

Doc No.	MINT-OHS-SOP-002
Version No.	01

OCCUPATIONAL HEALTH AND SAFETY (OHS) INCIDENTS INVESTIGATION STANDARD OPERATING PROCEDURE

1. PURPOSE

This standard operating procedure (SOP) provides guidance on systemic approach for investigating occupational health safety (OHS) incidents that occurred, to ensure that all OHS incidents are investigated under the same standards across Minor’s businesses, finding root causes of the incident, and developing recommendations for corrective and preventive actions to prevent recurrences.

The use of this SOP is not intended to replace or supersede local legal reporting requirements.

2. SCOPE

2.1. This SOP is applicable to all business units under both Minor’s operational control including employees and contractors under Minor supervision.

3. RESPONSIBILITY

- 3.1. Incident-related employees and contractors are responsible for providing information related to the incident and participating in the investigation if necessary.
- 3.2. Designated person or function of operating unit where the incident occurred are responsible for
 - 3.2.1. Conducting the investigation of the incident in any levels of level I-IV in accordance with section 4.4 of this SOP and in corporation with occupational health and safety (OHS) personnel or experts, and formal joint management-worker health and safety committee (if applicable) and reporting the result of the investigation to Business Unit.
 - 3.2.2. Setting and executing corrective and preventive actions with target dates and responsible person(s) developed as part of the incident investigation in corporation with relevant functions.
- 3.3. Formal joint management-worker health and safety committee (if applicable) is responsible for reviewing the investigation results and providing recommendations of mitigations for prevention and reduction of OHS incidents.
- 3.4. Each Business Unit is responsible for supporting and ensuring all incident is investigated effectively and in a timely manner, and the completion of corrective and preventive actions to prevent recurrence and effective OHS programs implementation.
- 3.5. The People and Culture member or assigned people of each Business Unit is responsible for submitting incident investigation results reports to the Minor Corporate People & Culture team in accordance with MINT-OHS-SOP-003 OHS Information Reporting Standard Operating Procedure.

4. PROCEDURE

4.1. Legal Involvement

For an incident caused Level I (fatality) and high-consequence injury, the focal Legal department or personnel must be contacted immediately after the awareness of occurrence and before initiating the investigation.

4.2. Identify Incidents

An OHS incident that meets the criteria in section 4.1 of MINT-OHS-SOP-001 OHS Incidents Recording and Reporting Standard Operating Procedure must be investigated.

4.3. Timely Investigation

An investigation should be conducted promptly after the incident occurred or is notified, not later than 7 days after awareness of the occurrence because the scene could be disturbed or changed, and the affected and witnessed people might forget what happened.

The incident investigation workflow is provided in appendix I OHS Incidents Investigation Workflow.

4.4. Elements of the Investigation

4.4.1. Preparation

4.4.1.1. Identify Related People and Document Needed

- (a) The related people can be, but not limited to:
- the person(s) who was part of or witnessed the incident,
 - the person(s) who has knowledge of operations relating to the incident.
- (b) The documents needed to be collected can be, but not limited to:
- existing risk identification, risk assessment, and risk management,
 - relevant work instruction or procedure of the process or operation,
 - relevant layout of the process or operation,
 - routine inspection records,
 - machine or equipment preventive maintenance plans and records,
 - training records of the affected person(s),
 - workplace environment measurement result.

4.4.1.2. Form an Investigation Team

The investigation team should consist of at least:

- supervisor or manager of the operating unit where the incident occurred,
- People & Culture member or assigned people of each Business Unit,
- OHS personnel or experts (e.g., safety officer, safety professional)
- formal joint management-worker health and safety committee (if applicable),
- the person(s) who witnessed the incident and/or have knowledge of operations relating to the incident might be requested to participate in the investigation.

If a contractor was injured or ill, contractor's employer or his or her representative should engage on the investigation team.

4.4.2. On-site Investigation

4.4.2.1. Collect the Facts at the Scene

Generally, it requires multi approaches to collect incident-related information as much as possible. Refer to practices guided by the U.S. Occupational Safety and Health Administration (OSHA) in appendix II MINT-OHS-FORM-001 Collecting the Facts at the Scene of Incident Form.

4.4.2.2. Adopt Root-Cause Analysis Tree

There is commonly more than one factor that caused an incident, directly or indirectly. Based upon the information collected in section 4.4.2.1, the root cause(s) of the incident can be determined by using root-cause analysis tree. It is a recommended systemic tool adopting to finding root causes taken into account of comprehensive casual factors: man, machine/material, method, and environment per guideline in appendix III MINT-OHS-FORM-002 Incident Root Cause Analysis Tree Form.

4.4.3. Develop the Investigation Result Report and Recommendations for Corrective and Preventive Actions

An investigation report should be created by operating unit supervisor and/or manager where the incident occurred and reviewed by formal joint management-worker health and safety committee (if applicable) including recommendations for corrective and preventive actions to prevent recurrence with assigned responsibilities and target dates of completion on the recommendations.

The recommendations for corrective and preventive actions should consider in accordance with the preferred order of the hierarchy of controls as guided in appendix IV The Hierarchy of Controls, and should address:

- Investigated root-cause of the specific incident
- Issues related to similar situations, conditions, equipment
- Management system deficiencies
- Effective controls and prevention actions
- Evaluation of controls and prevention Actions
- Follow-up

The result of the investigation should be recorded in appendix V MINT-OHS-FORM-003 OHS Incidents Investigation Result Reporting Form

4.5. Record the Incident in One-page Summary for Lesson Learned

All recordable work-related injury and illness that falls into Level I – IV or an incident that the Business Unit considers a significant event, should be also recorded in one-page summary of incident as templated in appendix VI MINT-OHS-FORM-004 One-page Incident Summary for Lesson Learned Form for further lesson learned sharing within the Business Unit and Minor Corporate People & Culture team.

