

Incident Reporting and Investigation

Procedure

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About This Procedure

Purpose	This Procedure describes the requirements for the systematic reporting (i.e. classifying, notifying and recording), investigation (i.e. planning, organising and analysing data, and reporting findings) and learning from incidents and near misses for INPEX Australia (the Company). This procedure supports the implementation of the Company Incident Reporting and Investigation Standard and HSE Legal and Other Requirements Standard.
Scope	This procedure shall apply to workers and entities performing working for or on behalf of the Company at Prevailing Influence (PI) 1 sites for all Company-led investigations. For Contractor led investigations at PI 2 or 3 sites, Company involvement in the investigation shall be undertaken, where requested and meet the requirements of this Procedure.
Intended user	Workers performing activities for or on behalf of the Company.

1 Business Rules

1.1 Competency to report and investigate incidents

Competency requirements

- Workers nominated to report, investigate and share lessons from incidents and near misses, shall be trained and competent to perform their nominated role as specified in Table 1 within this Procedure.

1.2 Reporting and classification of incidents and near misses

Requirements for reporting incidents and near misses

- Incidents and near misses for PI 1 worksites shall be reported in accordance with Table 2 and 3 within this Procedure.
- Incidents and near misses for PI 2 worksites shall be reported in accordance with Table 4 within this Procedure.

Types of incidents and near misses to report

- The types of Process Safety incidents that are reported, include those that have the following impacts:
 - Resulted in a loss of containment from the process.
 - Resulted in a demand on a safety system or failure of / damage to a Safety Critical Element; or
 - Resulted in an excursion outside of Safe Operating Limits; or
 - Resulted in primary containment envelope inspection or test results outside of acceptable limits; or
 - Resulted in a failure of operating discipline or management system with the potential to cause a process safety impact.
- The other types of incidents and near misses that are reported, include those that have the following actual or potential consequences:
 - Harm, or have potential to cause harm, to people.
 - Impact, or have potential to impact the environment.
 - Damage, or have potential to cause damage, to any Company asset, including plant or equipment damage.
 - Threaten, or have the potential to threaten, the security of people, or Company information or assets.
 - Undermine, or have the potential to undermine asset integrity safety due to non-conformance with technical specifications, scope requirements, or applicable standards; or
 - Non-compliance with relevant HSEQ legislative requirements (including breaches or potential breaches); or

- When products, services or processes do not meet their intended requirements or specified use, which results in, or has the potential to result in, financial impact being incurred.
- All incidents and near misses shall be classified in accordance with the Company [Incident Reporting and Classification Guideline](#).
- All psychological injuries and illnesses including those associated with bullying and harassment shall be classified as confidential and be managed in accordance with the [Psychosocial Hazard Management Procedure](#) and [Equal Opportunity, Bullying, Discrimination and Harassment Standard](#).



NOTE: Where a psychological injury, illness or incident of bullying or harassment occurs, the Location Manager is responsible for ensuring that a HR Business Partner is made aware, and the incident shall be recorded within the HR Confidential Incidents Register (not recorded in Company's electronic incident management system).

1.3 Legal review of major incidents

Requirements for legal review

- The Location Manager (PI 1 worksite) or Company Representative (PI 2 worksite) or their approved delegates shall ensure Legal Counsel is notified of all Major incidents.
- Legal Counsel will conduct a review of the incident details and will determine whether legal professional privilege will be applied to the investigation.
- Where legal professional privilege is required, then the investigation will be carried out in accordance with the [Legal Privilege - Events and Investigation Procedure](#).



NOTE: Where legal professional privilege is claimed, the External Notification of Incidents Process and flow charts (Table 7 and 8) no longer apply.

1.4 Notification to external stakeholders and regulatory authorities

Requirements for external reporting and notification

- The HSE GM (or their approved delegate), shall report all Major incidents to the INPEX Corporate GM of the HSE Unit (Tokyo) in accordance with Table 2, Table 3 and Table 4 in this Procedure.
- For a PI 1 worksite, the relevant Location Manager (or their approved delegate) will commence the external regulatory notification in accordance with Table 7 (Offshore External Notification of Incidents) or Table 8 (Onshore External Notification of Incidents) in this Procedure.

- For a PI 2 worksite, the relevant Company Representative will liaise with the Contractor Representative and verify that they have completed the necessary external regulatory notifications. The Contract Holder shall receive a copy of the external notifications provided by the Contractor Representative.

1.5 Selecting the investigation team

Responsibility for appointing the investigation team

- For a PI 1 worksite, the Location Manager (or their approved delegate) shall notify the relevant investigation sponsor and the investigation sponsor shall appoint an investigation team in accordance with considerations specified in Table 2 and Table 3.
- For a PI 2 worksite, the Company Representative (or their approved delegate) shall be invited to participate in the Contractor led investigation as specified in Table 4.

1.6 Investigation processes to identify causes

All Investigations

- The level of effort, time and resources required for each investigation shall be proportionate to the complexity and severity of the Incident. For guidance when planning, refer to Table 6 - Investigation Level Requirements Guidance Table.
- An Incident scene is to be secured and preserved. Securing and preserving the scene does not prevent any required action to:
 - Assist an injured person.
 - Make the site safe or mitigate any further risk or escalation of incident.
 - Enable facilitation of police or regulator investigation.
- Incident scenes shall remain secured and preserved until all relevant authorities, (e.g. regulator, police) confirm release of the scene. Refer to the relevant site emergency response plan and/ or the [INPEX Australia Management of Fatalities Plan](#) for further guidance.



NOTE: For Quality defects / non-conformances, the Quality Investigation and Non-Conformance Management Procedure shall also be followed.

Major Investigations

- For major investigations, the TapRoot® RCA methodology shall be used to enable the identification of causal factors, root causes, generic causes and appropriate actions that will prevent re-occurrence.

Minor Investigations

- For Minor Investigations, the Taproot RCA or 5 Whys RCA methodology may be used to enable the identification of causal factors, root causes and appropriate actions that will prevent reoccurrence. The selected methodology is at the discretion of the Investigation Sponsor.
- To aid investigations of Tier 3 Non-LOC incidents, the Process Safety Incident Investigation Form may be used. Relevant information recorded in this form shall be transferred into the Company's electronic incident management system (and the original form/analysis attached to the incident record).

No Investigation Required

- Certain incidents and near misses do not require a formal investigation (report only). For these, the following shall be documented in the Company's electronic incident management system:
 - key details (who, what, where and when), and
 - the management system element that has been impacted or failed.

Human Factors Analysis (HFA)

- The Human Factors Analysis (HFA) is a tool to analyse intentional and unintentional behaviours contributing to incidents.
- The HFA supplements a completed TapRoot® or 5-Whys investigation and should be conducted when:
 - A human behaviour or error is identified during the investigation as a contributing or causal factor, but the chosen methodology does not sufficiently explain the root cause/ reason for the behaviour.
- The HFA facilitator shall use a HFA tool (e.g. the Kiel Centre HFA Tool) to document findings, causes and corrective actions.
- The HFA facilitator shall discuss the outputs from the HFA with the investigation sponsor, investigation team leader, the involved party's one up supervisor and the nominated HR Business Partner.
- Once the investigation sponsor has approved the HFA findings, causes and corrective actions, they shall be recorded within the Company's electronic incident management system.

Just culture assessment

- A just culture assessment is only required to be conducted when a human behaviour or error is deemed to be a causal factor or has directly contributed to a major incident.
- Where a just culture assessment is deemed necessary, the [Just Culture Assessment Template](#) shall be used by the involved party's one up supervisor and the nominated HR Business Partner.

Psychosocial hazard investigation

- The just culture assessment shall be managed in accordance with the Company's [Managing Actions and Behaviours Procedure](#).
- All records associated with the just culture assessment shall be deemed confidential and retained by HR (not recorded in the Company's electronic incident management system).
- A psychosocial hazard investigation may be required where a psychosocial hazard has been identified or reported.
- Psychosocial hazards are hazards that arise from or in relation to the design or management of work, the working environment and workplace interactions or behaviours that may cause psychological and physical harm.
- Where a psychosocial hazard investigation is conducted, the psychosocial hazard investigation tool is used, and the findings are recorded and retained within the HR Confidential Incidents Register (not recorded in Company's electronic incident management system).
- All aspects of the psychosocial hazard investigation shall be managed and communicated in accordance with the Company Psychosocial Hazard Management Procedure

Hazardous Manual Task (HMT) Risk Assessment

- For Company-controlled (PI1) incidents which result in a Musculo-Skeletal Disorder (MSD) related to performing manual tasks (e.g., high exertion, awkward postures, repetition), an initial MSD screening tool shall be completed as part of the investigation within the Company's Incident Management System.
- This tool shall be used to determine if a formal Manual Task Risk Assessment (ManTRA) is required. If indicated, the requirement for a ManTRA shall be listed as a corrective action assigned to the Injury Management Coordinator.
- The ManTRA shall complement the investigation methodology used (e.g. Taproot, 5Why).
- The completed ManTRA and any subsequent actions shall be attached and/ or listed within the Company's Incident Management System and managed in accordance with the [Management of Hazardous Manual Tasks Procedure](#).

