to the authorities as part of national schemes and all other cases judged by a competent occupational health advisor to be work-related.

Only new cases (incidence) are reportable, i.e. new cases diagnosed during the reporting year. Existing cases are reportable if diagnosed for the first time during the reporting year. It is useful to keep records on existing cases (prevalence) as well but these are not reportable as part of this system. Exacerbation or recurrence of existing occupational or existing general illnesses is reportable if caused by new exposures at work. Cases should be reported whether or not they result in time lost from work, those not involving lost time or restricted duties should be reported under “other illnesses”.

An employee’s physical or mental defect or pre-existing physical or mental condition does not affect the reportability of a subsequently contracted occupational illness. If in such circumstances an illness is caused or contributed to by exposures at work, the case should be reported without regard to the employee’s pre-existing physical or mental condition.

Occupational Illness Work-relatedness: where the balance of probability is 50 per cent or more that the case was caused by work or work-related environmental factors.

Note: In some jurisdictions local law may prohibit the collection and reporting of data on illness and injury and/or the disclosure of that data to an employer.

Data entry requirements are as for Report 1, with the following exceptions:

No. Occupational Illness Fatalities: The total number of Company’s employees or Contractor’s employees who died as a result of an occupational illness.

Occupational Illness Permanent Disabilities: Persons having an incapacity to work due to work-related health problems. The incapacity may be partial, so that permanent disability may be used both for people who have taken early retirement for health reasons and for working people with a chronic disease or injury.

Occupational Illness No. Lost Workday Cases (LWDC): Any work-related illness other than a fatality which results in a person being unfit for work on any day during the reporting year where the illness was diagnosed during that year. “Any day” includes rest days, weekend days, leave days, public holidays or days after ceasing employment.

Occupational Illness No. Restricted Workday Cases (RWDC): Any work-related illness, other than a fatality or lost work day case, which results in a person being unfit for full performance of their regular job on any day during the reporting year, where the illness was diagnosed during that year. Work performed might be:

- an 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.

Where no meaningful restricted work is being performed, the incident should be recorded as a lost workday case (LWDC).

Note: At least 1 lost work day must be entered for each occupational illness LWDC reported. Similarly at least 1 RWDC Day must be entered for each occupational illness RWDC.

Other Occupational Illnesses (not L/RWDC): The number of work-related illnesses not involving lost work days or restricted duty days.

OGP Health & Safety Data Report

CONTACT NAME/TITLE

REPORT 4 - OCCUPATIONAL ILLNESSES - 2010 data

Year

Company

Country

COMPANY EMPLOYEES

The following data are collected (enter yes/no in appropriate box):

	Yes	No		Yes	No
Lost Workday Case (LWDC) Days	<input type="text"/>	<input type="text"/>	RWDC Days	<input type="text"/>	<input type="text"/>
Restricted Work Day Cases (RWDC)	<input type="text"/>	<input type="text"/>	Permanent Disabilities	<input type="text"/>	<input type="text"/>

A. ONSHORE		Number of hours worked (thousands): <input type="text"/>			Number of employees: <input type="text"/>		
Occupational Illness Category	No. Fatalities	Permanent Disabilities	No. Lost Workday Cases	No. days unfit for work	No. Restricted Workday Cases	No. days Restricted Work	Other Illnesses (not L/RWDC)
Back problems and lower limb disorder							
Cancer and malignant blood disease							
Infectious/preventable disease							
Mental ill-health							
Noise Induced Hearing Loss							
Poisoning							
Respiratory disease							
Skin disease							
Upper limb and neck disorder							
Other occupational illness							
Total	0	0	0	0	0	0	0

B. OFFSHORE		Number of hours worked (thousands): <input type="text"/>			Number of employees: <input type="text"/>		
Occupational Illness Category	No. Fatalities	Permanent Disabilities	No. Lost Workday Cases	No. days unfit for work	No. Restricted Workday Cases	No. days Restricted Work	Other Illnesses (not L/RWDC)
Back problems and lower limb disorder							
Cancer and malignant blood disease							
Infectious/preventable disease							
Mental ill-health							
Noise Induced Hearing Loss							
Poisoning							
Respiratory disease							
Skin disease							
Upper limb and neck disorder							
Other occupational illness							
Total	0	0	0	0	0	0	0

CONTRACTOR EMPLOYEES

The following data are collected (enter yes/no in appropriate box):

	Yes	No		Yes	No
Lost Workday Case (LWDC) Days	<input type="text"/>	<input type="text"/>	RWDC Days	<input type="text"/>	<input type="text"/>
Restricted Work Day Cases (RWDC)	<input type="text"/>	<input type="text"/>	Permanent Disabilities	<input type="text"/>	<input type="text"/>

C. ONSHORE		Number of hours worked (thousands): <input type="text"/>			Number of employees: <input type="text"/>		
Occupational Illness Category	No. Fatalities	Permanent Disabilities	No. Lost Workday Cases	No. days unfit for work	No. Restricted Workday Cases	No. days Restricted Work	Other Illnesses (not L/RWDC)
Back problems and lower limb disorder							
Cancer and malignant blood disease							
Infectious/preventable disease							
Mental ill-health							
Noise Induced Hearing Loss							
Poisoning							
Respiratory disease							
Skin disease							
Upper limb and neck disorder							
Other occupational illness							
Total	0	0	0	0	0	0	0

D. OFFSHORE		Number of hours worked (thousands): <input type="text"/>			Number of employees: <input type="text"/>		
Occupational Illness Category	No. Fatalities	Permanent Disabilities	No. Lost Workday Cases	No. days unfit for work	No. Restricted Workday Cases	No. days Restricted Work	Other Illnesses (not L/RWDC)
Back problems and lower limb disorder							
Cancer and malignant blood disease							
Infectious/preventable disease							
Mental ill-health							
Noise Induced Hearing Loss							
Poisoning							
Respiratory disease							
Skin disease							
Upper limb and neck disorder							
Other occupational illness							
Total	0	0	0	0	0	0	0

Occupational Illness Categories

Identification of an occupational illness may be made by an occupational physician or any other competent person. To assist in the categorisation of an occupational illness, some examples in the listed categories are provided below:

Back problems and lower limb disorder: This includes back problems and disorders of the lower limb associated with repeated and or cumulative trauma.

Cancers and malignant blood disease: Mesothelioma, bladder cancer, leukaemia.

Infectious and preventable disease: Malaria; food poisoning; infectious hepatitis; legionnaire's disease. Cases of infectious diseases, for example malaria, are reportable if they occur among non-immune staff, e.g. business travellers travelling to areas where the disease is endemic.

Mental ill-health: Depression, post traumatic disorder, stress.

Noise induced hearing loss: Cases which meet national or company criteria.

Poisoning: Poisoning by lead, mercury, arsenic, cadmium, carbon monoxide, hydrogen sulphide.

Respiratory disease: Asthma, silicosis, asbestosis, alveolitis.

Skin disease: Contact dermatitis (allergic or irritant).

Upper limb and neck disorder: This includes disorders of the upper limb associated with repeated and cumulative trauma.

Other occupational illness: Disorders due to physical agents (other than toxic materials), heat exhaustion, hypothermia, bends.

5.4 Report 5 – Motor Vehicle Crashes (MVC)

Motor Vehicle Crashes should be submitted on the Report 5 form. All light duty vehicles, heavy duty vehicles and heavy duty plant equipment (bulldozer, earthmoving equipment etc.) including buses or coaches (see MVC definitions at the end of this section for additional clarification).

Company and Contractor Motor Vehicle Crashes shall be reported separately.

Exclusions from reporting

The following should not be reported as motor vehicle crashes when the vehicle is properly parked:

- injuries that occur when entering or exiting the vehicle;
- any event involving loading or unloading from the vehicle;
- damage to or total loss of a vehicle solely due to environmental conditions or vandalism;
- another vehicle crashes into the parked vehicle.

In addition the following should not be reported as a motor vehicle crash:

- superficial damage, such as a stone or rock chip damaging a windscreen or paintwork while the vehicle is being driven;
- damage related to the theft of a vehicle.