4.6. Communicate the Incident Investigation Results Report

4.6.1. Communicate the Report to Related Functions, and Employees and Contractors within the Business Unit

The summary of the incident investigation should be communicated by several methods such as posting it in the work area, bulletin, informing in routine safety meetings in order to raise safety and health awareness among employees and contractors.

4.6.2. Communicate the Report to Minor Corporate People & Culture Team

The incident investigation information and results can be communicated by submitting to Minor Corporate People & Culture team in accordance with MINT-OHS-SOP-003 OHS Information Reporting Standard Operating Procedure.

4.7. Provide Periodic Follow up to the Recommendations for Corrective and Preventive Actions

The Business Unit Operations team and formal joint management-worker health and safety committee (if applicable) is responsible for periodically following-up to assure actions on the recommendations are completed as planned.

5. DEFINITION

Employee: individual who is in an employment relationship with Minor according to national law or practice. This includes full-time and part-time permanent employees.

Full-time permanent employee: employee whose working hours per week, month, or year are defined according to national law or practice regarding working time including contract or fixed-term employee who is employed for a specified period of time and task, and at the end of the period, contract is considered to be expired.

Part-time permanent employee: employee whose working hours per week, month, or year are less than the number of working hours for full-time employees.

Contractor: person who is not employee but whose work and/or workplace is controlled and supervised by Minor.

Formal joint management–worker health and safety committee: committee composed of management and worker representatives, whose function is integrated into an organizational structure, and which operates according to agreed written policies, procedures, and rules, and helps facilitate worker participation and consultation on matters of occupational health and safety.

6. REFERENCE

- 6.1. Global Reporting Initiative (GRI), GRI 403: Occupational Health and Safety 2018
- 6.2. U.S. Occupational Safety and Health Administration (OSHA), A Step-by-Step Guide: Incident Investigations, https://www.osha.gov/sites/default/files/2018-12/fy11_sh-22246-11_IncidentInvestigationGuide.pdf, accessed on 5 July 2023
- 6.3. U.S. Occupational Safety and Health Administration (OSHA), Fact Sheet: The Important of Root Cause Analysis During Incident Investigation, <https://www.osha.gov/sites/default/files/publications/OSHA3895.pdf>, accessed on 5 July 2023
- 6.4. U.S. National Institute for Occupational Safety and Health (NIOSH), The Hierarchy of Controls, <https://www.cdc.gov/niosh/topics/hierarchy/default.html>, accessed on 5 July 2023