1.7 Recording the investigation findings

Approving and recording findings from investigations

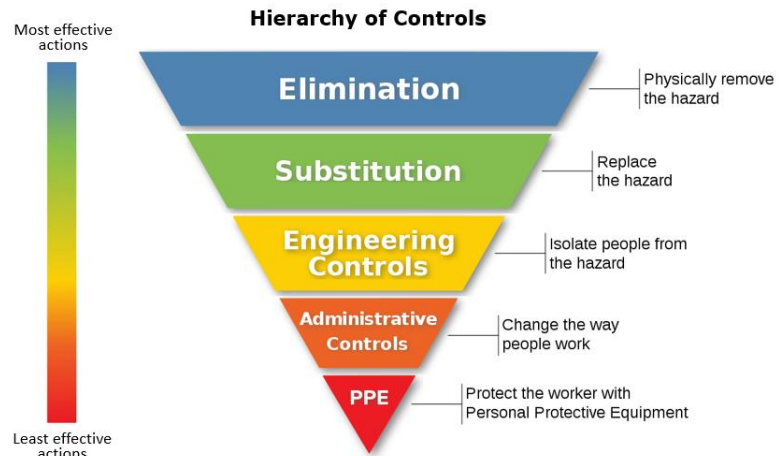
- All incident investigations shall be:
 - completed in accordance with timeframes specified in Table 2, Table 3 and Table 4 of this Procedure unless a time extension has been approved by the investigation sponsor (or their approved delegate); and

- considered complete once the investigation sponsor has reviewed and endorsed the findings (causal factors, root causes, generic causes, human factors) and associated actions.
- For major investigations:
 - the investigation findings, causes and associated actions shall be documented using the Company's Incident Investigation Report Template.
 - the investigation sponsor (or their approved delegate) shall decide whether to use the Microsoft Word or PowerPoint version of the incident investigation report (dependant on the complexity and circumstances of the investigation).
 - an incident investigation report shall be prepared by the investigation team leader (or their approved delegate), reviewed by the investigation team (including a Technical Authority (TA) where deemed required by the sponsor), endorsed by the Facility GM and HSE GM, and relevant HSEQ/ Process Safety Manager and approved by the investigation sponsor.
 - the approved Incident Investigation Report shall be formally recorded within the Company's controlled document system (CDS) and a signed PDF copy uploaded into the Company's electronic incident management system; and
 - the approved investigation findings (causal factors, root causes, generic causes, human factors) and associated actions shall be documented in the Company's electronic incident management system by the investigation team leader (or their approved delegate).
- For minor investigations:
 - the investigation findings (causal factors, root causes, generic causes, human factors) and associated actions shall be prepared by the investigation team leader and approved by the investigation sponsor; and
 - the Company's incident Investigation Report Template is not required to be used to document the investigation findings and associated actions. The entry of the approved findings and actions into the Company's electronic incident management system shall suffice.
- For 'Report Only' (no investigation required):
 - the incident details (who, what, where and when) and the management system element that has been impacted or failed shall be documented in the Company's electronic incident management system by the investigation team leader (or their approved delegate). This is the minimum information required to facilitate grouping incidents together for trending.

1.8 Actions to prevent incident reoccurrence

Determining and assigning actions

- Actions shall be:
 - developed considering the hierarchy of controls and shall address each of the identified root causes.



- developed by the investigation team in consultation with the investigation sponsor and location manager using a defined process (S-M-A-R-T-E-R):
 - **Specific** – clearly stated (what to do and how to do it) and specific enough for the action owner to understand what is required. Corrective actions must outline the necessary work to ensure the identified risk is mitigated or controlled.
 - **Measurable** – quantifiable and able to be tracked (action shall remain open until clear evidence of work completion is confirmed, and the identified risk is mitigated or controlled). Raised, open or incomplete corrective activities (e.g., Work Order/ SAP Notification/ MoC) are not considered a sufficient mitigation or control to demonstrate closure of action.
 - **Agreed and Realistic** – discussed with the proposed actionee and the functional manager (of the proposed actionee) to ensure that the proposed action description, owner, priority and completion date are understood, practical and appropriate. Once agreed, the actions shall then be recorded within the Company's electronic action management system by the investigation team leader (or their approved delegate).
 - **Time based** – prioritised for completion considering the severity of the incident and potential for a re-occurrence. The action priority shall be determined using the [Operations Prioritisation Matrix](#).

- **Evaluated** – assigned actions should be evaluated regularly to ensure that progress is being made to complete / close the action and to make any necessary adjustments; and
- **Reviewed** – For major investigations, once a corrective action has been completed and closed by the actionee, an effectiveness review should be conducted after an appropriate period to verify that the action has achieved its intended outcome and that the risk has been adequately controlled.

The effectiveness review shall be completed through existing Company effectiveness review activities.

Where the corrective action is found to be ineffective, or partially effective, the deficiencies identified shall be recorded with additional corrective action/s in the Incident Management System to ensure the risk is adequately mitigated or controlled.

Actions from minor investigations do not require an effectiveness review unless requested by the Investigation Sponsor, HSEQ Manager or their delegate.

- assigned to an action verifier if deemed necessary by the investigation sponsor. Verifiers for all actions will ensure that the action is completed, the risk is mitigated and no incomplete corrective activities for that action remain outstanding. For major investigations, action closeout shall be verified by the Facility GM.
- reviewed and endorsed by a TA (where a TA is required to participate as part of the investigation team).
- completed prior to or by the assigned due date and approved in accordance with the Company's [Action Management Procedure](#). Any proposed changes (including due date extensions) shall be requested of and agreed with the Investigation Sponsor (or their approved delegate) prior to the action becoming overdue.

1.9 Review of incident investigations

Requirements for a senior management review

- For major investigations:
 - the investigation findings, causal factors, root causes, generic causes and actions to prevent recurrence, shall be reviewed by senior management (prior to investigation close out).
 - the HSE GM, HSEQ/ Process Safety Manager, (or their approved delegate) shall invite the investigation

sponsor (and other relevant persons supporting the investigation) to present the major incident investigation findings at the senior management review meeting (as per the timeframes specified in Tables 2, 3 or 4).

- the Quality Manager shall be invited to participate in the investigation review meeting whenever a vendor or specification non-conformance is involved; and
- recommendations arising from the senior management review meeting shall be considered by the investigation sponsor. Where a recommendation is agreed and adopted by the investigation sponsor, it shall be recorded within the major incident investigation report and saved within the Company's electronic incident management system.
- For minor investigations:
 - the investigation findings, causal factors, root causes, generic causes and actions shall be reviewed by the investigation sponsor and location manager during routine worksite management meetings.

Requirements for an investigation review

- For major investigations:
 - an investigation review is mandatory. The HSE GM, HSEQ/ Process Safety Manager (or their approved delegate) shall nominate a competent person (as specified in Table 1 within this Procedure) to undertake a review to verify that all aspects of the investigation have been conducted in accordance with the Company's [Incident Reporting and Investigation Standard](#).
 - The investigation review shall be conducted in accordance with the specified timeframes and requirements detailed in Tables 2, 3 or 4 within this Procedure.
 - The person nominated to complete the investigation review shall engage with the investigation sponsor and investigation team leader to discuss observations, provide formative feedback and agree outcomes from the review; and
 - Completed investigation reviews shall be recorded within the Company's electronic incident management system.
- For minor investigations:
 - an investigation review is not required unless deemed necessary by the investigation sponsor and relevant HSE Team Lead or Process Safety Team Lead (or their approved delegates).

1.10 Sharing and communicating lessons from incidents

Requirements for communicating and sharing lessons from incidents

- For major investigations:
 1. An Incident Bulletin (initial and final) shall be prepared using the Company's Incident Bulletin Template.
 2. Incident Bulletins shall be prepared in accordance with responsibilities and timeframes specified in Table 2, Table 3 and Figure 1 within this Procedure.
 3. Prior to sharing an Incident Bulletin (final) externally, it shall be reviewed by Legal Counsel and Corporate Affairs (or their approved delegates).
 4. Where incident information is relevant to an area, site or workplace, the Responsible Manager or Location Manager shall ensure the lessons learned are communicated to the roles / workers specified and recommendations to prevent a re-occurrence are implemented; and
 5. The investigation team leader (or their approved delegate) shall enter any lessons learned (agreed with the investigation sponsor) into the Company's electronic Incident Management System.
- For minor investigations:
 1. an Incident Bulletin and capturing of Lessons Learned is not required unless deemed necessary by the investigation sponsor and relevant HSEQ/ Process Safety Team Lead.



NOTE: Wherever an initial incident bulletin is issued, a final incident bulletin must also be issued regardless of whether the incident has been downgraded.