OGP Health & Safety Data Report

CONTACT NAME/TITLE

REPORT 5 - MOTOR VEHICLE CRASHES (MVC) - 2010 data

Year Company Country

A COMPANY

Million kilometers driven

Indicate types of crash incidents for which you have data and will be reporting (even if there were 0 incidents) and the number of crash incidents

			Reported		Number of crash incidents
			YES	NO	
If a value is known to be 0 enter 0. Enter n/k if not known (as you have indicated using the yes/no boxes)					
1	MVCs leading to at least one fatality (includes 3rd party fatality)	a. Not involving a rollover			
		b. Involving a rollover			
		c. Unknown if rollover involved			
2	MVCs leading to LWDC as most severe outcome	a. Not involving a rollover			
		b. Involving a rollover			
		c. Unknown if rollover involved			
3	MVC leading to MTC or RWDC as most severe outcome (not a rollover)	a. Not involving a rollover			
		b. Involving a rollover			
		c. Unknown if rollover involved			
4	MVC involving a rollover - not resulting in a fatality, LWDC, RWDC or MTC				
5	MVC, where the vehicle cannot be driven from the scene under its own power in a roadworthy state - not resulting in a fatality, LWDC, RWDC or MTC				
Sum total of the above, or, if breakdown is not available, total number of MVCs leading to fatality, LWDC, TRI, rollover or where the vehicle cannot be driven from the scene under its own power.			Total		0

B CONTRACTOR

Million kilometers driven

Indicate types of crash incidents you have data on and will be reporting (even if there were 0 incidents) and the number of crash

			Reported		Number of crash incidents
			YES	NO	
If a value is known to be 0 enter 0. Enter n/k if not known (as you have indicated using the yes/no boxes)					
1	MVCs leading to at least one fatality (includes 3rd party fatality)	a. Not involving a rollover			
		b. Involving a rollover			
		c. Unknown if rollover involved			
2	MVCs leading to LWDC as most severe outcome	a. Not involving a rollover			
		b. Involving a rollover			
		c. Unknown if rollover involved			
3	MVC leading to MTC or RWDC as most severe outcome (not a rollover)	a. Not involving a rollover			
		b. Involving a rollover			
		c. Unknown if rollover involved			
4	MVC involving a rollover - not resulting in a fatality, LWDC, RWDC or MTC				
5	MVC, where the vehicle cannot be driven from the scene under its own power in a roadworthy state - not resulting in a fatality, LWDC, RWDC or MTC				
Sum total of the above, or, if breakdown is not available, total number of MVCs leading to fatality, LWDC, TRI, rollover or where the vehicle cannot be driven from the scene under its own power.			Total		0

MVC Definitions

MVC Work-relatedness

Any crash involving a company, rental or personal vehicle while performing company business.

Work-relationship is presumed for crashes resulting from business being conducted on behalf of the company while operating a company assigned vehicle. Examples of company business include driving a client to the airport, driving to the airport for a business trip, taking a client or work colleague out for a meal, deliveries, visiting clients or customers, or driving to a business related appointment.

Personal business which should not be counted includes, but is not limited to, personal shopping, getting a meal by yourself, commuting to and from home, or driving to a private medical appointment.

Contractor Motor Vehicle Crash includes any vehicle procured (owned, leased, fleeted or rented) by a contractor or sub-contractor while performing work on behalf of the company.

Crash: Work-related Vehicle Damage or Personal injury due to a vehicle related event, or rollover.

Motor Vehicle: Any mechanically or electrically powered device (excluding one moved by human power), upon which or by which any person or property may be transported upon a land roadway. This includes motorcycles. Specifically excluded from the definition of motor vehicle are vehicles operated on fixed rails. In addition, vehicles which are not capable of more than 10 mph (16 kph) may be exempted.

Rollover: Any crash where the vehicle has flipped to its sides, top and/or rolled 360 degrees via any axis.

Data field descriptions

Million kilometres driven: If available, enter the number of kilometres driven in millions. Otherwise enter 'unknown'.

Number of Crash Incidents: Indicate types of crash incidents for which you have data using the Yes/No boxes, use the Yes option and zero in they number of crash incidents if you are reporting MVCs but have had no crashes.

Enter the number of MVCs. If the breakdown is available, the number of crashes should be entered for each category. Alternatively the total or uncategorised MVCs can be entered as "Total No of MVCs leading to fatality, LWDC, TRI, rollover or where the vehicle cannot be driven from the scene under its own power.

Under lines 1, 2 and 3 please indicate how many of each classification of MVC involved a roll-over, option a indicates there was no roll-over, option b. indicates there was a roll-over, the sum of a and b should equal the total number of crash incidents under each classification.

Note: There should be no double counting in the above, i.e. an MVC leading to fatality and LTI should only be counted as MVC with fatality.

5.5 Report 6 – Asset integrity/process safety events

Asset Integrity Events, also referred to here as Process Safety Events (PSE), is a new request for 2010 safety data using the template below. As a PSE can result in a fatality or can be a high potential event it should be noted that the scope of Reports 2 and 3 now includes PSE reporting.

Data field descriptions

Process Safety Event (PSE): Indicator definitions and consequences are provided below for both Tier 1 PSE and Tier 2 PSE, together with respective tables of Material Release Threshold Quantities. Further guidance and examples are provided in the new OGP Report - *“Asset Integrity - Key Performance Indicators”* (expected early 2011) and in the API Recommended Practice No. 754 - *“Process Safety Performance Indicators for the Refining and Petrochemical Industries”*. Note that “days away from work” injury should be taken to be the same as the OGP defined LWDC.

Tier 1 Indicator definition and consequences

A Tier 1 Process Safety Event (PSE) is a Loss of Primary Containment (LOPC) with the greatest consequence as defined by this RP. A Tier 1 PSE is an unplanned or uncontrolled release of any material, including non-toxic and non-flammable materials (e.g. steam, hot condensate, nitrogen, compressed CO₂ or compressed air), from a process that results in one or more of the consequences listed below:

- An employee, contractor or subcontractor “days away from work” injury and/or fatality;
- A hospital admission and/or fatality of a third-party;
- An officially declared community evacuation or community shelter-in-place;
- A fire or explosion resulting in greater than or equal to \$25,000 of direct cost to the Company;
- A pressure relief device (PRD) discharge to atmosphere whether directly or via a downstream destructive device that results in one or more of the following four consequences:
 - liquid carryover;
 - discharge to a potentially unsafe location;
 - an onsite shelter-in-place;
 - public protective measures (e.g. road closure);
 and a PRD discharge quantity greater than the threshold quantities in Table 1 in any one-hour; or
- A release of material greater than the threshold quantities described in Table 1 in any one-hour period.

Tier 2 Indicator Definition and Consequences

A Tier 2 Process Safety Event (PSE) is a LOPC with lesser consequence. A Tier 2 PSE is an unplanned or uncontrolled release of any material, including non-toxic and non-flammable materials (e.g. steam, hot condensate, nitrogen, compressed CO₂ or compressed air), from a process that results in one or more of the consequences listed below and is not reported in Tier 1:

- An employee, contractor or subcontractor recordable injury;
- A fire or explosion resulting in greater than or equal to \$2,500 of direct cost to the Company;
- A pressure relief device (PRD) discharge to atmosphere whether directly or via a downstream destructive device that results in one or more of the following four consequences:
 - liquid carryover;

- discharge to a potentially unsafe location;
 - an onsite shelter-in-place;
 - public protective measures (e.g. road closure);
- and a PRD discharge quantity greater than the threshold quantity in Table 2 in any one-hour period; or
- A release of material greater than the threshold quantities described in Table 2 in any one-hour period.

Note: Non-toxic and non-flammable materials (e.g. steam, hot water, nitrogen, compressed CO₂ or compressed air) have no threshold quantities and are only included in the definitions above as a result of their potential to result in one of the other consequences.