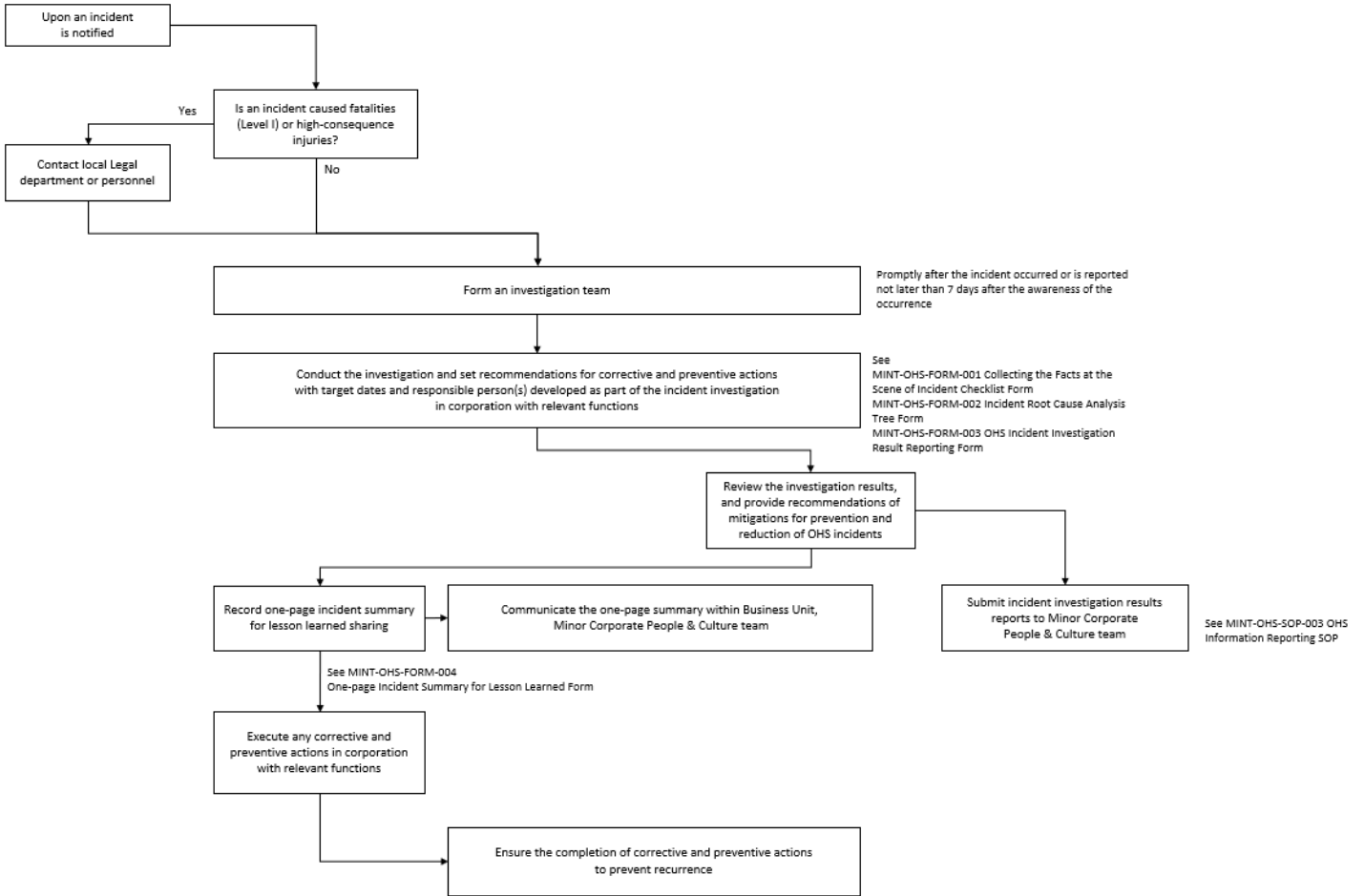
APPENDIX I: OHS INCIDENTS INVESTIGATION WORKFLOW

Designated person or function of operating unit where the incident occurred

Designated person or function of operating unit where the incident occurred, OHS personnel or experts

Formal joint management-worker health and safety committee (if applicable)

The People & Culture member or assigned people of each Business Unit



Appendix II: MINT-OHS-FORM-001 Collecting the Facts at the Scene of Incident Checklist Form

Reference: A Step-by-Step Guide: Incident Investigations, U.S. Occupational Safety and Health Administration (OSHA)

Access to the checklist form [here](#).

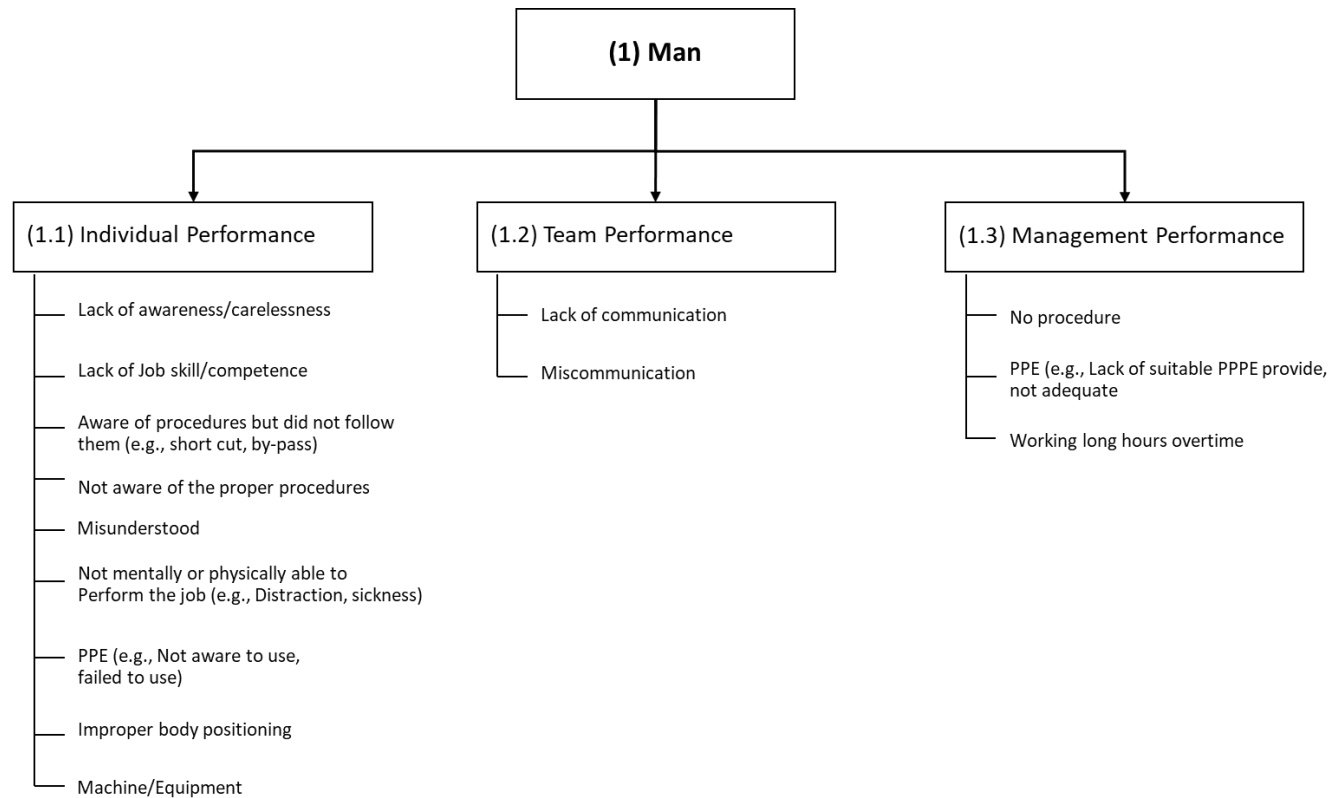
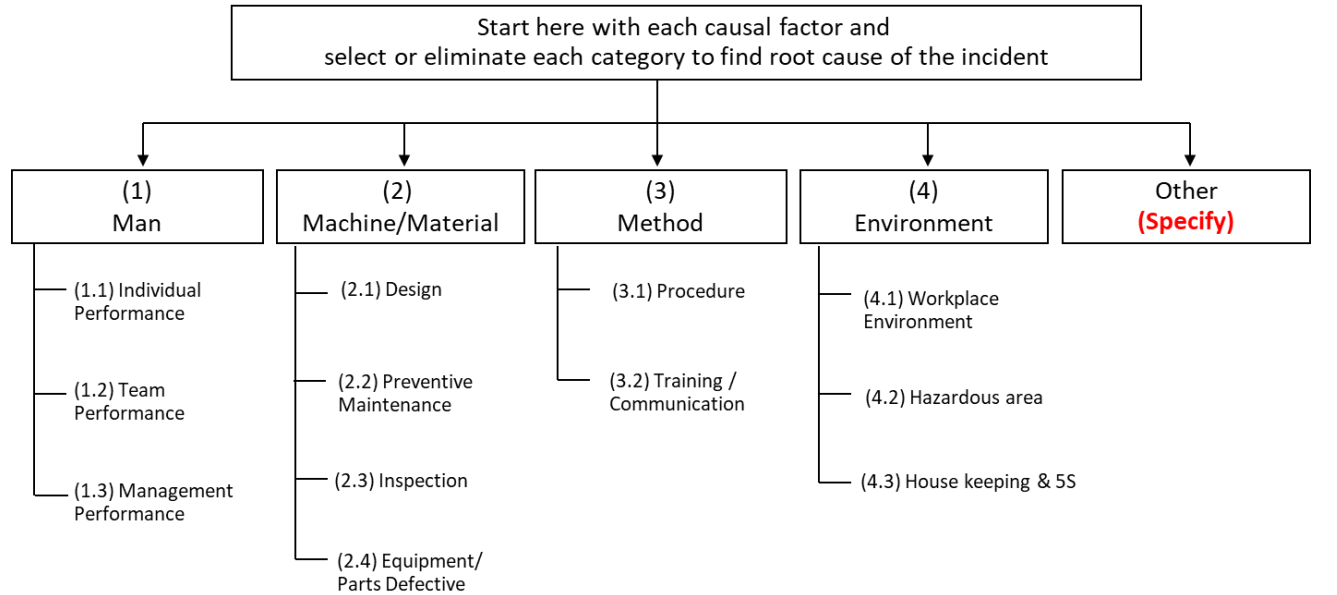
- 1) Document the scene conditions in respect of personal privacy and Personal Data Protection Act (PDPA), and using appropriate channel. The documentation can be in the following forms:
 - Photographs
 - Video recordings
 - Written notes
 - Taking measurements
 - etc.
- 2) What to focus on and what information to gather:
 - Machines, equipment, or tools involved
 - Nature or condition of the equipment (e.g., sharp edges, broken pieces, leaks, frayed electric cords)
 - Tools used (e.g., knives, ice-cream maker)
 - Manufacturer and model number of machines, equipment, or tools being operated at time of incident (if appropriate)
 - Manufacturer, year, and model number of forklift or other industrial truck, if incident involved such equipment
 - Workplace environmental conditions including air temperature, noise, and lighting, airborne chemicals, dusts. These may have contributed to the incident
 - In the area where the incident occurred, look for conditions such as steam, fog, or haze from chemicals which may have contributed to problems with visibility
 - Safety conditions (e.g., slippery floors, uneven floors, cracked floors, ice or water on floors, clogged drains)
 - Physical obstacles (e.g., tripping hazards, blocked exits, obstructed objects)
 - Were appropriate machine guards, floor guards, guards for moving augers or other types of guards in place?
- 3) Interviews
 - 3.1) Who to interview?
 - Injured or ill employees and contractors
 - Co-worked of the injured or ill employees and contractors
 - Person who reported the incident, in case this person is different from the injured or ill employees and contractors
 - Supervisor of area where the incident occurred
 - Witnesses
 - OHS personnel and experts (e.g., safety officer or safety professional)
 - Person who may have been involved (maintenance, sanitation, etc.)
 - Person who has knowledge of operations relating to the incident.
 - etc.

