



ESTVOLD OILFIELD SERVICES

INCIDENT INVESTIGATION POLICY

Document Number: EST-HSE-402
 Title: Incident Investigation Policy
 Revision: 1
 Effective Date: 06/01/2026
 Owner: HSE Department

Policy Control Item	Policy Information
Company	Estvold Oilfield Services
Document Type	Policy / Program Manual / Field Forms / Incident Investigation and Audit Package
Applies To	All employees, contractors, company-controlled worksites, vehicles, shops, yards, customer sites, and field operations
Program Intent	Incident reporting, scene preservation, root cause evaluation, corrective action development, trend analysis, lessons learned, and continuous improvement
Regulatory Alignment	OSHA incident investigation expectations, root cause analysis principles, corrective action management expectations, and client reporting requirements
Revision	Comprehensive V2 - Editable Master
Approval	Management / HSE / Operations

INCLUDED IN THIS PACKAGE

- Expanded Incident Investigation policy and management-system manual
- Roles, responsibilities, ownership, and accountability expectations
- Incident reporting, initial response, and scene preservation requirements
- Investigation process, evidence gathering, witness interview, and classification guidance
- Root cause evaluation, corrective action tracking, verification, and management review tools
- Trend analysis, KPIs, audit expectations, and lessons learned communication process
- Stop Work Authority integration and contractor/third-party expectations
- Comprehensive forms package, logs, worksheets, and closeout tools

DOCUMENT CONTROL

Revision	Date	Description of Change	Approved By
0	Initial Release	Original controlled document issue	Management
1	Current Draft	Expanded incident investigation manual and forms package	Management
2	Current Revision	Comprehensive management-system language, implementation requirements, root cause tools, tracking logs, and audit tools expanded	Management / HSE / Operations

This document is considered a controlled safety management document. Printed copies are considered uncontrolled unless verified current through the company safety management system or authorized document control location.

DISTRIBUTION AND CONTROL

Controlled copies may be distributed to HSE, operations management, field supervision, training coordinators, company shared safety systems, client-required safety documentation platforms, and field locations where incident investigation activities are implemented.

HOW TO USE THIS MANUAL

- Use Sections 1-26 as the governing incident investigation program standard.
- Use the Supervisor Quick Response Guide during incident response, scene preservation, near miss review, serious incident escalation, and corrective action follow-up.
- Use Forms A-L as field-ready documentation tools for incident reporting, witness statements, root cause evaluation, corrective action tracking, management review, and lessons learned communication.
- Review investigation data monthly and assign corrective actions with accountable owners, due dates, verification requirements, and effectiveness review.
- Use lessons learned and trend review to correct system weaknesses before repeat incidents occur.

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1. PURPOSE AND POLICY STATEMENT

Estvold Oilfield Services is committed to identifying, investigating, correcting, and preventing unsafe conditions, operational failures, and contributing factors associated with incidents, near misses, injuries, environmental events, equipment damage, property damage, and unsafe exposures during company operations.

Incident investigation is intended to be a learning and prevention process. The company recognizes that incidents are often influenced by a combination of human behavior, work planning, communication, equipment condition, environmental conditions, procedure quality, supervision, training, operational pressure, and management systems.

No production expectation, operational pressure, schedule demand, customer request, or client expectation shall take priority over employee safety, incident reporting, scene preservation, or corrective action completion.

2. SCOPE AND APPLICATION

This policy applies to all Estvold Oilfield Services employees, temporary workers under company supervision, supervisors, management personnel, contractors, company-controlled worksites, vehicles, shops, yards, customer sites, and field operations.

The process applies to injuries, illnesses, vehicle incidents, equipment damage, property damage, environmental releases, fires, utility strikes, dropped objects, near misses, high-potential events, unsafe conditions, operational failures, and events requiring corrective action review.

This process complements existing company systems including Stop Work Authority, JSA review, BBS observations, CAPA tracking, emergency response, contractor management, environmental reporting, and management review.