Table 1: Tier 1 Material Release Threshold Quantities (from API RP 754)

Threshold release category	Material hazard classification ^{1,3,4}	Threshold quantity (outdoor release)	Threshold quantity (indoor ² release)
1	TIH Zone A Materials	5kg (11lbs)	2.5kg (5.5lbs)
2	TIH Zone B Materials	25kg (55lbs)	12.5kg (27.5lbs)
3	TIH Zone C Materials	100kg (220lbs)	50kg (110lbs)
4	TIH Zone D Materials	200kg (440lbs)	100kg (220lbs)
5	Flammable Gases or Liquids with Boiling Point $\leq 35^{\circ}\text{C}$ (95°F) and Flash Point $< 23^{\circ}\text{C}$ (73°F) or Other Packing Group I Materials excluding strong acids/bases	500kg (1100lbs)	250kg (550lbs)
6	Liquids with Boiling Point $> 35^{\circ}\text{C}$ (95°F) and Flash Point $< 23^{\circ}\text{C}$ (73°F) or Other Packing Group II Materials excluding moderate acids/bases	1000kg (2200lbs) or 7bbl	500kg (1100lbs) or 3.5bbl
7	Liquids with Flash Point $\geq 23^{\circ}\text{C}$ (73°F) and $\leq 60^{\circ}\text{C}$ (140°F) or Liquids with Flash Point $> 60^{\circ}\text{C}$ (140°F) released at a temperature at or above Flash Point or strong acids/bases or Other Packing Group III Materials	2000kg (4400lbs) or 14bbl	1000kg (2200lbs) or 7bbl

Notes

¹Many materials exhibit more than one hazard. Correct placement in Hazard Zone or Packing Group shall follow the rules of DOT 49 CFR 173.2a [REF 14] or UN Recommendations on the Transportation of Dangerous Goods, Section 2 [REF 10].

²A structure composed of four complete (floor to ceiling) walls, floor and roof.

³For solutions not listed on the UNDG, the anhydrous component shall determine the Toxic Inhalation Hazard (TIH) zone or Packing Group classification. The threshold quantity of the solution shall be back calculated based on the threshold quantity of the dry component weight.

⁴For mixtures where the UNDG classification is unknown, the fraction of threshold quantity release for each component may be calculated. If the sum of the fractions is equal to or greater than 100%, the mixture exceeds the threshold quantity. Where there are clear and independent toxic and flammable consequences associated with the mixture, the toxic and flammable hazards are calculated independently.

Table 2: Tier 2 Material Release Threshold Quantities (from API RP 754)

Threshold release category	Material hazard classification ^{1,3,4}	Threshold quantity (outdoor release)	Threshold quantity (indoor ² release)
1	TIH Zone A Materials	0.5kg (1.1lbs)	0.25kg (0.55lbs)
2	TIH Zone B Materials	2.5kg (5.5lbs)	1.2kg (2.8lbs)
3	TIH Zone C Materials	10kg (22lbs)	5kg (11lbs)
4	TIH Zone D Materials	20kg (44lbs)	10kg (22lbs)
5	Flammable Gases or Liquids with Boiling Point ≤35°C (95°F) and Flash Point <23°C (73°F) or Other Packing Group I Materials excluding strong acids/bases	50kg (110lbs)	25kg (55lbs)
6	Liquids with Boiling Point >35°C (95°F) and Flash Point <60°C (140°F) or Liquids with Flash Point >60°C (140°F) released at or above Flash Point or Other Packing Group II and III Materials or Strong acids and bases excluding moderate acids/bases	100kg (220lbs) or 1bbl	50kg (110lbs) or 0.5bbl
7	Liquids with Flash Point >60°C (140°F) released at a temperature below Flash Point or Moderate acids/bases	1000kg (2200lbs) or 10bbl	500kg (1100lbs) or 5bbl

Notes

¹Many materials exhibit more than one hazard. Correct placement in Hazard Zone or Packing Group shall follow the rules of DOT 49 CFR 173.2a [REF 14] or UN Recommendations on the Transportation of Dangerous Goods, Section 2 [REF 10].

²A structure composed of four complete (floor to ceiling) walls, floor and roof.

³For solutions not listed on the UNDG, the anhydrous component shall determine the Toxic Inhalation Hazard (TIH) zone or Packing Group classification. The threshold quantity of the solution shall be back calculated based on the threshold quantity of the dry component weight.

⁴For mixtures where the UNDG classification is unknown, the fraction of threshold quantity release for each component may be calculated. If the sum of the fractions is equal to or greater than 100%, the mixture exceeds the threshold quantity. Where there are clear and independent toxic and flammable consequences associated with the mixture, the toxic and flammable hazards are calculated independently.

OGP Health & Safety Data Report

CONTACT NAME/TITLE

REPORT 6 - ASSET INTEGRITY / PROCESS SAFETY EVENTS

Year

Company

Country

Asset Integrity Events, also referred to here as Process Safety Events (PSE), is a lagging indicator based on Loss of Primary Containment (LOPC). There are two "tiers" of PSE: Tier 1 is more severe than Tier 2. By applying the indicator definitions, companies can determine whether an LOPC is a Tier 1 or a Tier 2 PSE. The aim of this report is to collect both Tier 1 and Tier 2 PSE data from member companies using the four tables below. Two of the tables request additional PSE data about the material released and the operational activities, but it is recognised that some of this data may not be readily available within a company's internal reporting system.

The first data table below reports the number of offshore or onshore Tier 1 PSE for both drilling and production. The table also requests that companies report the number of consequences related to their Tier 1 PSE. Note that one PSE can result in multiple consequences, so the total number of consequences reported may equal or exceed the total number of PSE.

In addition to reporting an injury or fatality as a consequence in the "Employee or Contractor Fatality or LWDC" column, the first table also requests data on fatalities that resulted from PSE. Companies should enter the number of PSE that resulted in one or more fatalities, then in the next two columns enter the actual number of fatalities - employees and contractors, or third parties.

The Tier 2 tables should be completed in the same way as the Tier 1 tables, noting that certain categories, such as fatalities, are not relevant for Tier 2.

EXAMPLE EVENT: A unintended gas release from a valve (i.e. an LOPC) results in a fire causing damage with an estimated cost of \$10,000 to replace the valve, and also two people are treated for burns from the fire, and the return to work. This counts as one Tier 2 event in the "Total Process Safety Events" column of the Tier 2 table. However, this single event had 2 separate consequences, and is reported in each of the consequence columns of the Tier 2 table below; as 1 PSE causing injury and 1 PSE causing a fire (note the two injuries on count as one PSE causing injury). If the amount of gas released during any hour of the event exceeded the thresholds given in Table 2, then this would add a third consequence for the same PSE, and count as one PSE in the material release column of the Tier 2 table. Note that if the gas released exceeded any of the Table 1 thresholds, then this would be a Tier 1 event.

TIER 1			Note: A single PSE may result in multiple consequences; therefore the total of all columns below should equal or exceed Total PSE								
			Number of PSE that resulted in these consequences (all that apply)						Fatalities		
Location	Function	Total Process Safety Events (PSE)	Employee or Contractor Fatality or LWDC	Third party hospitalizaion or fatality	Community Evacuation or Shelter-in-place	Fire or explosion >\$25,000 loss	PRD discharges above Tier 1 thresholds	Material release above Tier 1 threshold	Number of PSE resulting in one or more fatalities	Total number of Employee and Contractor Fatalities	Total number of 3rd Party Fatalities
Onshore	production										
	drilling										
Offshore	production										
	drilling										
	Total	0	0	0	0	0	0	0	0	0	0

Additional data (if available)			Note: Total numbers of PSE recorded in both tables below should equal Total PSE above								
Location	Function	Total Process Safety Events (PSE)	Number of PSE by Material (only one category per event)				Total Process Safety Events (PSE)	Number of PSE by Activity (only one activity per event)			
			Toxics (cat. 1-4)	Flammable gas (cat. 5)	Hazardous Liquid (cat 6 or 7)	Other gases or liquids		Start-up	Normal Operations	Shutdown	Other
Onshore	production	0				0					
	drilling	0				0					
Offshore	production	0				0					
	drilling	0				0					
	Total	0	0	0	0	0	0	0	0	0	0

TIER 2			Note: A single PSE may result in multiple consequences; therefore the total of all columns below should equal or exceed Total PSE			
			Number of PSE that resulted in these consequences (all that apply)			
Location	Function	Total Process Safety Events (PSE)	Employee or Contractor Recordable Injury	Fire or explosion > \$2,500 loss	PRD discharges above Tier 2 thresholds	Material release above Tier 2 threshold
Onshore	production					
	drilling					
Offshore	production					
	drilling					
	Total	0	0	0	0	0

Additional data (if available)			Note: Total numbers of PSE recorded in both tables below should equal Total PSE above								
Location	Function	Total Process Safety Events (PSE)	Number of PSE by Material (only one category per event)				Total Process Safety Events (PSE)	Number of PSE by Activity (only one activity per event)			
			Toxics (cat. 1-4)	Flammable gas (cat. 5)	Hazardous Liquid (cat 6 or 7)	Other gases or liquids		Start-up	Normal Operations	Shutdown	Other
Onshore	production	0				0					
	drilling	0				0					
Offshore	production	0				0					
	drilling	0				0					
	Total	0	0	0	0	0	0	0	0	0	0

6 Returning data to OGP

If you used the web-based system the data you submit are transferred directly to the main database for analysis by OGP. Once you have finished entering data you should advise Wendy Poore (wendy.poore@ogp.org.uk) to that effect. For other methods of submission data should be forwarded to Wendy Poore, preferably by email. Wendy may contact you if anomalies arise in your data.