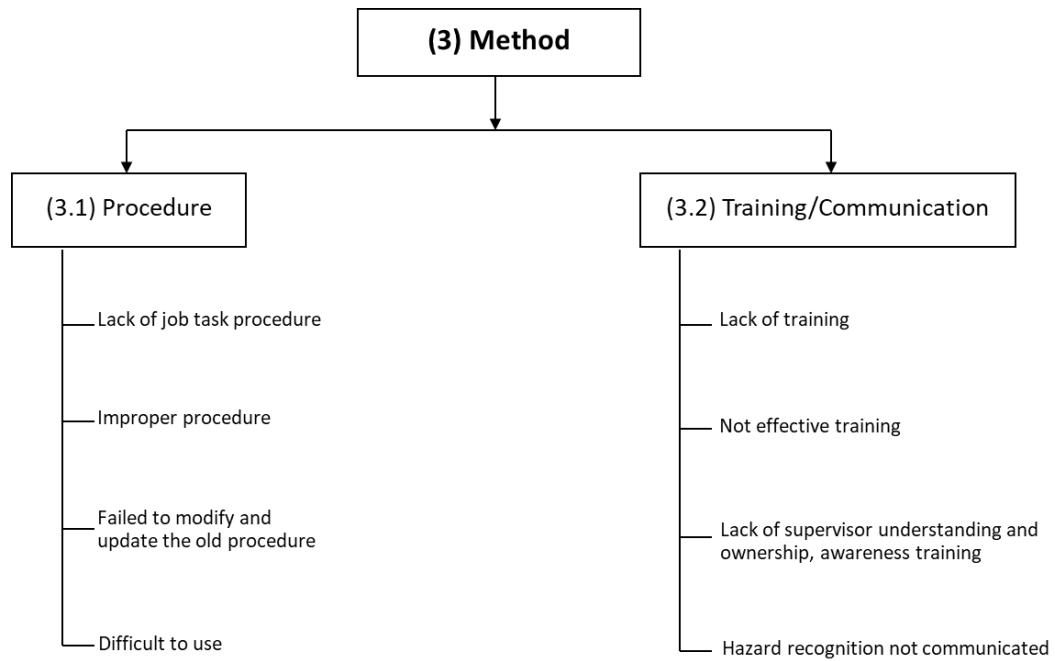
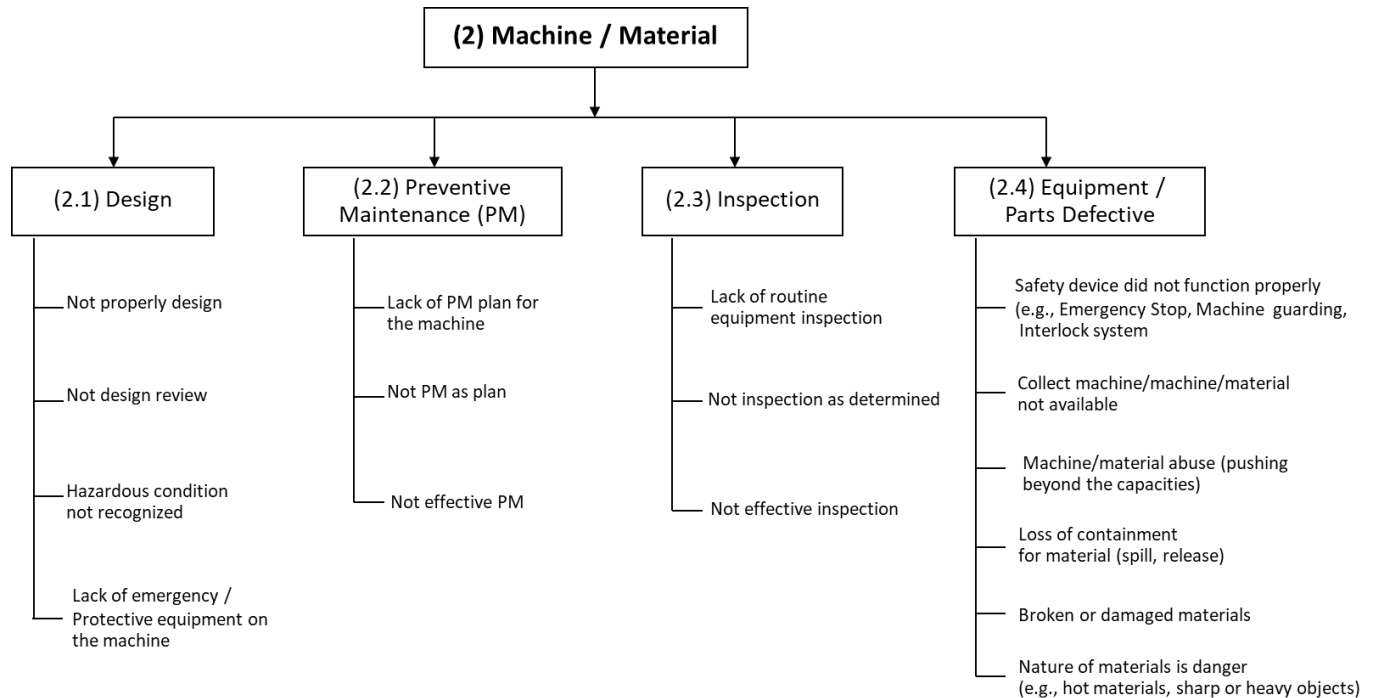
- 3.2) Where should interview(s) take place?
- Conference room, private room or other quiet places
 - Not at the scene
- 3.3) The purpose of interviews is to obtain the facts and find out what happened. It is not to blame or find faulty.
- 3.4) Getting the facts: Asking the questions: when, who, where, what, why?
- When: (Time questions)
 - What time did incident occur?
 - What day of the week did the incident occur?
 - How long had the affected person been working on the day of the incident before he or she was injured or ill?
 - Was the individual working overtime?
 - What shift did the incident occur on? When did shift start?
 - How long had the affected person worked on his or her particular job (in days, weeks, months, years) before incident occurred?
 - Who:
 - Who was injured or ill?
 - Who witnessed incident?
 - Who first responded after incident occurred?
 - Who supervised the affected person?
 - Who has done the same job before?
 - Who trained the affected person on the job?
 - Who installed equipment (if incident involved a piece of equipment)?
 - Who provided maintenance on the equipment?
 - Who inspected the equipment? When was the equipment last inspected and/or maintained?
 - Who told the affected person to do the work he or she was involved in at time of incident?
 - Where:
 - Where did incident occur?
 - Where was the affected person at the time of the incident?
 - Where were the witnesses?
 - Where was the supervisor?
 - What:
 - What happened?
 - What was the affected person doing at the time of the incident?
 - What was the affected person doing immediately prior to the incident?
 - If this was not the affected person's regular job, what was his or her regular job?
 - Questions about conditions on the day of the incident:
 - Was the affected person working in crowded conditions? i.e., too close to another worker?
 - Was there anything different or abnormal on the day of the incident, with respect to working conditions or the work being done?