Table 1 - Incident Reporting and Investigation Competency Matrix

For Major Incident Investigations

		Training For Role						Prior Experience For Role	Independence For Role
	Interview Techniques (classroom training)	Taproot RCA (classroom training)	5-Whys (e-learning training)	Human Factors Analysis Tool for investigations (classroom training)	Human Factors General Awareness (classroom training)	Cority Advanced User (e-learning training)	Cority General User (e-learning training)	Investigation Team Member in x1 Major Investigation	Role required to be independent from management team responsible for the worksite where incident occurred
Investigation Sponsor	×	×	×	×	💡	💡	💡	💡	💡
Investigation Team Leader	💡	💡	×	💡	💡	✓	×	💡	✓
RCA Facilitator	💡	✓	×	💡	×	✓	×	💡	✓
HFA Facilitator	💡	💡	×	✓	×	✓	×	💡	✓
Investigation Team Member (i.e. Quality focal point, HSER, TA, HRBP, Legal)	×	×	×	×	💡	✓	×	×	×
Investigation Reviewer	💡	✓	×	✓	×	✓	×	✓	✓

For Minor Incident Investigations

		Training For Role						Experience For Role	Independence For Role
	Interview Techniques (classroom training)	Taproot RCA (classroom training)	5-Whys (e-learning training)	Human Factors Analysis Tool for investigations (classroom training)	Human Factors General Awareness (classroom training)	Cority Advanced User (e-learning training)	Cority General User (e-learning training)	Investigation Team Member in x1 Minor Investigation	Role required to be independent from management team responsible for the worksite where incident occurred
Investigation Sponsor	×	×	×	×	💡	💡	💡	💡	×
Investigation Team Leader	×	💡	💡	💡	💡	✓	×	💡	×
RCA Facilitator ¹	💡	✓	✓	💡	×	✓	×	💡	×
HFA Facilitator	💡	💡	💡	✓	×	✓	×	💡	×
Investigation Team Member (i.e. Quality focal point, HSER, TA, HRBP)	×	×	×	×	💡	✓	×	×	×
Investigation Reviewer	💡	✓	✓	✓	×	✓	×	💡	×

1. For minor investigations, the Taproot RCA or 5-Whys RCA methodology may be used at the discretion of the Investigation Sponsor. The selected RCA Facilitator must be trained in the selected RCA methodology.

Recommended

💡

Required

✓

Not Applicable

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Table 2 - Occupational Health, Safety, Environment and Quality Incident Management Matrix for PI 1 Sites

Classification	Sponsor	Investigation Level	Internal and External Notifications		Investigation	
Risk Matrix Consequence Severity			Notify and Record	Plan & Investigate	Report & Review	
HSEQ incident Actual Impact – A or B	President Director or Executive VP	Major	Incident Reporter’s Supervisor Tasks: - Notify the Location Manager of initial incident details as soon as practicable. Location Manager Tasks: - Endorse entry of the initial incident details into Company’s electronic Incident Management System within 24 hours of incident occurrence. - Coordinate the necessary external notifications to regulatory authorities. HSE GM Tasks: Provide email notification to Corporate GM of HSE Unit (Tokyo) within 4 hours of the incident occurrence or as soon as practicable. Legal Counsel Tasks: - Review the incident details and determine whether legal professional privilege will be applied to the investigation. Investigation Sponsor - Verbal notification to Security GM of HSE Unit (Tokyo) within 4 hours of any security incident or as soon as practicable.	Sponsor Tasks: - Appoint investigation team leader and investigation team members. - If a HFA³ is required (where human behaviour / error is a causal factor) appoint a HFA facilitator on the investigation team. - If a Just Culture assessment⁵ or a Psychosocial Hazard Investigation⁶ is required, notify the HR Business Partner. - If a ManTRA is required⁸, notify Injury Management Coordinator. - Approve the investigation ToR¹. - Confirm initial incident classification and arrange investigation planning meeting within 72hrs of incident occurring. - Approve initial incident bulletin⁷ and ensure it is issued within 72hrs of incident occurring. Investigation Team Leader Tasks: (Independent ²) - Draft and issue investigation ToR¹. - Draft and issue Initial Incident Bulletin⁷. - Coordinate and lead investigation team members. - Inform Sponsor if HFA³ is required (where human behaviour / error is a causal factor). - Inform Sponsor if Psychosocial Hazard Investigation⁶ is required. - Inform Sponsor if a ManTRA is required⁸. - Inform Sponsor if Just Culture assessment⁵ is required. - Coordinate investigation team members and brief the investigation sponsor on investigation progress. HSE GM/ relevant HSEQ Manager Tasks: - Endorse the investigation ToR¹. Facility GM Tasks: - Endorse the investigation ToR¹.	Sponsor Tasks: - Approve final incident bulletin⁷ and ensure it is issued (within 28 days of incident occurrence). - Approve final incident classification and major incident investigation report⁴. - Close out investigation within electronic Incident Management System within 28 days of incident occurrence. - Approve lessons learned to be recorded in Company’s electronic Incident Management System. Investigation Team Leader Tasks: (Independent ²) - Draft and issue final incident bulletin⁷. - Draft and issue the major incident investigation report⁴. - Add final report details, agreed lessons learned and copy of approved Report into Company’s electronic Incident Management System. HSE GM / relevant HSEQ Manager Tasks: - Invite Sponsor (and investigation team leader) to present investigation findings at senior management review meeting (prior to investigation close out). - Endorse major incident investigation report⁴. - Appoint an independent person to complete an investigation review within 30 days of investigation close out. Facility GM Tasks: - Endorse the major incident investigation report⁴. - Verify action closeout Legal Counsel Tasks: Review major incident investigation report and final incident bulletin.	
HSEQ Incident or Near Miss Actual Impact – C or Potential Impact – A, B or C (HiPo)			EVP, SVP or VP	Incident Reporter’s Supervisor Tasks: - Notify the Location Manager of initial incident details as soon as practicable. Location Manager Tasks: - Endorse entry of the initial incident details into Company’s electronic Incident Management System within 24 hours of incident occurrence. - Coordinate the necessary external notifications to regulatory authorities.⁹ HSE GM Tasks: - Provide email notification to Corporate GM of HSE Unit (Tokyo) within 4 hours of the incident occurrence or as soon as practicable. Legal Counsel Tasks: Review the incident details and determine whether legal professional privilege will be applied to the investigation.		
HSEQ incident Actual Impact – D ⁹			Divisional VP			
HSEQ Incident or Near Miss Actual Impact – E Potential Impact – D ⁹	Location Manager	Minor	Incident Reporter’s Supervisor Tasks: - Notify the Location Manager of initial incident details as soon as practicable. Location Manager Tasks: - Endorse entry of the initial incident details into Company’s electronic Incident Management System within 24 hours of incident occurrence. - Coordinate the necessary external notifications to regulatory authorities (if deemed necessary).⁹	Sponsor Tasks: - Appoint investigation team leader and investigation team members. - If a HFA³ is required (where human behaviour / error is a causal factor) appoint a HFA facilitator on the investigation team. - If a Just Culture assessment⁵ or a Psychosocial Hazard Investigation⁶ is required, notify the HR Business Partner. - Confirm initial incident classification and scope of investigation within 72hrs of incident occurring. - Decide if initial incident bulletin is required. If so, ensure it is issued within 72 hours of incident occurrence. Investigation Team Leader Tasks: - Draft and issue initial incident bulletin (if requested by sponsor). - Coordinate and lead investigation team members. - Inform Sponsor HFA³ is required (where human behaviour / error is a causal factor). - Inform Sponsor if Just Culture assessment⁵ is required. - Inform Sponsor if Psychosocial Hazard Investigation⁶ is required. - Inform Sponsor if a ManTRA is required⁸. - Brief the investigation sponsor on investigation progress.	Sponsor Tasks: - Approve final incident bulletin (if required) and ensure it is issued within 14 days of incident occurrence. - Approve final incident classification, investigation details and close out within Company’s electronic Incident Management System within 14 days of incident occurrence. Investigation Team Leader Tasks: - Draft and issue final incident bulletin (if requested by sponsor). - Add final investigation details into Company’s electronic Incident Management System. HSEQ Team Lead Tasks: - Determine if incident investigation review is required (not mandatory for minor incidents). If so, appoint a person to complete an incident investigation review within 30 days of investigation close out.	
HSEQ Incident or Near Miss Actual Impact – F Potential Impact – E or F		Report Only investigation may not be required ⁹)	Incident Reporter’s Supervisor Tasks: - Notify the Location Manager of initial incident details as soon as practicable. Location Manager Tasks: - Endorse entry of the initial incident details into Company’s electronic Incident Management System within 24 hours of incident occurrence.	- If an investigation is <u>not required</u> (report only), the incident details (who, what, where and when) and the management system element that has been impacted or failed shall be recorded within Company’s electronic incident management system by the investigation team leader (or their approved delegate). These details are the minimum information that is required to facilitate grouping incidents for analysis and trending purposes. - If an investigation <u>is requested</u> by the Regulator, Location Manager or HSE Manager, (<u>or investigation of a minor event is a legal obligation</u>), follow the same process for minor or major investigation (depending on decision) as described above within this table.		
Footnotes						
1- Major incident investigation terms of reference template (0000-AH-TPL-60037) shall be used (for major incidents only). 2- For major investigations, it is mandatory to appoint an independent investigation team leader, taproot facilitator and HFA facilitator (where a HFA is required). 3- Where a HFA is required, an HFA facilitator (appointed by the sponsor) shall use the Kiel Centre HFA Tool to document findings and actions. 4- Investigation findings, causes and associated actions shall be documented using Incident Investigation Report Template (0000-AH-TPL-60006). The investigation sponsor shall decide whether to use the Microsoft Word or PowerPoint version of the incident investigation report (dependant on the complexity and circumstances of the investigation).			5- Where a just culture assessment is required (based outcomes from the HFA), the just culture assessment template (0000-AN-TPL-60028) shall be used, and the process shall be managed according to the Managing Actions and Behaviours Procedure (000-AN-PRC-60023). 6- Where a psychosocial hazard investigation is required, the psychosocial hazard investigation tool shall be used, and findings shall be recorded within the HR Confidential Incidents Register in accordance with Psychosocial Hazard Management Procedure (0000-AH-PRC-70006). 7- Incident bulletin template (0000-AH-TPL-60030) shall be used. Incident Bulletins are mandatory for all Major Investigations (optional for Minor Investigations). Where an Initial Incident Bulletin is issued, it is mandatory to also issue a Final Incident Bulletin. 8- For incidents resulting in an MSD, an MSD screening shall be completed by the HSE Advisor to determine if a ManTRA should be conducted with the support of Injury Management Coordinator, and in accordance with the Management of Hazardous Manual Tasks Procedure (0000-AH-PRC-70007). 9- Refer to the Incident Reporting and Classification Guideline (0000-AH-GLN-60060) for further guidance.			