Appendix 1

Completed examples for Reports 2 & 3

Report 2 completed example page 1 of 2

OGP Health & Safety **Data** Report
CONTACT NAME/TITLE

Page 1 of 2

REPORT 2 - FATAL INCIDENTS - 2010 data

Year	2010
------	------

Country	Malaysia
Company	XYZ Operating Co.

Incident details

Date of incident: day month year

Place of incident (select one) \

Time incident occurred (or time of day):

Incident description:

A Fast Crew Boat (FCB) was moored bow to an offshore buoy at sea. Another Standby Boat (SB) was moored stern to stern to it. Weather was calm. At 21.30hrs, the FCB started its engine and conducted propulsion system (water jet) tests whilst still moored. The FCB moved leading to tensioning and subsequent parting of the mooring rope between the two vessels. The parted mooring rope whip-lashed and hit the 2nd Engineer, who was off-duty, onboard the deck of the SB. The 2nd Engineer sustained severe multiple fractures to his right leg and bruises on his forehead. He was given immediate first aid and medevaced to the nearest onshore hospital. After 2 hours of resuscitation by a hospital doctor, he passed away.

What went wrong? (main root causes):

- Inadvertent vessel movement during testing of propulsion system
- Human error: clutch was inadvertently engaged
- No watchman/look-out assigned
- FCB Chief Eng did not inform his Captain just prior to starting vessel engine.
- The only positive feedback available of whether the clutch was engaged or otherwise is via the "Clutch OFF" indicator on bridge control panel which was malfunctioning
- The SB crew was not informed of the testing and hence not aware of the hazards related to the FCB propulsion testing. Thus unable to exercise Duty to STOP.
- Whilst all crewmembers have formal certifications, competency of the FCB key personnel is deemed lacking.
- Inadequate procedure for vessel inspection and acceptance, in particular after major repair
- Inadequate procedure related to mooring configuration of multiple vessels at offshore mooring buoys
- Inconsistent management practices between primary versus secondary marine logistics
- Lack of enforcement and involvement in management of subcontractor
- Low hazard awareness and high tolerance for non-compliances.

Lessons learnt and recommendations to prevent reoccurrence:

Communicated initial findings across the region and issued Safety Alert on

- Testing of vessel propulsion system (other than for pre-departure checks) shall not be carried out whilst moored.
- All vessels to conduct re-tests of the following safety-critical systems for full functionality: propulsion controls, emergency stops, bridge controls and indicators.
- Vessel's inspection and acceptance by a competent team shall be conducted for initial mobilization as well as after every major repair.
- Communication with all affected parties shall be established prior to starting any risk activity
- "Duty to Stop Work" must be exercised whenever and before tasks are carried out without prior hazard assessments/communication
- The danger of mooring ropes under tension and the importance of effective site communication to be reiterated at toolbox meetings.
- To hold a Regional Marine Workshop of marine experts to cascade learnings and address/decide on key issues related to the underlying causes.
- To commit resources to effectively manage the totality of marine operations, which are responsive to the tight vessel market.
- To support and consider as global standard, recommendations arising from a planned review of mooring practices and alternative mooring ropes (which may be costlier).

Was this incident also classified as a Tier 1 Asset Integrity / Process Safety Event? (see Report 6) Yes No

A COMPANY EMPLOYEES				
FUNCTION (VICTIM)	No. of Fatalities from Incident	Age & Sex of Victim	Occupation of Victim	Medical Cause of Death
Exploration	1	26, Male	2nd Engineer	Severe multiple fractures
Production				
Drilling				
Construction				
Unspecified				

B CONTRACTOR EMPLOYEES				
FUNCTION (VICTIM)	No. of Fatalities from Incident	Age & Sex of Victim	Occupation of Victim	Medical Cause of Death
Exploration				
Production				
Drilling				
Construction				
Unspecified				

C THIRD PARTIES	
No. of Fatalities from Incident	

Report 2 completed example page 2 of 2

OGP Health & Safety Data Report		CONTACT NAME/TITLE <input style="width: 100%;" type="text"/>			
REPORT 2 - FATAL INCIDENTS		Page 2 of 2			
		Country	Malaysia		
Year	2010	Company	XYZ Operating Co.		
Function (Incident): (ring one only)	<input type="checkbox"/> Exploration	<input type="checkbox"/> Production	<input type="checkbox"/> Drilling	<input type="checkbox"/> Construction:	<input type="checkbox"/> Unspecified
Incident category (ring one - required)	<input type="checkbox"/> Assault and Violent act <input type="checkbox"/> Caught In, Under or Between <input type="checkbox"/> Confined Space <input type="checkbox"/> Cut, Puncture, Scrape <input type="checkbox"/> Explosion / Burn <input type="checkbox"/> Exposure Electrical <input checked="" type="checkbox"/> Exposure Noise, Chemical, Biological, Vibration		<input type="checkbox"/> Falls from height <input type="checkbox"/> Overexertion / Strain <input checked="" type="checkbox"/> Pressure release <input type="checkbox"/> Slips and Trips (at same height) <input type="checkbox"/> Struck By <input checked="" type="checkbox"/> Water related, Drowning <input type="checkbox"/> Other		
Type of activity: (ring one - required)	<input checked="" type="checkbox"/> Construction, Commissioning, Decommissioning <input type="checkbox"/> Diving, Subsea, ROV <input type="checkbox"/> Drilling / Workover / Well Services <input type="checkbox"/> Lifting, Crane, Rigging, Deck Operations <input type="checkbox"/> Maintenance, Inspection, Testing <input type="checkbox"/> Office, Warehouse, Accommodation, Catering		<input checked="" type="checkbox"/> Production Operations <input type="checkbox"/> Seismic / Survey Operations <input type="checkbox"/> Transport - Air <input type="checkbox"/> Transport - Land <input checked="" type="checkbox"/> Transport - Water, incl. Marine Activity <input type="checkbox"/> Unspecified - Other		
Causal factors (ring as many as apply See User Guide Appendix 3A)	PEOPLE (ACTS) Following Procedures: <input type="checkbox"/> Violation intentional (by individual or group) <input type="checkbox"/> Violation unintentional (by individual or group) <input checked="" type="checkbox"/> Improper position (in the line of fire) <input type="checkbox"/> Overexertion or improper position/posture for task <input type="checkbox"/> Work or motion at improper speed <input type="checkbox"/> Improper lifting or loading Use of Tools, Equipment, Materials and Products: <input checked="" type="checkbox"/> Improper use/position of tools/equipment/materials/products <input type="checkbox"/> Servicing of energized equipment/inadequate energy isolation Use of Protective Methods: <input type="checkbox"/> Failure to warn of hazard <input type="checkbox"/> Inadequate use of safety systems <input type="checkbox"/> Personal Protective Equipment not used or used improperly <input type="checkbox"/> Equipment or materials not secured <input type="checkbox"/> Disabled or remove guards, warning systems or safety devices Inattention/Lack of Awareness: <input checked="" type="checkbox"/> Improper decision making or lack of judgment <input type="checkbox"/> Lack of attention/distracted by other concerns/stress <input type="checkbox"/> Acts of violence <input type="checkbox"/> Use of drugs or alcohol <input type="checkbox"/> Fatigue		PROCESS (CONDITIONS) Protective Systems: <input type="checkbox"/> Inadequate/defective guards or protective barriers <input type="checkbox"/> Inadequate/defective Personal Protective Equipment <input type="checkbox"/> Inadequate/defective warning systems/safety devices <input type="checkbox"/> Inadequate security provisions or systems Tools, Equipment, Materials, Products: <input type="checkbox"/> Inadequate design/specification or management of change <input type="checkbox"/> Inadequate/defective tools/equipment/materials/ products <input type="checkbox"/> Inadequate maintenance/inspection/testing Work Place Hazards: <input type="checkbox"/> Congestion, clutter or restricted motion <input type="checkbox"/> Inadequate surfaces, floors, walkways or roads <input type="checkbox"/> Hazardous atmosphere (explosive/toxic/asphyxiant) <input type="checkbox"/> Storms or acts of nature Organisational: <input type="checkbox"/> Inadequate training/competence <input type="checkbox"/> Inadequate work standards/procedures <input type="checkbox"/> Inadequate hazard identification or risk assessment <input type="checkbox"/> Inadequate communication <input type="checkbox"/> Inadequate supervision <input type="checkbox"/> Poor leadership/organisational culture <input type="checkbox"/> Failure to report/learn from incidents		