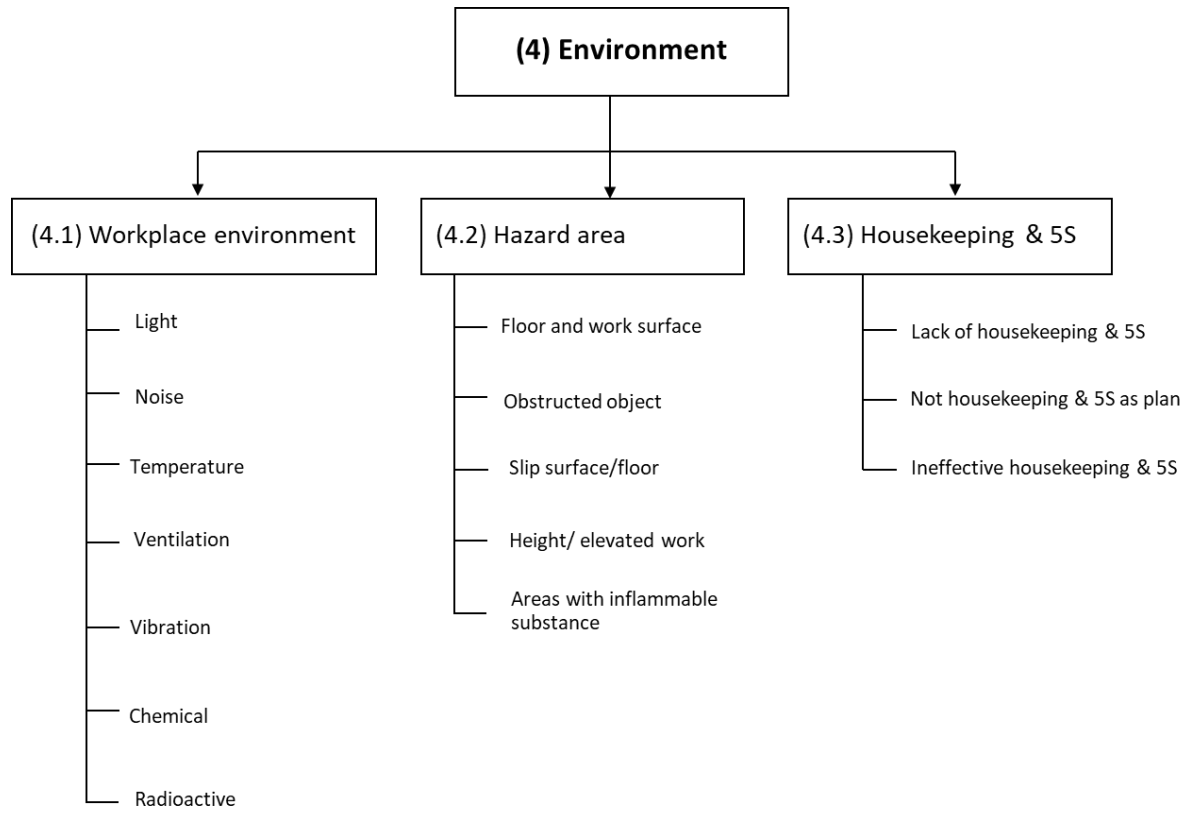
- Was the job understaffed or under crewed on the day of the incident or at the time of the incident? i.e., if three people are needed to do the job safely, were all three people working and present?
- If line speed was a factor, was the line moving at normal speed, or was there speed up on the day of the incident?
- Was there more work to do than normal on the day of the incident (thus putting pressure on the affected person to work faster or to bypass safety devices)?
- Was the affected person asked to work overtime on the day of the incident?
- Other Important Questions to Ask:
 - Had anyone else ever been injured on the same job, same piece of machinery, etc. (Go back in time as far as you think reasonable)?
 - Had there been any near misses on the same job, same piece of machinery, etc.?
 - Had concerns about the safety of the job, piece of machinery, or environmental conditions, been raised with management previous to the incident occurring?
 - What language does (did) the affected person speak? What language does the affected person's supervisor speak? In what language was the safety training and any other training concerning the job conducted?
- Regarding Personal Protective Equipment (PPE)
 - Was PPE required for the job on which the incident occurred?
 - If PPE was required, exactly what kind of PPE was required?
 - In the course of the investigation, does it appear that the PPE was inappropriate for this particular job?
 - Was the affected person wearing the required/appropriate PPE?
 - Were there any problems with the PPE on the day of the incident? i.e., was the PPE defective, ill-fitting, had holes, etc.?
 - Could the PPE in any way have been a contributing factor to the occurrence of the incident?