3. REGULATORY ALIGNMENT AND REFERENCES

This policy is written to align with OSHA incident investigation expectations, root cause analysis principles, corrective action management practices, employee involvement principles, applicable client standards, and company safety management expectations.

The incident investigation process does not replace OSHA recordkeeping, client notification requirements, environmental reporting requirements, DOT reporting requirements, workers compensation administration, or emergency response procedures. Where another requirement is more stringent, the more protective requirement shall apply.

Applicable references may include company incident reporting procedures, CAPA procedures, Stop Work Authority policy, JSA requirements, emergency response procedures, environmental reporting procedures, client requirements, and applicable regulatory requirements.

4. DEFINITIONS

Incident: An unplanned event resulting in injury, illness, environmental impact, equipment damage, property damage, operational disruption, regulatory exposure, or unsafe condition requiring investigation.

Near Miss: An unplanned event that could have resulted in injury, damage, environmental impact, or operational loss but did not due to timing, barriers, or chance.

Root Cause: An underlying system, process, communication, training, equipment, supervision, planning, or organizational factor that contributed to an event or allowed the condition to exist.

Corrective Action: Action taken to eliminate or reduce the cause of an identified hazard, deficiency, incident, or contributing factor.

High-Potential Event: An incident or near miss that had credible potential for serious injury, fatality, significant environmental impact, or major operational loss.

5. INCIDENT INVESTIGATION PROGRAM PHILOSOPHY AND CORE PRINCIPLES

The Estvold Oilfield Services incident investigation process is based on the belief that meaningful investigations look beyond the immediate event and identify why the event made sense at the time. Investigations shall evaluate the task, work environment, equipment, communication, procedures, supervision, training, and organizational systems influencing the event.

Investigations shall be conducted professionally and factually. The process is intended to improve systems, prevent recurrence, reinforce accountability, and protect employees rather than assign blame without understanding contributing factors.

Incident learning is most effective when employees trust that reporting concerns, near misses, and unsafe conditions will be used to improve controls, not to create fear or discourage participation.

6. INCIDENT AND NEAR MISS RECOGNITION

Employees and supervisors shall recognize and report incidents, near misses, unsafe conditions, high-potential events, and operational failures immediately. Early reporting allows the company to protect personnel, preserve information, correct hazards, and prevent recurrence.

- Injuries, illnesses, and first aid events
- Vehicle incidents, backing events, and property damage
- Environmental releases, spills, leaks, or contamination concerns
- Equipment damage, tool failure, and dropped objects
- Utility strikes, fires, electrical events, or pressure-related incidents
- Near misses, good catches, and high-potential unsafe conditions

Event Category	Example Event	Investigation Focus
Injury / Illness	Strain, cut, burn, exposure, medical treatment case	Task planning, tools, ergonomics, PPE, supervision, corrective actions
Vehicle / Equipment	Backing incident, equipment contact, property damage	Driver behavior, spotter use, route planning, visibility, equipment condition
Environmental	Spill, leak, uncontrolled release, improper disposal	Containment, response, reporting, controls, training, contractor coordination
High-Potential Near Miss	Dropped object, line-of-fire exposure, uncontrolled energy	Serious injury potential, barriers, human performance, leadership review
Process / Procedure	Missed step, permit failure, JSA gap, communication breakdown	Procedure clarity, training, supervision, operational pressure

7. ROLES AND RESPONSIBILITIES

Incident investigation responsibilities shall be understood before an event occurs. Employees, supervisors, management, and HSE each have specific responsibilities for reporting, preserving information, participating in fact-finding, assigning corrective actions, and communicating lessons learned.