Report 3 completed example page 1 of 1

OGP Health & Safety Data Report

CONTACT NAME/TITLE

REPORT 3 - HIGH POTENTIAL EVENTS - 2010 data

Year	2010	Company	XYZ Operating Co.	Country	Gasland
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Event details

Place of event (please ring one):	ONSHORE	<input type="checkbox"/> OFFSHORE	
Function (please ring one):	<input checked="" type="checkbox"/> EXPLORATION <input checked="" type="checkbox"/> PRODUCTION	<input type="checkbox"/> DRILLING <input type="checkbox"/> UNSPECIFIED	<input type="checkbox"/> CONSTRUCTION
Date of event:	<input type="text" value="20"/> day	<input type="text" value="September"/> month	<input type="text" value="2010"/> year

Event description:
 At 3.40am on the 30 year old Big Fish platform in the western North Sea, during a start-up of the oil / gas separator, a substantial release of hydrocarbon gas occurred over a two hour period when a pipe flange failed downstream of a recently installed 4 inch valve. The gas was under high pressure and it was estimated that about 720kg of gas was released in 30 minutes before alarms in the neighbouring gas lift module alerted operations to manually shutdown. The gas alarm in the oil / gas gas lift aerator module had failed to operate. The propane rich gas cloud was released into an enclosed area but there were no people in the area at the time of the event. Had people been in the vicinity and accidentally caused ignition, the resulting explosion could have caused multiple deaths and potentially fire could have spread endangering the entire platform. The leak was arrested following an local Operator visually identifying the leak, shutting the platform in and depressuring to flare.

What went wrong? (main root causes):
 The flange failure occurred due to corrosion between the flange and pipe. The newly fitted valve was an improved but heavier design fitted before start-up and had placed additional strain on the flange area precipitating the failure. The gas detector that had failed to operate was designed to detect such a release, but an intermittent fault had been noticed for some month. The detector head had not been replaced despite a maintenance work order requiring completion some time before the incident. The incident was recognised to be a High Potential Incident and also an Asset Integrity / Process Safety Event, requiring independent investigation and escalation to executive management. The investigation revealed failures of three procedural barriers, including Management of Change (MoC), Critical Maintenance back-log control, and Corrosion Testing & Inspection, as well as weaknesses on other underlying barriers, particularly Leadership and Competence.

Lessons learnt and recommendations to prevent recurrence:
 MoC procedures strengthened to be precise about requirements for more extensive corrosion testing as part of every start-up where new components are fitted. Alarm Maintenance requirements tracked through new KPIs which escalate to rig manager when any actions are behind schedule, and link to MoC to prevent start-up if any alarm action is incomplete. Leadership tasked to review assurance of engineering and maintenance competency for each team of operators and first line supervisors on the rig, to revise staff training and testing requirements as necessary, and track measures to provide assurance that new competence levels are maintained. All lesson learned were to be shared with the Oil OpCo's senior line and functional management who would share lessons learned as appropriate and ensure failure is included in next review of the corporate risk control systems.

Event category (ring one - required)	<input type="checkbox"/> Assault and Violent act <input type="checkbox"/> Caught In, Under or Between <input type="checkbox"/> Confined Space <input type="checkbox"/> Cut, Puncture, Scrape <input checked="" type="checkbox"/> Explosion / Burn <input type="checkbox"/> Exposure Electrical <input checked="" type="checkbox"/> Exposure Noise, Chemical, Biological, Vibration	<input type="checkbox"/> Falls from height <input type="checkbox"/> Overexertion / Strain <input checked="" type="checkbox"/> Pressure release <input type="checkbox"/> Slips and Trips (at same height) <input type="checkbox"/> Struck By <input checked="" type="checkbox"/> Water related <input type="checkbox"/> Other
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Type of activity: (ring one - required)	<input checked="" type="checkbox"/> Construction, commissioning, decommissioning <input type="checkbox"/> Diving, Subsea, ROV <input type="checkbox"/> Drilling, Workover, Well Services <input type="checkbox"/> Lifting, Crane, Rigging, Deck Operations <input checked="" type="checkbox"/> Maintenance, Inspection, Testing <input type="checkbox"/> Office, Warehouse, Accomodation, Catering	<input checked="" type="checkbox"/> Production operations <input type="checkbox"/> Seismic / Survey Operations <input type="checkbox"/> Transport - Air <input type="checkbox"/> Transport - Land <input checked="" type="checkbox"/> Transport - Water, incl. Marine Activity <input type="checkbox"/> Unspecified - Other
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Causal factors (ring as many as apply) See User Guide Appendix 3A	PEOPLE (ACTS) Following <input type="checkbox"/> Violation intentional (by individual or group) <input type="checkbox"/> Violation unintentional (by individual or group) <input type="checkbox"/> Improper position (in the line of fire) <input type="checkbox"/> Overexertion or improper position/posture for task <input type="checkbox"/> Work or motion at improper speed <input type="checkbox"/> Improper lifting or loading Use of Tools, Equipment, Materials and Products: <input type="checkbox"/> Improper use/position of tools/equipment/materials/products <input type="checkbox"/> Servicing of energized equipment/inadequate energy isolation Use of Protective Methods: <input type="checkbox"/> Failure to warn of hazard <input type="checkbox"/> Inadequate use of safety systems <input type="checkbox"/> Personal Protective Equipment not used or used improperly <input type="checkbox"/> Equipment or materials not secured <input type="checkbox"/> Disabled or remove guards, warning systems or safety devices Inattention/Lack of Awareness: <input type="checkbox"/> Improper decision making or lack of judgment <input type="checkbox"/> Lack of attention/distracted by other concerns/stress <input type="checkbox"/> Acts of violence <input type="checkbox"/> Use of drugs or alcohol <input type="checkbox"/> Fatigue	PROCESS (CONDITIONS) Protective Systems: <input type="checkbox"/> Inadequate/defective guards or protective barriers <input type="checkbox"/> Inadequate/defective Personal Protective Equipment <input checked="" type="checkbox"/> Inadequate/defective warning systems/safety devices <input type="checkbox"/> Inadequate security provisions or systems Tools, Equipment, Materials, Products: <input checked="" type="checkbox"/> Inadequate design/specification or management of change <input checked="" type="checkbox"/> Inadequate/defective tools/equipment/materials/ products <input checked="" type="checkbox"/> Inadequate maintenance/inspection/testing Work Place Hazards: <input type="checkbox"/> Congestion, clutter or restricted motion <input type="checkbox"/> Inadequate surfaces, floors, walkways or roads <input type="checkbox"/> Hazardous atmosphere (explosive/toxic/asphyxiant) <input type="checkbox"/> Storms or acts of nature Organisational: <input checked="" type="checkbox"/> Inadequate training/competence <input checked="" type="checkbox"/> Inadequate work standards/procedures <input checked="" type="checkbox"/> Inadequate hazard identification or risk assessment <input type="checkbox"/> Inadequate communication <input type="checkbox"/> Inadequate supervision <input type="checkbox"/> Poor leadership/organisational culture <input checked="" type="checkbox"/> Failure to report/learn from incidents
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Appendix 2 – Medical treatment cases (MT)