Table 3 - Process Safety Incident Management Matrix for PI 1 Sites

Classification	Sponsor	Investigation Level	Internal and External Notifications	Investigation	
Process Safety Tier			Notify and Record	Plan & Investigate	Report & Review
Tier 1 LOC Or Tier 2 LOC ⁹	President Director or Executive VP	Major	Incident Reporter’s Supervisor Tasks: - Notify the Location Manager of initial incident details as soon as practicable. Location Manager Tasks: - Endorse entry of the initial incident details into Company’s electronic Incident Management System within 24 hours of incident occurrence. - Coordinate the necessary external notifications to regulatory authorities. HSE GM Tasks: - Provide email notification to Corporate GM of HSE Unit (Tokyo) within 4 hours of the incident occurrence or as soon as practicable. Legal Counsel Tasks: - Review the incident details and determine whether legal professional privilege will be applied to the investigation.	Sponsor Tasks: - Appoint investigation team leader and investigation team members. - If a HFA³ is required (where human behaviour / error is a causal factor) appoint a HFA facilitator on the investigation team. - If a Just Culture assessment⁵ or a Psychosocial Hazard Investigation⁶ is required, notify the HR Business Partner. - Approve the investigation ToR¹. - Confirm initial incident classification and arrange investigation planning meeting within 72hrs of incident occurring. - Approve initial incident bulletin⁷ and ensure it is issued within 72hrs of incident occurring. Investigation Team Leader Tasks: (Independent ²) - Draft and issue investigation ToR¹. - Draft and issue Initial Incident Bulletin⁷. - Coordinate and lead investigation team members. - Inform Sponsor if HFA³ is required (where human behaviour / error is a causal factor). - Inform Sponsor if Psychosocial Hazard Investigation⁶ is required. - Inform Sponsor if Just Culture assessment⁵ is required. - Coordinate investigation team members and brief the investigation sponsor on investigation progress. HSE GM / Process Safety Manager Tasks: - Endorse the investigation ToR¹. Facility GM Tasks: - Endorse the investigation ToR¹.	Sponsor Tasks: - Approve final incident bulletin⁷ and ensure it is issued (within 28 days of incident occurrence). - Approve final incident classification and major incident investigation report⁴. Close out investigation within electronic Incident Management System within 28 days of incident occurrence. - Approve lessons learned to be recorded in Company’s electronic Incident Management System. Investigation Team Leader Tasks: (Independent ²) - Draft and issue final incident bulletin⁷. - Draft and issue the major incident investigation report⁴. - Add final report details, agreed lessons learned and copy of approved Report into Company’s electronic Incident Management System. HSE GM / Process Safety Manager Tasks: - Invite Sponsor (& investigation team leader) to present investigation findings at senior management review meeting (prior to investigation close out). - Endorse major incident investigation report⁴. - Appoint an independent person to complete an investigation review within 30 days of investigation close out. Facility GM Tasks: - Endorse the major incident investigation report⁴. - Verify action closeout Legal Counsel Tasks: - Review major incident investigation report and final incident bulletin.
Tier 3 (LOC incident) Or Tier 3 (non-LOC incident) ¹⁰ Or Tier 4 (non-LOC incident) ¹¹		Minor	Incident Reporter’s Supervisor Tasks: - Notify the Location Manager of initial incident details as soon as practicable. Location Manager Tasks: - Endorse entry of the initial incident details into Company’s electronic Incident Management System within 24 hours of incident occurrence. - Coordinate the necessary external notifications to regulatory authorities (if deemed necessary). - Determine whether the type of investigation should be escalated to major based on the severity of the incident.	Sponsor Tasks: - Liaise with Facilities Engineering Team Lead for investigation team leader and investigation team members (based on incident details can be an engineer from frontline or strategic) ⁸. - If a HFA³ is required (where human behaviour / error is a causal factor) appoint a HFA facilitator on the investigation team. - If a Just Culture assessment⁵ or a Psychosocial Hazard Investigation⁶ is required, notify the HR Business Partner. - Decide if initial incident bulletin is required. If so, ensure it is issued within 72 hours of incident occurrence. Investigation Team Leader Tasks: (Engineer from relevant discipline) - Arrange incident review meeting (if required) to determine initial incident classification and scope of investigation within 72hrs of incident occurring. - Draft and issue initial incident bulletin (if requested by sponsor). - Coordinate and lead investigation team members. - Inform Sponsor HFA³ is required (where human behaviour / error is a causal factor). - Inform Sponsor if Just Culture assessment⁵ is required. - Inform Sponsor if Psychosocial Hazard Investigation⁶ is required. - Brief the investigation sponsor on investigation progress.	Sponsor Tasks: - Approve final incident bulletin (if required) and ensure it is issued within 14 days of incident occurrence. - Approve final incident classification, investigation details and close out within Company’s electronic Incident Management System within 14 days of incident occurrence. Investigation Team Leader Tasks: (Engineer from relevant discipline) - Conduct engineering assessment. Identify if further assessment is required (i.e. HAZOP / LOPA). - Draft and issue final incident bulletin (if requested by sponsor). - Add final investigation details into Company’s electronic Incident Management System. HSE Team Lead /Process Safety Team Lead Tasks: - Appoint person to support investigation team (if requested) ⁸ - Determine if incident investigation review is required (not mandatory for minor incidents). If so, appoint a person to complete an incident investigation review within 30 days of investigation close out.
Tier 4 (LOC incident)	Location Manager or Delegate	Report Only	An investigation is not required. Tier 4 LoC incidents (previously known as weeps and seeps) shall be recorded to ensure that each facility maintains a register of minor leaks for future correction and Green House Gas Reporting purposes. Only in an exceptional circumstance would these require further investigation.		