Role	Primary Responsibilities
Employees	Report incidents and near misses immediately, preserve information when safe, provide factual statements, participate honestly, and support corrective actions.
Supervisors	Initiate response, secure the scene, notify management/HSE, gather facts, conduct initial investigation activities, and assign immediate controls.
Management	Support investigation quality, remove barriers, review significant incidents, provide resources, and ensure corrective actions are completed.
HSE	Support investigation facilitation, root cause analysis, reporting, trend tracking, audit review, and consistency across departments.
Contractors	Report incidents immediately, cooperate with investigation requirements, preserve evidence, and complete assigned corrective actions.

8. INCIDENT REPORTING REQUIREMENTS

Incidents and near misses shall be reported immediately according to company requirements. Timely reporting is required so emergency response can be initiated, hazards controlled, scene conditions preserved, regulatory or client notifications evaluated, and investigation activities started before information is lost.

- Report injuries, illnesses, near misses, equipment damage, vehicle incidents, environmental releases, fires, utility strikes, and uncontrolled hazards immediately.
- Notify supervision and HSE according to event severity and client requirements.
- Do not delay reporting because injury severity, damage cost, or root cause is uncertain.
- Escalate high-potential events promptly for management and HSE review.

9. INITIAL RESPONSE AND SCENE PRESERVATION

Initial response activities shall prioritize life safety, emergency response, hazard control, environmental protection, and preservation of critical information. Scene preservation is important because physical conditions, equipment placement, weather, tools, controls, and witness observations may change quickly after an event.

Initial Response Step	Expectation
Protect Personnel	Provide first aid, activate emergency response, evacuate or isolate the area as needed.
Control Hazards	Stop work, control energy, prevent secondary incidents, and secure unsafe equipment.
Preserve Scene	Do not move tools, equipment, vehicles, or materials unless needed for life safety or hazard control.
Notify Leadership	Contact supervision, HSE, management, customer representatives, or emergency responders as required.
Document Early Facts	Record names, times, locations, photos, weather, equipment involved, and immediate actions taken.



10. INVESTIGATION PROCESS REQUIREMENTS

Investigations shall evaluate the work activity, JSA quality, procedures, equipment condition, tools, PPE, environmental conditions, communication, staffing, training, supervision, contractor involvement, and operational pressures associated with the event. Investigation depth shall match actual and potential severity.

11. WITNESS INTERVIEW AND INFORMATION GATHERING EXPECTATIONS

Witness interviews shall be conducted promptly, respectfully, and factually. Investigators shall ask open-ended questions, avoid blame-based language, and document what was seen, heard, done, and understood at the time of the event.

12. ROOT CAUSE EVALUATION EXPECTATIONS

Root cause evaluations shall identify direct causes, contributing factors, system weaknesses, and management-system conditions that allowed the event to occur or continue. Root cause analysis shall consider communication, training, procedure quality, supervision, staffing, equipment, environmental conditions, time pressure, fatigue, and human performance factors.

13. INCIDENT CLASSIFICATION AND SEVERITY REVIEW

Incidents shall be classified based on actual outcome and credible potential severity. High-potential near misses and serious incidents shall receive additional management review because they reveal conditions that could produce serious injury, fatality, environmental impact, or major operational loss.

14. CORRECTIVE ACTION DEVELOPMENT AND TRACKING

Corrective actions shall address identified contributing factors, system weaknesses, hazards, operational deficiencies, procedural gaps, equipment concerns, and communication failures. Corrective actions shall include accountable owners, target dates, completion status, verification, and effectiveness review where appropriate.

15. VERIFICATION AND EFFECTIVENESS REVIEW

Corrective action closure shall not be based only on completion of a task. Supervisors and HSE shall verify that the corrective action reduced exposure, addressed the contributing factor, was communicated to affected personnel, and remains effective during follow-up activities.

16. MANAGEMENT REVIEW AND ESCALATION EXPECTATIONS

Serious incidents, repeat events, high-potential near misses, overdue corrective actions, failed corrective actions, and significant operational failures shall be escalated to management for review, resource support, accountability, and prevention planning.