Medical Treatment (MT)

An incident is classified as Medical Treatment (MT) when the management and care of the patient to address the injury or illness is above and beyond First Aid (see the 14 First Aid treatments listed below)

Medical Treatment does not include:

- The conduct of diagnostic procedures, such as x-rays and blood tests, including the administration of prescription medications used solely for diagnostic purposes (e.g. eye drops to dilate pupils)
- Visits to a physician or other licensed health care professional solely for observation or counselling

The following may not involve any treatment but for purposes of severity classification, will be reported as Medical Treatment:

- any loss of consciousness
- significant injury or illness diagnosed by a physician or other licensed health care professional for which no treatment is given or recommended at the time of diagnosis. Examples include: punctured ear drums, fractured ribs or toes, byssinosis and some types of occupational cancer
- needle stick injuries and cuts from sharp objects that are contaminated with another person's blood or other potentially infectious material
- occupational hearing loss
- medical removal under a government standard

Note: First Aid carries a very specific meaning for this purpose – please refer to the definition of First Aid.

First Aid

An incident is classified as a First Aid if the treatment of the resultant injury or illness is limited to one or more of the 14 specific treatments. These are:

1. using a non-prescription medication at non-prescription strength
2. administering tetanus immunizations
3. cleaning, flushing or soaking wounds on the surface of the skin
4. using wound coverings such as bandages, Band-Aids™, gauze pads, etc. or using butterfly bandages or Steri-Strips™
5. using hot or cold therapy
6. using any non-rigid means of support, such as elastic bandages, wraps, non-rigid back belts, etc.
7. using temporary immobilization devices while transporting an accident victim (e.g. splints, slings, neck collars, back boards, etc.)
8. drilling of a fingernail or toenail to relieve pressure, or draining fluid from a blister
9. using eye patches
10. removing foreign bodies from the eye using only irrigation or a cotton swab
11. removing splinters or foreign material from areas other than the eye by irrigation, tweezers, cotton swabs or other simple means
12. using finger guards
13. using massages
14. drinking fluids for relief of heat stress

Prescription medication

When making the classification, it should be remembered that the intent is to distinguish those more severe situations that require a medical practitioner to use strong antibiotics and painkillers from those that only require first aid.

For medications available in both prescription and non-prescription form, a recommendation by a physician or other licensed health care professional to use a non-prescription medication at prescription strength is considered medical treatment. The definition of Prescription Medication may be used to determine when the prescription strength threshold has been crossed.

Where local regulations specify prescription medication and dosage, these will be followed for the purposes of OGP reporting. Where 'prescription medication' is not defined by the local regulatory system, the reporting company is responsible for defining prescription medicines and dose rate. The following is provided as guidance.

These criteria are provided in order to list those medications that, when prescribed or provided for occupational exposures, illnesses or injuries, uniformly result in recordable incidents, for the purposes of corporate occupational exposure, injury and illness reporting. They are to be used in conjunction with other corporate occupational illness and injury recording guidelines addressing diagnosis and level of treatment provided/required, as a means of achieving greater standardization of reporting across global operations.

For purposes of corporate reporting, prescription medication means:

- All antibiotics, including those dispensed as prophylaxis where injury or occupational illness has occurred to the subject individual.
Exceptions: dermal applications of Bacitracin, Neosporin, Polysporin, Polymyxin, iodine, or similar preparation.
- Diphenhydramine greater than 50 milligrams (mg) in a single application or any dose "injected".
- All analgesic and nonsteroidal anti-inflammatory medication (NSAID) including:
 - Ibuprofen– greater than 467mg in a single dose
 - Naproxen Sodium– greater than 220mg in a single dose
 - Ketoprofen– greater than 25mg in a single dose
 - Codeine analgesics – greater than 16mg in a single dose

Note: Shortening the dosing interval to less than the label instructions for over the counter medications should be reviewed. If it produces a total dose of the above listed listed or labeled allowed OTC amount it is considered reportable.

Exceptions: Acetylsalicylic acid (aspirin), acetaminophen (paracetamol) and dermal applications of NSAIDs not obtained by prescription are not considered medical treatment.
- All dermally applied steroid applications.
Exceptions: Hydrocortisone preparations in strengths of 1 percent or less
- All vaccinations used for work-related exposure.
Exceptions: Tetanus
- All narcotic analgesics (except codeine as listed above)
- All bronchodilators.
Exceptions: Epinephrine aerosol 5.5mg/ml or less
- All muscle relaxants (e.g. benzodiazepines, methocarbamol, and cyclobenzaprine)
- All injections are reportable unless specified above
- All other medications (not listed above) that legally require a prescription for purchase or use in the state or country where the injury or illness occurred.

Exception: Medication used for the sole purpose of diagnosis (e.g. dilating or numbing an eye for exam purposes only) is not considered medical treatment.

For areas that are not clear, please seek the advice from a company physician or medical consultant and document your reasoning for classification.

Appendix 3 – Glossary of terms

Caught Between

Injury where injured person is crushed or similarly injured between machinery moving parts or other objects, caught between rolling tubulars or objects being moved, crushed between a ship and a dock, or similar incidents.

Company Employee

Any person employed by and on the payroll of the reporting Company, including corporate and management personnel specifically involved in exploration & production. Persons employed under short-service contracts are included as Company employees provided they are paid directly by the Company.

Construction

Major construction, fabrication activities and also disassembly, removal and disposal (decommissioning) at the end of the facility life. Includes construction of process plant, yard construction of structures, offshore installation, hook-up and commissioning, and removal of redundant process facilities.

Contractor

A 'Contractor' is defined as an individual or organisation performing work for the reporting company, following verbal or written agreement. 'Sub-contractor' is synonymous with 'Contractor'.

Contractor Employee

Any person employed by a Contractor or Contractor's Sub-contractor(s) who is directly involved in execution of prescribed work under a contract with the reporting Company.

Drilling

All exploration, appraisal and production drilling and workover as well as their administrative, engineering, construction, materials supply and transportation aspects. It includes site preparation, rigging up and down and restoration of the drilling site upon work completion. Drilling includes ALL exploration, appraisal and production drilling.

Event

An unplanned or uncontrolled outcome of a business operation or activity that has or could have contributed to an injury, illness or physical damage or environmental damage.

Exploration

Geophysical, seismographic and geological operations, including their administrative and engineering aspects, construction, maintenance, materials supply, and transportation of personnel and equipment; excludes drilling.

Explosion or Burn

Incident caused by burns, toxic gases, asphyxiation or other effects of fires and explosions. 'Explosion' means a rapid combustion, not an overpressure.

Fall

Incident caused by falling off, over, or onto something.

Fatal Accident Rate (FAR)

The number of fatalities per 100,000,000 (100 million) work hours.

Fatal Incident Rate (FIR)

The number of fatal incidents per 100,000,000 (100 million) work hours.

First Aid Case

Cases that are not sufficiently serious to be reported as medical treatment or more serious cases but nevertheless require minor first aid treatment, e.g. dressing on a minor cut, removal of a splinter from a finger. First aid cases are not recordable incidents. See Appendix 2.

High Potential Event

Any incident or near miss that could have realistically resulted in one or more fatalities.

Hours Worked

The actual 'hours worked', including overtime hours, are recorded in the case of onshore operations. The hours worked by an individual will generally be about 2,000 per year.

For offshore workers, the 'hours worked' are calculated on a 12-hour work day. Consequently average manhours worked per year will vary from 1,600 to 2,300 hours per person depending upon the on/off shift ratio. Vacations and leave are excluded.

Hours Worked in Year (000s)

Hours worked must be reported in multiples of one thousand and should be rounded to the nearest thousand.

Incident

An unplanned or uncontrolled Event or chain of Events that has resulted in recordable injury, illness or physical damage or environmental damage.