Footnotes 1. Major incident investigation terms of reference template (0000-AH-TPL-60037) shall be used (for major incidents only). 2. Independent means a neutral party who is not connected, affected or influenced by the incident and does not report to the management team responsible for the worksite where incident occurred. 3. Where a HFA is required, a HFA facilitator (appointed by the sponsor) shall use the Kiel Centre HFA Tool to document findings and actions. 4. Investigation findings, causes and associated actions shall be documented using Incident Investigation Report Template (0000-AH-TPL-60006). 5. Where a just culture assessment is required (based outcomes from the HFA), the just culture assessment template (0000-AN-TPL-60028) shall be used and the process shall be managed according to the Managing Actions and Behaviours Procedure (000-AN-PRC-60023).	6. Where a psychosocial hazard investigation is required, the psychosocial hazard investigation tool shall be used and findings shall be recorded within the HR Confidential Incidents Register in accordance with Psychosocial Hazard Management Procedure (0000-AH-PRC-70006). 7. Incident bulletin template (0000-AH-TPL-60030) shall be used. Incident Bulletins are mandatory for all Major investigations (optional for Minor Investigations). Where an Initial Incident Bulletin is issued, it is mandatory to also issue an Final Incident Bulletin. 8. The following are examples to assist with selecting the appropriate engineering discipline but is not an exhaustive list: LOC: engineer from relevant discipline e.g. team lead for a flange leak can be a mechanical, process or technical safety engineer. SIF demand / excursion from SOL: process engineer, process control engineer, technical safety engineer. SCE failure: engineer from relevant discipline e.g. team lead for a PSV failure can be a mechanical or process engineer. 9. Tier 2 LOC from utility systems may have a minor investigation, with endorsement from the Process Safety TA 1 and approval from Sponsor. 10. Tier 3 (non-LOC) Category D & E CUI involving primary containment envelope inspection or test results outside acceptable limits are report only & do not require investigation. 11. Tier 4 (Non-LOC) incidents may be entered as Report Only where the Location Manager considers that there are no human factor or system issues that require investigation or the issue is subject to a previous / existing investigation (with reference to the previous Incident number).
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Table 4 - Incident Management Matrix for PI 2 Sites

Classification		Internal and External Notifications		Investigation	
Risk Matrix Consequence Severity or Process Safety Tier	Investigation Level	Notify and Record		Plan and Investigate	Report & Review
Process Safety Tier 1 (LOC Incident) & Tier 2 (LOC Incident) or HSEQ incident Actual Impact – A or B	Major	Contractor Representative Tasks: - Notify the Company Representative of initial incident details as soon as practicable. Company Representative Tasks: - Endorse entry of the initial incident details into Company’s electronic Incident Management System within 24 hours of incident occurrence. - Confirm with Contractor Representative that the necessary external notifications to regulatory authorities have been completed. HSE GM Tasks: - Provide email notification to Corporate GM of HSE Unit (Tokyo) within 4 hours of the incident occurrence or as soon as practicable. Legal Counsel Tasks: - Review the incident details and determine whether legal professional privilege will be applied to the investigation.		Contractor Representative Tasks: - Appoint investigation team members, coordinate and lead investigation, - Develop investigation ToR and arrange investigation planning meeting. - Brief the Company Representative on investigation progress. Company Representative Tasks: - Participate in Contractor led investigation. - Review investigation ToR. - Confirm initial incident classification with Contractor Representative (within 72hrs of incident occurring). - Draft and issue initial incident bulletin¹ within 72 hrs of incident occurring.	Contractor Representative Tasks: - Manage development of major incident investigation report as per ToR (using Contractors RCA methodology, process and report template). - Submit major incident investigation report to Company Representative for review. Company Representative Tasks: - Develop and issue final incident bulletin¹ within 28 days of incident occurrence. - Endorse final incident classification and major incident investigation report. Close out investigation within Company’s electronic Incident Management System within 28 days of incident occurrence. HSE GM / Process Safety Manager/ Relevant HSEQ Manager Tasks: - Invite Company Representative (and Contractor Representative) to present investigation findings at senior management review meeting (prior to investigation close out). - Appoint an independent person to complete an investigation review within 30 days of investigation close out. Legal Counsel Tasks: - Review major incident investigation report and final incident bulletin.
HSEQ Incident or Near Miss Actual Impact – C or Potential Impact – A, B or C (HiPo)		Contractor Representative Tasks: - Notify the Company Representative of initial incident details as soon as practicable. Company Representative Tasks: - Endorse entry of the initial incident details into Company’s electronic Incident Management System within 24 hours of incident occurrence. - Confirm with Contractor Representative that the necessary external notifications to regulatory authorities have been completed. HSE GM Tasks: - Provide email notification to Corporate GM of HSE Unit (Tokyo) within 4 hours of the incident occurrence or as soon as practicable. Legal Counsel Tasks: - Review the incident details and determine whether legal professional privilege will be applied to the investigation.			
HSEQ incident Actual Impact – D					
Process Safety Tier 3 (LOC incident) Tier 3 (non-LOC incident) or HSEQ Incident or Near Miss Actual Impact – E Potential Impact – D ³	Minor (may be upgraded to Major or downgraded to Report Only – decision is determined by Company Representative, Process Safety Manager or HSE Manager)	Contractor Representative Tasks: - Notify the Company Representative of initial incident details as soon as practicable. Company Representative Tasks: - Endorse entry of the initial incident details into Company’s electronic Incident Management System within 24 hours of incident occurrence. - Confirm with Contractor Representative whether external notification to regulatory authorities has been completed (where deemed necessary). ³		Contractor Representative Tasks: - Appoint investigation team members, coordinate and lead investigation. - Confirm scope of investigation. - Brief the Company Representative on investigation progress. Company Representative Tasks: - Participate in Contractor led investigation. - Confirm incident classification with Contractor Representative within 72hrs of incident occurring. - Decide if initial incident bulletin¹ is required. If so, ensure it is issued within 72 hours of incident occurrence.	Contractor Representative Tasks: - Manage development incident investigation findings and actions and submit copy to sponsor for review. Company Representative Tasks: - Endorse entry of final investigation details into Company’s electronic Incident Management System within 14 days of incident occurrence, - Draft and issue final incident bulletin¹ (where deemed required) within 14 days of incident occurrence, and - Determine if incident investigation review is required (not mandatory for minor incidents). Relevant HSEQ Manager /Process Safety Manager Tasks: - Assist investigation sponsor to select a person to complete the investigation review (if review is required).
HSEQ Incident or Near Miss Actual Impact – F Potential Impact – E or F	Report Only (investigation may not be required ³)	Contractor Representative Tasks: - Notify the Company Representative of initial incident details as soon as practicable. Company Representative Tasks: - Endorse entry of the initial incident details into Company’s electronic Incident Management System within 24 hours of incident occurrence.			
Footnotes					
1- Incident bulletin template (0000-AH-TPL-60030) shall be used. Incident Bulletins are mandatory for all Major Incidents (optional for Minor Incidents). Where an Initial Incident Bulletin is issued, it is mandatory to also issue a Final Incident Bulletin. 2- Process Safety Tier 4 LOC and non-LOC incidents are not reportable for PI 2 sites. 3- Refer to Incident Reporting and Classification Guideline (0000-AH-GLN-60060) for further guidance.					