Appendix III: MINT-OHS-FORM-002 Incident Root Cause Analysis Tree

Access to the form [here](#).







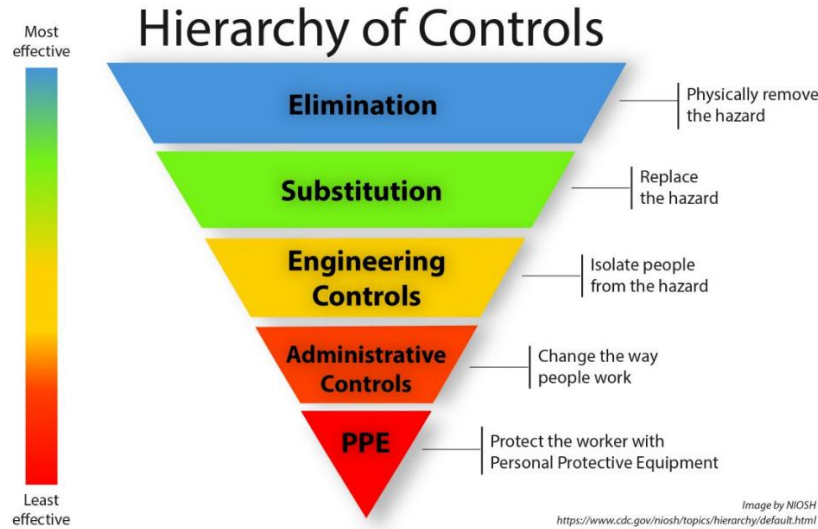
APPENDIX IV: THE HIERARCHY OF CONTROLS

Reference: Hierarchy of Controls, U.S. National Institute for Occupational Safety and Health (NIOSH)