Lost Time Injury (LTI)

A fatality or lost work day case. The number of LTIs is the sum of fatalities and lost work day cases.

Lost Time Injury Frequency (LTIF)

The number of lost time injuries (fatalities + lost work day cases) per 1,000,000 work hours.

Lost Work Day Case (LWDC)

Any work-related injury or illness, other than a fatal injury, which results in a person being unfit for work on any day after the day of occurrence of the occupational injury. 'Any day' includes rest days, weekend days, leave days, public holidays or days after ceasing employment.

Loss of Primary Containment (LOPC)

An unplanned or uncontrollable release of any material from primary containment, including non-toxic and non-flammable materials (e.g. steam, hot condensate, nitrogen, compressed CO₂ or compressed air).

Medical Cause of Death

This is the cause of death given on the death certificate. Where two types of causes are provided, such as ‘pulmonary oedema’ caused by ‘inhalation of hot gases from a fire’, both are recorded.

Medical Treatment Case (MTC)

Cases that are not severe enough to be reported as fatalities or lost work day cases or restricted work day cases but are more severe than requiring simple first aid treatment. *Note: A MTC reported under the OSHA reporting requirements should also be reported to OGP. See Appendix 2 for further information.*

Near Miss

An unplanned or uncontrolled event or chain of events that has not resulted in a recordable injury, illness or physical damage or environmental damage but had the potential to do so in other circumstances.

Number of Lost Workdays

The sum total of calendar days (consecutive or otherwise) after the days on which the occupational injuries occurred, where the persons involved were unfit for work and did not work.

Number of Employees

Average number of full-time and part-time employees involved in exploration and production, calculated on a full-time basis, during the reporting year.

Number of Fatalities

The total number of Company’s employees and/or Contractor’s employees who died as a result of an incident. ‘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 are reported. In some cases, a delayed fatality occurs in the next calendar year after the incident. For example, if the above fire occurred on December 21, 2007, the second death from it might occur in January 2008. All fatalities from an incident are included in the report for the year of that incident. In the above case, the fatality in 2008 is reported with the 2007 data.

Occupational Illness

Any abnormal condition or disorder, other than one resulting from an occupational injury, caused by exposure to environmental factors associated with employment. Occupational illness may be caused by inhalation, absorption, ingestion of, or direct contact with the hazard, as well as exposure to physical and psychological hazards. It will generally result from prolonged or repeated exposure. Refer to OGP/IPIECA Report № 393, *Health performance indicators*, published 2007.

Occupational Injury

Any injury such as a cut, fracture, sprain, amputation etc. 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, insect or snake bite.

Offshore Work

All activities and operations that take place at sea, including activities in bays, in major inland seas, such as the Caspian Sea, or in other inland seas directly connected to oceans. Incidents including transportation of people and equipment from shore to the offshore location, either by vessel or helicopter, should be recorded as ‘offshore’.

Onshore Work

All activities and operations that take place within a landmass, including those on swamps, rivers and lakes. Land-to-land aircraft operations are counted as onshore, even though flights are over water.

Primary Containment

A tank, vessel, pipe, truck, rail car, or other equipment designed to keep a material within it, typically for purposes of storage, separation, processing or transfer of gases or liquids.

Process Safety Event Rate

The number of process safety events per 1,000,000 (1 million) work hours (production and drilling work hours only).

Production

Petroleum and natural gas producing operations, including their administrative and engineering aspects, minor construction, repairs, maintenance and servicing, materials supply, and transportation of personnel and equipment. It covers all mainstream production operations including wireline. Gas processing activities with the primary intent of producing gas liquids for sale including:

- secondary liquid separation (i.e. Natural Gas Liquids [NGL] extraction using refrigeration processing)
- Liquefied Natural Gas (LNG) and Gas to Liquids (GTL) operations

See Section 4 for more detail of exclusions.

Recordable

A type of event, incident, injury, illness, release or other outcome which has been determined to meet or exceed definitions, criteria or thresholds for inclusion and classification in reported data.

Restricted Work Day Case (RWDC)

Any work-related injury other than a fatality or lost work day case which results in a person being unfit for full performance of the regular job on any day after the occupational injury. Work performed might be:

- an 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

Where no meaningful restricted work is being performed, the incident should be recorded as a lost work day case (LWDC).

Secondary containment

An impermeable physical barrier specifically designed to prevent release of materials into the environment that have breached primary containment.

Significant incidents

- Incidents (excluding fatalities) which cause or have the potential to cause serious injury and/or fatality, or significant structural damage (which may place personnel at risk); these need not even be recordable incidents.

Struck By

Incidents where injury results from being hit by moving equipment and machinery, or by flying or falling objects.

Third Party

A person with no business relation with the company or contractor.

Total recordable incidents

The sum of fatalities, lost work day cases, restricted work day cases and medical treatment cases.

Work-Related Injury

See Occupational Injury.

Appendix 3a - Glossary of causal factors

This glossary is provided to assist the user of the OGP list of causal factors, to further define and explain the classifications. Since the causal factors selected will be used for trend analysis, accuracy in selecting the appropriate cause is important. Users are encouraged to use this glossary to ensure proper understanding of each cause category.

Following Procedures:

Violation intentional (by individual or group): deliberate deviations from rules, procedures, regulations etc. An individual or a group of people fully aware that they were taking a risk i.e. knowingly take short cuts, or failing to follow procedures, to save time or effort. Usually well-meaning, but misguided in an attempt to “get the job done” e.g. operating equipment that they know they were not authorized for.

Violation unintentional (by individual or group): an individual or a group of people not aware that they were taking a risk, did not identify the hazard or were unaware of HSE requirements. The persons involved did not have sufficient awareness, training or competence to perform the tasks required in accordance with procedures, procedures were inadequate or were not properly implemented, no procedures available for the task.

Improper position (in the line of fire): person(s) were located in a position where they were exposed to a hazard e.g. between a moving and a fixed object, in the line of a moving counterweight, standing under a suspended load, positioned under or behind a vehicle, in the path of a material release from an energised system etc.

Overexertion or improper position/posture for task: the person did more than they were physically able to do or did not follow the proper ergonomic practices. e.g. carrying too much weight, or placing body parts in unsafe positions which resulted in physical strain.

Work or motion at improper speed: the person involved was not working at the proper speed, not taking time to do things safely, e.g. driving too fast, running down stairs or adding chemicals too fast or too slowly etc.

Improper lifting or loading: material being lifted, either by human or mechanical means, was not lifted or loaded/unloaded in accordance with proper practices or was over the capacity of the person or the lifting equipment. e.g. a vehicle or equipment loaded to one side or overloaded.

Use of Tools, Equipment, Materials & Products:

Improper use/position of tools/equipment/materials/products: tools/equipment/materials or products were used for activities for which they were not designed or were misused, e.g. wrong tool for the job, using excessive force on a tool (such as the use of cheater bars), operating equipment beyond the maximum recommended temperature, operating speed or pressure. Knowing that the tools or equipment were defective and continuing the work, e.g. running a forklift with leaking hydraulics. Using a product which was known to be out of specification or wrong for the application. Materials placed in potentially hazardous position e.g. equipment too heavy for surface it was placed on, restricted access to essential controls, products placed in location where likely to be damaged etc.

Servicing of energized equipment/inadequate energy isolation: servicing equipment without turning it off or without it being electrically or mechanically safeguarded according to energy isolation and equipment opening procedures e.g. lockout tag out e.g. trying to clear a jammed machine, cleaning out a plugged line etc.

Use of Protective Methods:

Failure to warn of hazard: the person involved in the event was not warned about a dangerous condition or activity, or an individual was aware of a hazard but did not warn current or future persons involved of the exposure, e.g. not using “out of service” tags on a defective tool, inadequate signage, no barriers placed around an open hole.

Inadequate use of safety systems: safety systems were not adequately used e.g. any permit to work not properly used, confined space entry requirements were not followed e.g. no gas testing performed, equipment was not properly isolated and the people involved were exposed to chemicals, hot surfaces, pressure, electricity etc.