17. COMMUNICATION AND LESSONS LEARNED EXPECTATIONS

Lessons learned shall be communicated to affected employees, supervisors, contractors, and management in a manner that improves awareness without creating blame or embarrassment. Communication shall focus on exposure, contributing factors, controls, and prevention expectations.

18. CONTRACTOR AND THIRD-PARTY EXPECTATIONS

Contractors working on company-controlled sites are expected to comply with incident reporting requirements, investigation cooperation expectations, scene preservation expectations, and corrective action responsibilities. Immediate serious hazards shall be stopped regardless of employer.

19. STOP WORK AUTHORITY

All employees and contractors have the authority and responsibility to stop work when unsafe conditions exist, incident potential is present, controls are missing, procedures are unclear, or serious injury exposure cannot be controlled. Employees shall not face retaliation for exercising Stop Work Authority in good faith.

20. DOCUMENTATION AND RECORDKEEPING

The company shall maintain investigation reports, witness statements, photographs, evidence records, root cause worksheets, corrective action logs, management review notes, training documentation, audit records, and lessons learned communication records according to company and applicable requirements.

21. TRAINING REQUIREMENTS

Training may include incident reporting expectations, investigation process requirements, root cause evaluation methods, witness interview expectations, corrective action tracking, scene preservation, documentation quality, communication expectations, and Stop Work Authority.

22. TREND ANALYSIS, KPIS, AND DATA REVIEW

Incident and near miss data shall be reviewed periodically to identify repeated exposures, system weaknesses, department trends, corrective action delays, serious injury potential, and improvement opportunities. Data review shall focus on learning and prevention rather than fear-based reporting control.

Metric	Purpose
Investigation Timeliness	Confirms incidents are reported, reviewed, and documented promptly.
Root Cause Quality	Evaluates whether investigations identify system-level contributing factors.
Corrective Action Closure	Confirms actions have owners, due dates, completion status, and verification.
Repeat Incident Trends	Identifies recurring exposures requiring deeper management review.
Near Miss Reporting	Measures proactive reporting culture and hazard recognition.
Lessons Learned Communication	Confirms learning is shared with affected crews and leadership.

23. LEADERSHIP AND SUPERVISOR ACCOUNTABILITY

Leadership personnel shall participate visibly in the incident investigation process through timely response, fact-based review, corrective action support, barrier removal, lessons learned communication, and follow-up verification. Employees judge the value of investigations by how leaders respond after events.

Leadership Expectation	Evidence of Completion
Timely Response	Incident notifications, initial response notes, and supervisor involvement documented.
Barrier Removal	Resources provided and system weaknesses corrected.
Corrective Action Support	Owners, due dates, verification, and closure status reviewed.
Trend Review	Monthly incident, near miss, and corrective action summaries reviewed with operations and HSE.
Learning Culture	Lessons learned shared without naming, shaming, or discouraging reporting.

24. CONFIDENTIALITY, FAIRNESS, AND NON-PUNITIVE LEARNING EXPECTATIONS

Investigation information shall be handled professionally and limited to those with a business need to know. The investigation process shall distinguish between human error, at-risk behavior, system weakness, and willful disregard. Discipline, when necessary, shall follow company policy and shall not replace root cause evaluation or system improvement.

25. AUDITING AND PROGRAM REVIEW

The company shall periodically review investigation quality, reporting consistency, corrective action effectiveness, documentation quality, management review, contractor coordination, employee feedback, and overall program implementation.

Audit Item	Satisfactory Evidence
Investigation Completion	Reports are complete, factual, and reviewed according to severity.
Root Cause Evaluation	Investigations consider contributing factors and system influences.
Corrective Action Closure	Actions include owner, due date, completion, and verification.
Trend Review	Incident and near miss data are reviewed and shared with leadership.
Employee Trust	Employees understand the process and report incidents without fear.