Controlling exposures to hazards in the workplace is vital to protecting workers. The hierarchy of controls is a way of determining which actions will best control exposures. The hierarchy of controls has five levels of actions to reduce or remove hazards. The preferred order of action based on general effectiveness is:

- 1) Elimination
- 2) Substitution
- 3) Engineering controls
- 4) Administrative controls
- 5) Personal protective equipment (PPE)

Using this hierarchy can lower worker exposures and reduce risk of illness or injury.



Elimination

Elimination removes the hazard at the source. This could include changing the work process to stop using a toxic chemical, heavy object, or sharp tool. It is the preferred solution to protect workers because no exposure can occur.

Substitution

Substitution is using a safer alternative to the source of the hazard. An example is using plant-based printing inks as a substitute for solvent-based inks.

When considering a substitute, it's important to compare the potential new risks of the substitute to the original risks. This review should consider how the substitute will combine with other agents

in the workplace. Effective substitutes reduce the potential for harmful effects and do not create new risks.

Elimination and substitution can be the most difficult actions to adopt into an existing process. These methods are best used at the design or development stage of a work process, place, or tool. At the development stage, elimination and substitution may be the simplest and cheapest option. Another good opportunity to use elimination and substitution is when selecting new equipment or procedures. [Prevention through Design](#) is an approach to proactively include prevention when designing work equipment, tools, operations, and spaces.

Engineering Controls

[Engineering controls](#) reduce or prevent hazards from coming into contact with workers. Engineering controls can include modifying equipment or the workspace, using protective barriers, ventilation, and more. The NIOSH Engineering Controls Database has examples of published engineering control research findings.

The most effective engineering controls:

- are part of the original equipment design
- remove or block the hazard at the source before it comes into contact with the worker
- prevent users from modifying or interfering with the control
- need minimal user input for the controls to work
- operate correctly without interfering with the work process or making the work process more difficult

Engineering controls can cost more upfront than administrative controls or PPE. However, long-term operating costs tend to be lower, especially when protecting multiple workers. In addition, engineering controls can save money in other areas of the work process or facility operation.

Administrative Controls

Administrative controls establish work practices that reduce the duration, frequency, or intensity of exposure to hazards. This may include:

- work process training
- job rotation
- ensuring adequate rest breaks
- limiting access to hazardous areas or machinery
- adjusting line speeds

PPE

PPE is equipment worn to minimize exposure to hazards. Examples of PPE include gloves, safety glasses, hearing protection, hard hats, and respirators. When employees use PPE, employers should implement a PPE program. While elements of the PPE program depend on the work process and the identified PPE, the program should address:

- workplace hazards assessment
- PPE selection and use
- inspection and replacement of damaged or worn-out PPE
- employee training
- program monitoring for continued effectiveness

Employers should not rely on PPE alone to control hazards when other effective control options are available. PPE can be effective, but only when workers use it correctly and consistently. PPE might seem to be less expensive than other controls, but can be costly over time. This is especially true when used for multiple workers on a daily basis.


When other control methods are unable to reduce the hazardous exposure to safe levels, employers must provide PPE. This includes:

- while other controls are under development
- when other controls cannot sufficiently reduce the hazardous exposure
- when PPE is the only control option available

Administrative controls and PPE require significant and ongoing effort by workers and their supervisors. They are useful when employers are in the process of implementing other control methods from the hierarchy. Additionally, administrative controls and PPE are often applied to existing processes where hazards are not well controlled.

APPENDIX V: MINT-OHS-FORM-003 OHS INCIDENTS INVESTIGATION RESULT REPORTING FORM

Access to the form [here](#).