Table 5 - Incident Investigation Team Selection and Roles

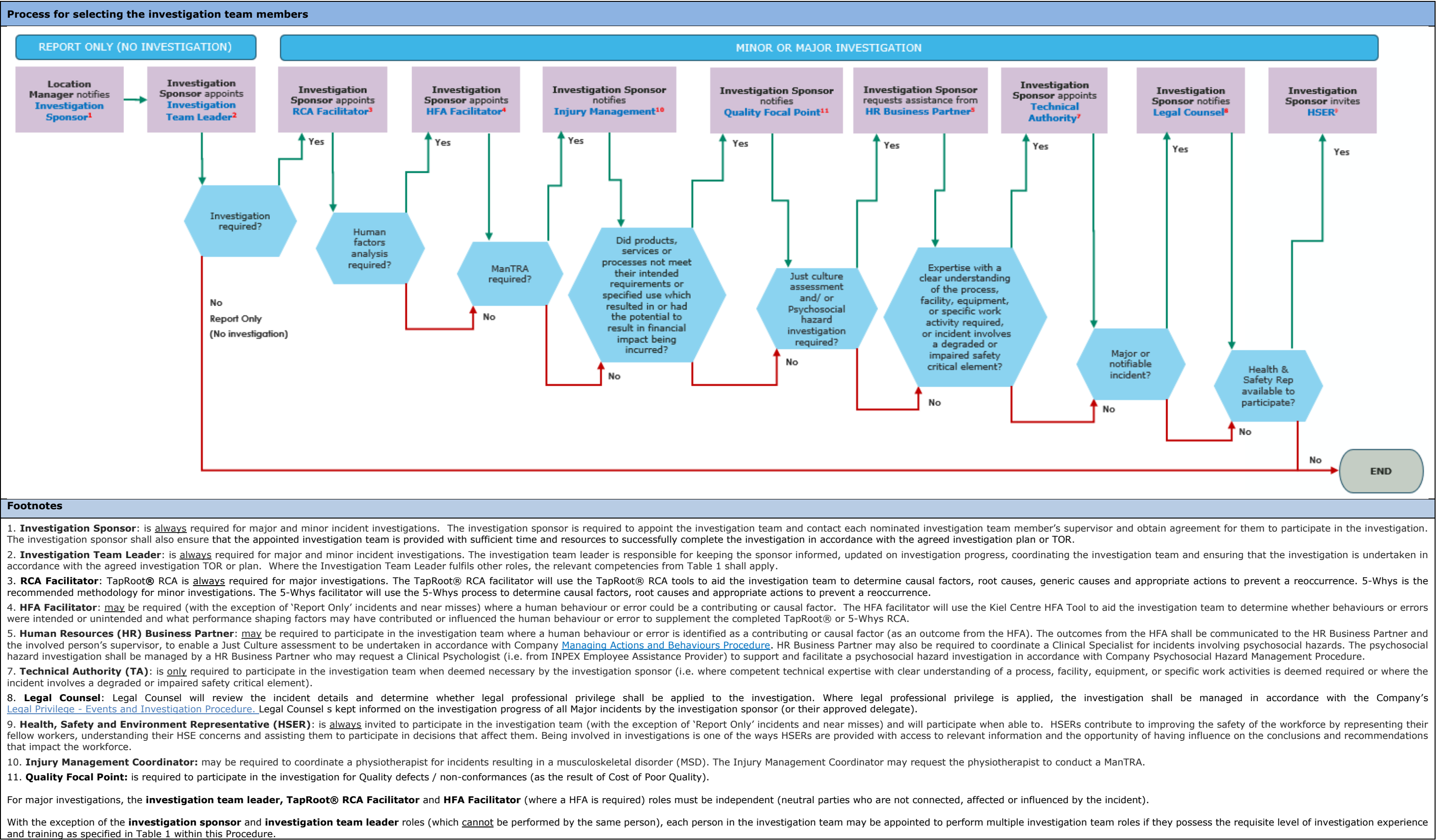


Table 6 - Investigation Level Requirements Guidance Table

Level of investigation	TOR	Bulletin	Team Size	Timeframe	Amount of data / fact gathering	Event Timeline	Identify Causal Factors	RCA Methodology	Human Factors Analysis Tool	Cority Records	Actions	Report Template	Lessons Learned	Total Time
Major	Yes	Yes (initial & final)	Larger (4+)	28 days (additional time can be agreed with Sponsor approval)	A large volume of records will be gathered and filed, typically >5 documents.	Yes – detailed snapchart detailing sequence of events, causal factors and historical events relevant to the incident	Yes	TapRoot®	Yes (if behaviour or error contributed or caused the incident)	Typically >5 records including all relevant information, may include historical data	Yes (must address all identified causal factors and root causes)	Yes (PPT/Word format)	Yes (recorded in Report and in Cority)	As appropriate - Dependent on complexity
Minor	No	Optional (as requested by Sponsor)	Smaller (1 to 3)	14 days (additional time can be agreed with Sponsor approval)	Just key documents, typically <5	Yes – simplified table (or snapchart) detailing sequence of key events	Yes	5-Whys or TapRoot®	Yes (if behaviour or error contributed or caused the incident)	Typically 1-5 records	Yes (must address all identified causal factors and root causes)	No	Optional (as requested by sponsor)	Typically 1 week
No Investigation (Report Only)	No	No	Smaller (minimum of a sponsor, investigation lead)	14 days (additional time can be agreed with Sponsor approval)	Less (just record basic facts to substantiate incident type and classification)	No	No	No	No	Less (just record basic facts)	No	No	No	Less than 1 hour per person involved

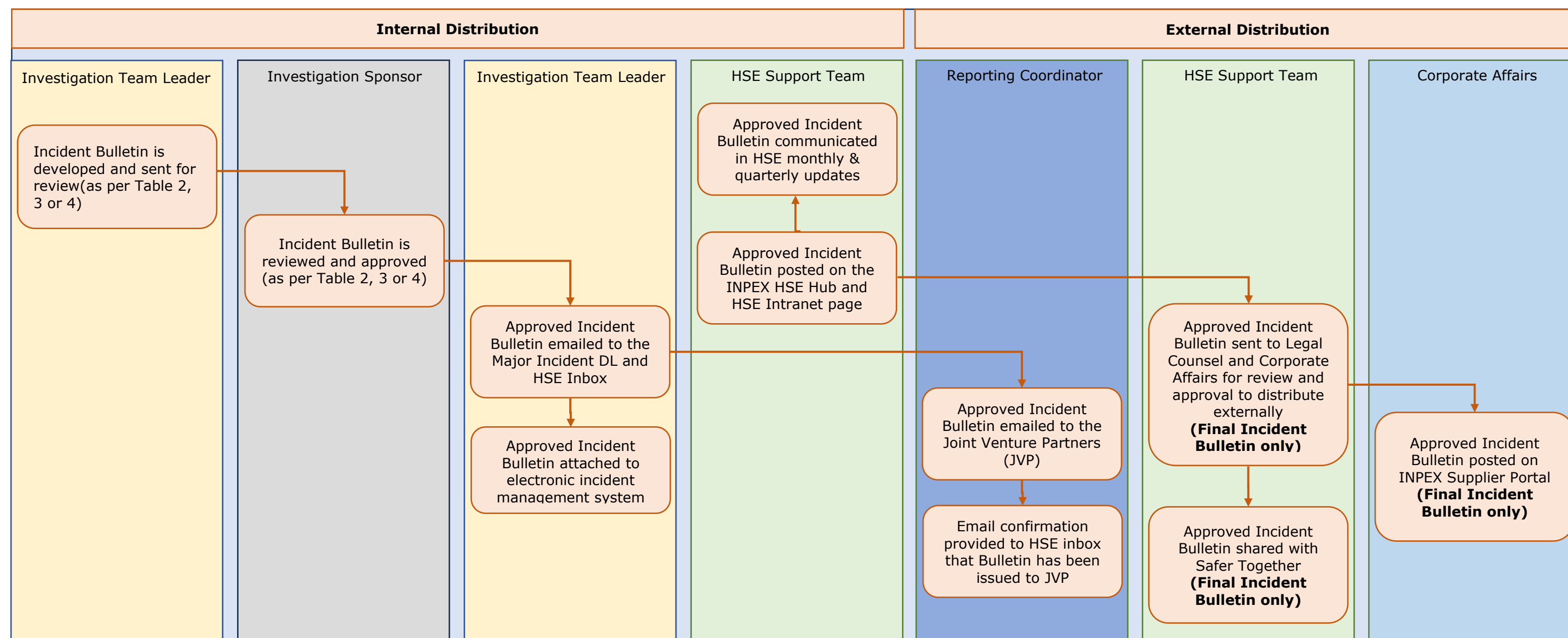
Table 7 - Offshore External Notification of Incidents Table

Health and Safety	Stakeholder	Initial Notification	Follow Up Notification/s
Accidents - Death or serious injury - Lost Time injury >=3 days Dangerous Occurrence - Hydrocarbon release >1kg or >=80L (gas or liquid) - Fire or explosion - Collision marine vessel and facility - Could have cause death, serious injury or LTI - Damage to safety critical equipment - Unplanned incident-implement ERP - Pipeline incident - Well kick>50 barrels	NOPSEMA	Notification by: OIM Method: Verbal Timing: As soon as practicable Contact: 1300 674 472	Notification by: OIM Method: NOPSEMA Form FM0831 Timing: Part 1: Within 3 days of incident Part 2: Within 30 days of incident* Contact: submissions@nopsema.gov.au
Fatality	Police (WA or NT)	Notification by: OIM or IMT Method: Verbal Timing: ASAP Contact: 131444	N/A
Bullying and Harassment Incident Including sexual harassment	NOPSEMA	Notification by: Health Team Method: NOPSEMA Form FM2299 Timing: Part 1: As soon as practicable Contact: psychosocial@nopsema.gov.au	Notification by: Health Team Method: NOPSEMA Form FM2299 Timing: Part 2: Within 30 days of incident* Contact: psychosocial@nopsema.gov.au
Marine Incident (involving a vessel) - Death of, or serious injury - Loss or presumed loss of a vessel - Loss of person from vessel - Significant damage to vessel	Australian Maritime Safety Authority (AMSA)	Notification by: Vessel Master Method: AMSA Form 18 Timing: within 4 hours Contact: reports@amsa.gov.au	Notification by: Vessel Master Method: AMSA Form 19 Timing: within 72 hours Contact: reports@amsa.gov.au
Environment/Spill Major Environmental Incident Defined as severity of actual/potential D or above in INPEX Risk Matrix (moderate or greater). Examples: - Fuel oil spill from vessel collision - A release of condensate resulting from a loss of containment of a production well	NOPSEMA	Notification by: IMT Method: Verbal & Email A email record must be submitted following verbal notification. Timing: within 2 hours of incident Contact: 1300 674 472 submissions@nopsema.gov.au	Notification by: Environment Team Method: NOPSEMA Form FM0831 Timing: Within 3 days of incident Contact: submissions@nopsema.gov.au
	NOPTA	Notification by: IMT Method: Email record (as above) Timing: Following verbal notification to NOPSEMA Contact: resources@nopta.gov.au	Notification by: Environment Team Method: NOPSEMA Form FM0831 Timing: Within 7 days of providing FM0831 to NOPSEMA Contact: resources@nopta.gov.au
	Applicable Department of State/Territory	Notification by: IMT Method: Email record (as above) Timing: Following verbal notification to NOPSEMA Contact: TBD	Notification by: Environment Team Method: NOPSEMA Form FM0831 Timing: Within 7 days of providing written report to NOPSEMA Contact: TBD
Vessel Spill An oil spill from a facility or vessel (of any volume)	Australian Maritime Safety Authority (AMSA)	Notification by: OIM/Vessel Master Method: Verbal Timing: ASAP Contact: 1800 641 792	Notification by: OIM/Vessel Master Method: AMSA Form 197 (POLREP) Timing: Within 2 hours Contact: rccaus@amsa.gov.au
A spill within WA state waters or potential to migrate into WA waters	WA Department of Transport	Notification by: IMT Method: Verbal Timing: ASAP Contact: +61 8 9480 9924	Notification by: IMT Method: POLREP Form Timing: Within 24 hours-Level 1 incident Within 2 hours-Level 2/3 incident Contact: marinepollution@transport.wa.gov.au
A spill within NT state waters Or potential to migrate into NT waters	NT Environment Protection Authority (NTEPA)	Notification by: IMT Method: Verbal Timing: within 24 hours Contact: 1800 064 567	N/A
Significant impacts to matters of national environmental significance, or habitat of listed species	Department of Climate Change, Energy and Water Compliance & Enforcement Branch	Notification by: Environment Team Method: Verbal/Written Timing: ASAP Contact: 1800 110 395 compliance@environment.gov.au	N/A
	Parks Australia	Notification by: Environment Team Method: Verbal Timing: ASAP Contact: 0419 293 465	N/A
Security			
Unauthorised Vessels	Australian Border Force	Notification by: S&EM Team Method: Verbal Timing: ASAP Contact: 1800 061 800	N/A
Security Zones and MSIC Maritime security incident under part 9 of the MTOFSA	Department of Home Affairs	Notification by: S&EM Team Method: Verbal Timing: ASAP Contact: 1300 791 581	N/A