Personal Protective Equipment not used or used improperly: equipment prescribed in the procedures was not used, was not available or the required Personal Protective Equipment was used, but it was not used in the proper way, e.g. no safety harness worn when required for working at height, poorly fitted respiratory protection, incorrect type of respirator or safety glasses worn when safety goggles were prescribed.

Equipment, or materials not secured: equipment or materials was not secured against movement or falling, e.g. ladder not secured, materials not stacked properly, insecure scaffolding, working at height with unsecured tools e.g. not tied off.

Disabled or removed guards, warning systems or safety devices: the proper guards, warning systems or other safety devices were either in place, but were disabled or overridden to allow the work to proceed without these protections or had been removed at some prior time, and not reinstalled or reactivated.

Inattention/Lack of Awareness:

Improper decision making or lack of judgement: the situation was wrongly judged and the wrong decision was made or person(s) involved in the event were engaged in inappropriate activities, including practical jokes.

Lack of attention/distracted by other concerns/stress: the person involved was performing a routine activity, such as walking, sitting down, stepping, etc. without conscious

thought or was distracted and not attentive to the work in progress. The person was under high stress from either work/personal issues or conflicting directions/demands contributed to an incident or the work being done required judgement and decision making that created stress, e.g. time sensitive decisions, high stakes in the outcome, incomplete information in which to base the decision.

Acts of violence: any type of physical or mental confrontations that can cause bodily injury or mental distress.

Use of drugs or alcohol: person(s) involved in the event may have been or were found to be under the influence of drugs or alcohol (illegal or legal which affect performance).

Fatigue: person(s) involved were mentally tired for whatever reason e.g. excessive work hours, shift patterns, staffing levels insufficient, ill-health etc. The loss of situational awareness, task fixation, distraction, and mental fatigue due to sleep loss are examples of conditions that apply to this causal factor.

Process (Conditions) Classifications

Process (Conditions) classifications usually involve some type of physical hazard or organisational aspect out with the control of the individual. There are five major classification categories, with an additional level of detail under each of the major categories.

Protective Systems:

Inadequate/defective guards or protective barriers: adequate guards and protective barriers that were needed to protect the worker were not present or did not provide sufficient protection or failed at the time of the incident.

Inadequate/defective Personal Protective Equipment: the Personal Protective Equipment used was not adequate for the situation at the time of the incident, the wrong type of PPE was specified, the PPE was defective at the time of the incident or PPE was not properly maintained or inspected.

Inadequate/defective safety devices/warning systems: safety devices such as pressure relief valves or over-speed trip devices were present, but did not act quickly enough to prevent the incident or failed to activate at the time of the event. No safety device(s) in place when it should have been. Inadequate warning systems were present or adequate warning systems failed to provide notice at the time of the incident or no warning system in place when it should have been.

Inadequate security provisions or systems: security systems were present such as perimeter fencing, alarm systems, security guards, security contracted services etc. but did not function as intended to protect facilities and personnel as appropriate. Also, no security provisions or systems in place when they should have been.

Tools, Equipment, Materials & Products:

Inadequate design/specification/management of change: the design or engineering of the plant/equipment did not adequately take into account HSE issues or the management of change processes were inadequate or not applied effectively. This could be applicable either to changes to the plant/equipment or to changes in procedures.

Inadequate/defective tools/equipment/materials/products: the tools/equipment/materials/products needed to do the job were in some way inadequate, not supplied, were defective or were not prepared adequately prior to the job e.g. tools in poor condition or not cleaned of contaminants, a vessel not thoroughly cleaned of chemicals prior to entry, a pallet of chemicals not adequately packaged, lifting equipment not suitably rated for a lift.

Inadequate maintenance/inspection/testing: facilities, infrastructure or equipment was not subject to adequate maintenance, inspection and/or testing not performed as required to ensure asset integrity.

Work Place Hazards:

Congestion, clutter or restricted motion: design of the workplace was poor and not enough clearances were available or accessibility was inadequate. Housekeeping was inadequate or work location was not clean and orderly.

Inadequate surfaces, floors, walkways or roads: the incident was caused by an inadequate surface, floor or walkway e.g. slippery stairs, uneven concrete or paving, ungraded road with potholes etc.

Hazardous atmosphere (explosive/toxic/asphyxiant): the workplace was contaminated with flammable or explosive materials in concentrations which on contact with a source of ignition may cause a fire or explosion or concentrations of toxic chemicals above workplace exposure limits or oxygen levels below safe breathing limits.

Storms or acts of nature: the incident was a direct or indirect result of a storm, tornado, hurricane, lightning, hail storm, flood, earthquake etc.

Organisational:

Inadequate training/competence: the organisation did not provide adequate training and/or did not take appropriate measures to ensure the competence of person(s) performing tasks.

Inadequate work standards/procedures: the systems of work, processes or procedures provided by the organisation were not adequate to effectively control the risks involved in the task *i.e.* procedures may have been in place and implemented but the requirements stated were insufficient e.g. confined space entry permit system which does not specify a requirement to gas test prior to entry.

Inadequate hazard identification or risk assessment: the person(s) involved in the work either did not recognise the hazard present or did not fully understand the risks involved e.g. the pre-job checks or tool box talks did not cover appropriate issues.

Inadequate communication: the communication of the requirements of the task and the controls required were inadequate to effectively control the risks and/or inform the involved person(s).

Inadequate supervision: the organisation did not provide adequate supervision for person(s) performing tasks.

Poor leadership/organisational culture: the organisation did not reinforce the correct behaviours, participation in safety efforts were not effective, and/or support of people not effective (*i.e.* the leaders in an area did not demonstrate appropriate personal behaviours with respect to their role in seeking out and supporting those individuals who identify and speak out about safety issues and concerns, or those people affected by an incident).

Failure to report/learn from events: one or more similar events has previously occurred, there was a failure to learn from these incidents e.g. not all events reported or those reported were inadequately investigated or additional control measures identified as required were not effectively implemented.

Appendix 4 – Frequently Asked Questions

Security – under what circumstances should security related incidents be reported?

Security related incidents (e.g. fatalities associated with an illegal detention of staff) should be reported where they are work-related, or where there is, or ought to be, management controls in place to reduce the possibility of the incident occurring.

Suicides – under what circumstances should suicides be reported?

It is not expected that suicides will be reported, however if an organisation deems it to be work-related it can be reported using Forms 1 and 2.

OSHA vs OGP – What are the differences between reporting under the OSHA and OGP requirements?

The main difference between OGP and OSHA reporting requirements relates to the need for E&P organisations to report incidents:

- associated with their own personnel
- contractor and sub-contractor personnel. The focus of the OSHA reporting requirements relates to company personnel. Additionally, OGP encourages the reporting of 3rd party fatalities

With respect to the reporting of medical treatment cases, the OGP and OSHA are aligned, such that a MTC reported under OSHA should also be reported to OGP. There are some differences in how OGP and OSHA establish work-relatedness with the OGP requirements being more inclusive:

- OGP collects data on stress related illness
- prescription medications
- home away from home does not apply
- OSHA 24 hours ruling does not apply
- OGP data are presented per million work hours
- parking lot or company property commuting incidents

What is ‘prescription medication’?

Where local regulations specify prescription medication and dosage these will be followed for the purposes of OGP reporting. Where ‘prescription medication’ is not defined by the local regulatory system the reporting company is responsible for defining prescription medicines and dose rates.

What is OGP?

The International Association of Oil & Gas Producers encompasses the world's leading private and state-owned oil & gas companies, their national and regional associations, and major upstream contractors and suppliers.

Vision

- To work on behalf of the world's oil and gas producing companies to promote responsible and profitable operations

Mission

- To represent the interests of oil and gas producing companies to international regulators and legislative bodies
- To liaise with other industry associations globally and provide a forum for sharing experiences, debating emerging issues and establishing common ground to promote cooperation, consistency and effectiveness
- To facilitate continuous improvement in HSE, CSR, engineering and operations

Objectives

- To improve understanding of our industry by being visible, accessible and a reliable source of information
- To represent and advocate industry views by developing effective proposals
- To improve the collection, analysis and dissemination of data on HSE performance
- To develop and disseminate best practice in HSE, engineering and operations
- To promote CSR awareness and best practice



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