	MINT-OHS-FORM-003
OHS Incidents Investigation Result Report Form	
Business Group: Location/Site/Store: Reported by:	Business Unit/Property/Brand: Department/Function: Date of Reporting:
Date and Time of Incident	
Name and Surname of Affected Person(s)	
Employment Status	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Contracted <input type="checkbox"/> Outsourced <input type="checkbox"/> Casual <input type="checkbox"/> Intern
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Number of Service Year (in current position)	
Level of Incident	<input type="checkbox"/> Level I: Fatality/Death <input type="checkbox"/> Level II: Lost days/Days Away from Work <input type="checkbox"/> Level III: Restricted work or Transfer to another job, <input type="checkbox"/> Level IV: Medical treatment beyond first aid, or Loss of consciousness
Primary Type of Incident	<input type="checkbox"/> Work-related Injury <input type="checkbox"/> Work-related Illness/Disease
Primary Subtype of Incident	<input type="checkbox"/> Injury - Wounds and superficial injuries <input type="checkbox"/> Illness - Musculoskeletal disorder <input type="checkbox"/> Injury - Bone fractures <input type="checkbox"/> Illness - Hearing impairment <input type="checkbox"/> Injury - Dislocations, sprains, and strains <input type="checkbox"/> Illness - Respiratory disease <input type="checkbox"/> Injury - Traumatic amputations (Loss of body parts) <input type="checkbox"/> Illness - Skin disease <input type="checkbox"/> Injury - Concussions and internal injuries <input type="checkbox"/> Illness - Mental/Stress <input type="checkbox"/> Injury - Burns, scalds, and frostbites <input type="checkbox"/> Illness - Poisoning and infections <input type="checkbox"/> Injury - Drownings and asphyxiations <input type="checkbox"/> Illness - Other specified illness not listed <input type="checkbox"/> Injury - Effects of sound, vibration, and pressure <input type="checkbox"/> Injury - Shocks <input type="checkbox"/> Injury - Multiple injuries <input type="checkbox"/> Injury - Other specified injuries not listed
Secondary Type of Incident	<input type="checkbox"/> Accident from equipment or tools - Falling Object <input type="checkbox"/> Illness from Exposure to Excessive Noise <input type="checkbox"/> Accident from equipment or tools - Cut <input type="checkbox"/> Illness from Exposure to Extreme Weathers <input type="checkbox"/> Accident from equipment or tools - Stuck By/ Pinched <input type="checkbox"/> Illness from Exposure to Chemicals and Dusts <input type="checkbox"/> Accident from equipment or tools - Bump/Hit <input type="checkbox"/> Illness from Exposure to Biological Agents <input type="checkbox"/> Accident from Road/Vehicle Accident <input type="checkbox"/> Illness from Repetitive Movement/Prolonged Awkward Posture <input type="checkbox"/> Accident from Falling from Height <input type="checkbox"/> Illness from Work-related Stress/Mental Health <input type="checkbox"/> Accident from Electricity <input type="checkbox"/> Illness from Others not listed <input type="checkbox"/> Accident from Hot Surface/Material <input type="checkbox"/> Accident from Chemicals Handling <input type="checkbox"/> Accident from Slips and Trips <input type="checkbox"/> Accident from Heavy Object Handling <input type="checkbox"/> Accident from others not listed

Brief Incident
(WHO, WHAT, WHEN, WHERE,
and HOW)

Part of Body Injured	<input type="checkbox"/> Head	<input type="checkbox"/> Facial Area	<input type="checkbox"/> Eye(s)	<input type="checkbox"/> Ear(s)	<input type="checkbox"/> Mouth
	<input type="checkbox"/> Teeth	<input type="checkbox"/> Neck	<input type="checkbox"/> Nose	<input type="checkbox"/> Torso	<input type="checkbox"/> Hand(s)
	<input type="checkbox"/> Shoulder and shoulder joints		<input type="checkbox"/> Arm, including elbow(s)		<input type="checkbox"/> Finger(s)
	<input type="checkbox"/> Hip and hip joints		<input type="checkbox"/> Leg(s), including knee(s)		<input type="checkbox"/> Wrists
	<input type="checkbox"/> Ankle(s)	<input type="checkbox"/> Foot/feet	<input type="checkbox"/> Toe(s)	<input type="checkbox"/> Others	
	<hr/>				
Involved Physical Activity of the Affected Person	<input type="checkbox"/> Operating machinery/equipment			<input type="checkbox"/> Worked with hand-held tool	
	<input type="checkbox"/> Driving or being on board handling equipment			<input type="checkbox"/> Handling object	
	<input type="checkbox"/> Carrying by hand	<input type="checkbox"/> Movement	<input type="checkbox"/> Others		
<hr/>					
Place of Incident	<input type="checkbox"/> Usual workstation or within the usual local unit of work		<input type="checkbox"/> Occasional or mobile workstation or in a journey on behalf of the employer		<input type="checkbox"/> Other workstation
	<hr/>				
Date of Absence	Start Date of Absence: (DDMMYYYY)			End Date of Absence: (DDMMYYYY)	
	<hr/>				
Root Causes of Incident (from investigation) <i>See MINT-OHS-SOP-002 OHS Incidents Investigation SOP</i>	Man:			Machine/Material:	
	Method:			Work Environment:	
<hr/>					
Corrective and Preventive Actions (CAPA)	Hierarchy of Controls			Target Date and Responsible Person(s):	
	Elimination:				
	Substitution:				
	Engineering Controls:				
	Administrative Controls:				
	Personal Protective Equipment (PPE):				

APPENDIX VI: ONE-PAGE SUMMARY OF INCIDENT FOR LESSON LEARNED TEMPLATE

Access the editable file [here](#).

One-page Incident Summary Lesson Learned				Internal Used Only	
Incident Title <small>(Specify: the work-related accident occurred or illness onset)</small>				Primary Type of Incident: <small>(Specify: Injury or Illness)</small> Primary Subtype of Incident:	
Incident Level (Severity) and Number of Affected Person(s) <small>(Specify: • Level I: Fatality/death • Level II: lost days/days away from work, • Level III: restricted work or transfer to another job, • Level IV: medical treatment beyond first aid, or loss of consciousness</small>	Incident Level:			No. of Affected Person:	
Where <small>(Specify: place of the work-related accident occurred or illness onset)</small>	Region:	Country:	Business Group:	Business Unit:	Location/Site:
When <small>(Specify: local date and time of the work-related accident occurred or illness onset)</small>	Date:		Time:		
Brief of the Accident/Illness <small>(Specify: Who, What, When, Where, How)</small>	Description:			Photos (if any)	
Root Causes from the Investigation <small>(Specify: root causes from root-cause analysis tree, see MINT-OHS-SOP-002 OHS Incident Investigation)</small>	Man:			Machine/Material:	
	Method:			Work Environment:	
Corrective and Preventive Actions <small>(Specify: key actions in preferred order of count measures taken/set to address the identified root-cause of the incident)</small>	Elimination: Substitution: Engineering Controls: Administrative Controls: Personal Protective Equipment:				