* Endorsement & Approval required by the HSE GM, a Legal Representative and the Offshore Operations GM

Table 8 - Onshore External Notification of Incidents Table

Health and Safety	Stakeholder	Initial Notification	Follow Up Notification/s
Death of a person A serious injury or illness A dangerous incident NT Refer to NT Worksafe for more details	Worksafe NT	Notification by: Production Manager Method: Verbal Timing: ASAP Contact: 1800 019 115	Notification by: Production Manager Method: NT Worksafe Incident Notification Form Timing: Within 48 hrs Contact: ntworksafe@nt.gov.au
Death of a person A serious injury or illness A dangerous incident WA Refer to Worksafe WA for more details	Worksafe WA	Notification by: Senior Company Rep/IMT Method: Verbal/Online Report Online for non life threatening incidents Timing: ASAP Contact: 1800 678 198 https://www.worksafe.wa.gov.au/report-incident	N/A
Fatality	Police (WA or NT)	Notification by: Senior Company Rep/IMT Method: Verbal Timing: ASAP Contact: 000	N/A
Marine Incident (involving a vessel) Death of, or serious injury Loss or presumed loss of a vessel Loss of person from vessel Significant damage to vessel	Australian Maritime Safety Authority (AMSA)	Notification by: Vessel Master Method: AMSA Form 18 Timing: within 4 hours Contact: reports@amsa.gov.au	Notification by: Vessel Master Method: AMSA Form 19 Timing: within 72 hours Contact: reports@amsa.gov.au
Environment/Spill			
Oil spill Incident Hydrocarbon Loss of Containment (LOC) from the GEP entering NT waters Hydrocarbon LOC from ILNG facility entering NT waters	NT Police Controlling Authority	Notification by: ERT or Vessel Master Method: Verbal Timing: ASAP Contact: 000	N/A
	Darwin Port	Notification by: DINT Method: Verbal Timing: ASAP Contact: +61 8 8919 0821	N/A
	NT Environment Protection Authority (NTEPA)	Notification by: DINT Method: Verbal & Email An email record must be submitted following verbal notification Timing: As soon as practicable Contact: 1800 064 567	N/A
	Department of Climate Change, Energy and Water	Notification by: DINT Method: Verbal/Email Timing: As soon as practicable Contact: 1800 110 395 environment.compliance@dcceew.gov.au	N/A
Oil Spill Incident Hydrocarbon LOC from export tanker secured to a ILNG Product Loading Jetty entering NT waters	Darwin Port	Notification by: DINT Method: Verbal Timing: ASAP Contact: +61 8 8919 0821	N/A
	NT Environment Protection Authority (NTEPA)	Notification by: DINT Method: Verbal & Email An email record must be submitted following verbal notification Timing: As soon as practicable Contact: 1800 064 567	N/A
	Department of Climate Change, Energy and Water	Notification by: DINT Method: Verbal Timing: As soon as practicable Contact: 1800 110 395	N/A
Environmental Incident An incident that caused or has the potential to cause material or serious environmental harm	NT Environment Protection Authority (NTEPA)	Notification by: Environment Team Method: Verbal/Online Pollution Report Timing: within 24 hours Contact: 1800 064 567 https://ntepa.nt.gov.au/make-a-report	N/A
Non Compliance Any Environmental approval conditions non compliance	NT Environment Protection Authority (NTEPA)	Notification by: Environment Team Method: Written Timing: within 24 hours Contact: environmentregulation@nt.gov.au	
Significant impacts to matters of national environmental significance, or habitat of listed species	Department of Climate Change, Energy and Water Compliance & Enforcement Branch	Notification by: Environment Team Method: Verbal/Written Timing: Within 24 hours or as specified within approved plans Contact: 1800 110 395 compliance@environment.gov.au	N/A
Security			
Unauthorised Vessels Water side restricted zone	Darwin Port	Notification by: S&EM Team Method: Verbal Timing: ASAP Contact: 1300 327 946	N/A
Security Zones and MSIC Maritime security incident under part 9 of the MTOFSA	Department of Home Affairs	Notification by: S&EM Team Method: Email Notification Timing: Within 24 hours Contact: nationalcoordinator@homeaffairs.gov.au	N/A

Figure 1 - Incident Bulletin Flow Chart

2 Abbreviations and Definitions

Abbreviation/Term	Definition
Action	Actions to rectify a situation which includes the prevention of a recurrence or action to correct an existing defect.
(The) Company	INPEX Australia (the subsidiaries of INPEX Corporation that are either Australian registered companies or registered foreign companies having an Australian branch) that employs or engages any workers, as applicable.
Consequence	The severity of an incident to people, environment or assets as determined by the Company Risk Matrix.
Contractor Holder	The person assigned by Company as having the responsibility to oversee the Contracting Activities.
Causal Factor (CF)	A mistake, error, or failure that directly leads to (or causes) an incident, or fails to mitigate the consequences of the original error.
Cost of Poor Quality (CoPQ)	Refers to the financial impact incurred when products, services or processes do not meet their intended requirements or specified use. It includes all expenses related to identifying, managing and correcting quality issues both before and after a product or service reaches its end user, representing the cost of failing to do work as planned.
External Stakeholder	Any organisation, government agency, group or person that has an interest in, or maybe affected by, a project or by the activities or decisions of the Company. Stakeholders including but not limited to Government Agencies, Lenders, Joint Venture Partners or Affected Communities that require notification of specific events.
Facility GM	The Facility GM for PI1 sites includes Offshore Operations General Manager and Onshore Operations General Manager. The role of Facility GM can be fulfilled by non-INPEX workers at PI2 sites.
Functional Manager	Manager of the business area responsible for the finding or action.
Generic Cause	The systemic problem that allows a root cause to exist.
GM	General Manager
Hazard	Any physical or psychosocial situation with the potential to cause harm to people, damage to property, damage to the environment or damage to Company reputation.

Abbreviation/Term	Definition
Hazardous Manual Tasks (HMT)	Hazardous Manual Tasks are manual tasks which increase the risk of sustaining a musculoskeletal disorder (MSD) and are characterised by certain risk factors.
High Potential (HiPo)	A HSE incident or near miss with a potential severity assessed at A, B or C in the Company Risk Matrix that either failed lucky (barrier failed to work as intended) or failed safe (barrier worked as intended).
HSE	Health, Safety and Environment
HSEQ	Health, Safety, Environment and Quality
Independent Investigation	Process where neutral parties (persons who are not connected, affected or influenced by the incident) are selected to conduct an investigation.
Occupational Injury	Any injury such as a cut, fracture, sprain, amputation, etc., or any fatality, 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.
Occupational Illness	Any abnormal condition or disorder, or any fatality 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. Generally resulting from prolonged or repeated exposure.
Lesson(s) Learned	An observation that can lead to improved capability/ increased performance and can be achieved through implementation of an action.
Location Manager	Person who is a head of a business unit, in charge of a team within a business unit, a package leader, a delegated authority in charge of a business unit or package, contract engineers, legal counsel members. The role of location manager can be fulfilled by non-INPEX workers at PI2 sites. Examples of Location Manager for PI1 sites include Offshore Installation Manager and Onshore Production Manager.
Major Incident	Incidents with an actual severity level of A, B, C or D and a potential consequence level of A, B or C on the Company Risk Matrix or Tier 1 or 2 Loss of Containment incidents.

Abbreviation/Term	Definition
Manual Task Risk Assessment (ManTRA)	A tool that is used for incidents that result in a musculoskeletal disorder (e.g. body stressing injuries) and complements the investigation methodology used by assisting in the identification of causes, risk factors and appropriate corrective actions to prevent a recurrence.
Prevailing Influence (PI)	The level of control the Company has over the activity under consideration. Such "control" could be due to: • Existing contractual obligations • The activity occurring on a Company lease, facility, office, operational location • The Company exerting significant influence over the activity itself Prevailing Influence is categorised in 3 levels, with Level 1 indicating direct Company control over the activity, through to Level 3 indicating the Company only monitors compliance.
Quality Defect / Non-Conformance	Any actual or potential failure to fulfil specified requirements, contractual obligations, codes, standards, approved specifications, procedures, or intended use of a product, process, or service, resulting in a deviation that may affect safety, performance, reliability, regulatory compliance, asset integrity, or business outcomes.
Root Cause	The absence of a best practice or the failure to apply knowledge that would have prevented the problem or significantly reduced its likelihood or consequences.
Responsible Manager	The manager immediately responsible for the people, area, site, facility or department where an incident occurred.
Site	Any location (project, office, yard, platform, facility, vessel) where the Company has HSE PI Level 1 or 2 as defined in the Company HSE Prevailing Influence procedure.
SMARTER	Specific, Measurable, Agreed, Realistic, Time-based, Effective and Reviewed.
TA	Technical Authority
VP	Vice President

3 Reference and Compliance Documents

The documents listed below are relevant to the execution of this Procedure:

Reference document (R) are documents referred to while completing this Procedure.

Compliance documents (C) include all standards, regulatory governance, contracts, business rules or policies applicable to this Procedure.

Document Name	R	C	Document Number
Policies			
Health, Safety, Security, Environment and Quality Policy		C	0000-AH-POL-70000
Standards			
Sensitive Information Protection Standard		C	0000-A9-STD-60008
Equal Opportunity, Bullying, Discrimination and Harassment Standard	R		000-AN-STD-60010
Records Management and Disposition Standard		C	0000-A9-STD-60015
HSE Legal and Other Requirements Standard		C	0000-AH-STD-60006
HSE Objectives, Targets, Reporting and Performance Evaluation Standard		C	0000-AH-STD-60015
Prevailing Influence Standard		C	0000-AH-STD-60017
Incident Reporting and Investigation Standard		C	0000-AH-STD-60050
Emergency and Crisis Management Standard		C	0000-AH-STD-60051
Procedures			
Action Management Procedure	R		0000-A0-PRC-70007
Legal Privilege - Events and Investigation Procedure	R		0000-A0-PRC-60046
Management of Hazardous Manual Tasks Procedure	R		0000-AH-PRC-70007
Managing Actions and Behaviours Procedure	R		0000-AN-PRC-60023

Document Name	R	C	Document Number
Psychosocial Hazard Management Procedure	R		0000-AH-PRC-70006
Quality Investigation and Non-conformance Management Procedure	R		0000-AQ-PRC-60006
Other Documents			
CPF Emergency Response Plan	R		B060-AH-PLN-60001
FPSO Emergency Response Plan	R		S060-AH-PLN-60001
ILNG Emergency Response Plan	R		L060-AH-PLN-60002
Incident Bulletin	R		0000-AH-TPL-60030
Incident Investigation Report Template	R		0000-AH-TPL-60006
Incident Reporting and Classification Guideline	R		0000-AH-GLN-60060
INPEX Australia Management of Fatalities Plan	R		0000-AH-PLN-60002
INPEX Risk Matrix	R		0000-A0-TPL-60003
Just Culture Assessment Template	R		0000-AN-TPL-60028
Kiel Centre Human Factors Analysis Tool	R		Version 3.21
Major Incident Investigation - Terms of Reference	R		0000-AH-TPL-60037
Operations Prioritisation Matrix	R		X060-A0-DAT-60001
Process Safety Incident Investigation Form	R		0000-AH-FRM-70075

4 Record of Amendment

Revision	Section	Amendment
14	Table 7 - Offshore External Notification of Incidents Table	Security: Australian Border Force and Department of Home Affairs contact numbers updated
	1.6 All Investigations	Inclusion of incident scene preservation requirements
	1.6 Hazardous Manual Task Risk Assessment	Inclusion of guidance for hazardous manual tasks and ManTRA tool.
	1.8 Actions to prevent incident reoccurrence	Further guidance to SMARTER actions, specifically; "Review" phase for verification and major investigation corrective action effectiveness reviews.
	Various	Inclusion of guidance and roles/ responsibilities for quality defects / non-conformances
13	1.2 Reporting and classification of incidents and near misses	Inclusion of bullying and harassment incidents under psychological injuries and illnesses. Added requirement to report incidents and near misses which undermine, or have the potential to undermine asset integrity safety due to non-conformance with technical specifications, scope requirements, or applicable standards.
	1.3 Legal review of major incidents	Removed 'notifiable' from verbiage and included definition of major incident in Section 2.
	1.6 Investigation processes to identify causes	Inclusion of the 5-Whys as an alternative RCA methodology for minor investigations. Inclusion of optional Process Safety Incident Investigation Form for simple Tier 3 Non-LOC incidents. Further clarification added for requirements, process, and timing of Human Factor Analysis application.
	1.7 Recording the investigation findings	Added requirement for 'Facility GM' to endorse major investigation report.
	1.8 Actions to prevent incident reoccurrence	Clarification for 'Specific' and 'Measurable' corrective action requirements. Added requirement for 'Facility GM' to verify action close out for major investigations.

Revision	Section	Amendment
	1.9 Review of incident investigations	Added requirement for the Quality Manager to be notified and invited to participate in the planned investigation reviews wherever a vendor or specification non-conformance is involved.
	Table 1 – Incident Reporting and Investigation Competency Matrix	Inclusion of a 5-Whys training competency for Minor investigations.
	Table 2 - Occupational Health, Safety and Environment Incident Management Matrix for PI 1 Sites	Added 'Investigation Sponsor - Verbal notification to Security GM of HSE Unit (Tokyo) within 4 hours of any security incident or as soon as practicable.' for Major Actual Impact – A or B investigation levels. Added 'Regulator' as an additional decision maker for 'Report Only (no investigation required)' investigation levels. Added 'Facility GM' responsibilities as a requirement of Major Investigations.
	Table 3 - Process Safety Incident Reporting and Investigation Matrix for PI 1 Sites	Reformatted table to align with table 2. Changed Investigation Sponsor for Minor Investigations from 'Facility Engineering Team Lead' to 'Location Manager or Delegate' Added cross-reference to Incident Reporting and Classification Guideline (0000-AH-GLN-60060) regarding reporting exemptions and inclusions for Tier 2 Loss of Containment from utility system, Tier 3 non-Loss of Containment incidents regarding a failure of a Safety Critical Element and Tier 3 non-LOC involving primary containment envelope inspection or test results outside acceptable limits related to corrosion under insulation.
	Table 5 - Incident Investigation Team Selection and Roles	Taproot® RCA Facilitator role amended to RCA Facilitator to reflect inclusion of 5-whys as an accepted methodology.
	Table 6 - Investigation Level Requirements/ Guidance Table	Table amended to reflect inclusion of 5-Whys as an accepted RCA methodology for Minor Investigations.
	Table 7 - Offshore External Notification of Incidents Table	Changed title of Flow Chart B to Table 7 to align with INPEX Procedure template requirements. Updated Table to reflect changes to agencies, contact details and notification processes.

Revision	Section	Amendment
	Table 8 - Onshore External Notification of Incidents Table	Changed title of Flow Chart C to Table 8 to align with INPEX Procedure template requirements. Updated Table to reflect changes to agencies, contact details and notification processes.
	Figure 1-Incident Bulletin Flow Chart	Changed title of Flow Chart A to Figure 1 to align with INPEX Procedure template requirements.
	Flow Chart D	Removal of Flow Chart D- Guidance for Process Safety Incident Minor Investigations (Engineering Led)
	2 Abbreviations and Definitions	Inclusion of Lesson(s) Learned and Major Incident definitions
	3 Reference and Compliance Documents	Addition of Process Safety Incident Investigation Form reference

Document Endorsement and Approvals

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Delegation of Authority

From Name	To Name	Date and Time	Action

Name	Title

Electronic Endorsement and Approval

Electronic approval of this document complies with the issued INPEX Electronic Approval Standard (0000-A9-STD-60011) and records evidence that the applicable person has either endorsed and/or approved the content contained within this document. The reviewers of this document are recorded in the CDS.

Name	Title	Date and Time	Action
Nigel Ross	HSE Support Manager	01/05/26 12:41	Approver