26. SUPERVISOR QUICK RESPONSE GUIDE

Situation	Immediate Action	Key Documentation / Control
Incident occurs	Initiate response, protect personnel, preserve scene, notify supervision/HSE.	Incident report / scene preservation checklist
Near miss identified	Document event and evaluate potential severity.	Near miss investigation form
Witness identified	Conduct interview promptly and factually.	Witness statement form
Corrective action overdue	Escalate and follow up with responsible owner.	Corrective action log
Repeat incident identified	Review root causes and system controls with management.	Management review form
High-potential event occurs	Stop work, secure area, notify leadership, conduct formal review.	Incident classification / management review

27. FORMS PACKAGE

The following forms are provided as editable templates. The company may convert these forms into electronic format, fillable PDF, shared drive logs, or safety management software entries as needed.

FORM A - INCIDENT INVESTIGATION REPORT FORM

Use this form to document initial event information, response actions, classification, root cause findings, and corrective action requirements.

Item	Details / Comments
Date / Time	
Jobsite / Location	
Incident Description	
Personnel Involved	
Immediate Actions Taken	
Injury / Damage Classification	
Root Causes Identified	
Corrective Actions Required	
Investigation Lead	
Management Review Required	

FORM B - WITNESS STATEMENT FORM

Use this form to collect factual witness information in a respectful and consistent manner.

Item	Details / Comments
Witness Name	
Date	
Location	
Observed Events	
Task Being Performed	
Equipment / Conditions Observed	
Additional Comments	
Witness Signature	

FORM C - ROOT CAUSE ANALYSIS WORKSHEET

Use this worksheet to evaluate direct causes, contributing factors, and system influences.

Item	Details / Comments
Immediate Cause	
Contributing Factors	
Environmental Conditions	
Procedure Concerns	
Training Concerns	
Communication Issues	
Equipment Factors	
Supervision / Planning Factors	
Root Cause Determination	
Corrective Actions	

FORM D - CORRECTIVE ACTION TRACKING FORM

Use this form to assign, track, verify, and close corrective actions.

Item	Details / Comments
Action ID	
Source / Incident	
Corrective Action	
Owner	
Due Date	
Completion Date	
Verified By	
Effectiveness Review Notes	
Status	



FORM E - NEAR MISS INVESTIGATION FORM

Use this form to evaluate near misses and high-potential events before injuries occur.

Item	Details / Comments
Date / Time	
Location	
Near Miss Description	
Potential Consequence	
Immediate Controls	
Root Cause / Contributing Factors	
Corrective Actions	
Follow-Up Owner	

FORM F - SCENE PRESERVATION CHECKLIST

Use this checklist to support initial response and preservation of key evidence.

Item	Details / Comments
Area Secured	
Photos Taken	
Equipment Position Documented	
Witnesses Identified	
Tools / Materials Preserved	
Weather / Lighting Noted	
Emergency Changes Documented	
Supervisor Approval	

FORM G - INCIDENT CLASSIFICATION FORM

Use this form to classify actual and potential severity of the event.

Item	Details / Comments
Incident Type	
Actual Severity	
Potential Severity	
Environmental Impact	
Equipment / Property Damage	
Regulatory / Client Notification Required	
Management Review Required	

FORM H - MANAGEMENT REVIEW FORM

Use this form to document leadership review of serious incidents, repeat events, or high-potential near misses.

Item	Details / Comments
Review Date	
Incident Reviewed	
Management Participants	
Root Cause Summary	
Resource Needs	
Corrective Action Status	
Lessons Learned Approved	
Follow-Up Required	

FORM I - LESSONS LEARNED COMMUNICATION RECORD

Use this record to document communication of findings and prevention expectations.

Item	Details / Comments
Date Shared	
Crew / Department	
Lesson Topic	
Controls Reviewed	
Employee Feedback	
Follow-Up Required	
Facilitator	



FORM J - SUPERVISOR AUDIT AND OBSERVATION FORM

Use this form to audit investigation quality and field implementation.

Item	Details / Comments
Investigation Timeliness	
Scene Preservation Adequate	
Witness Information Complete	
Root Cause Quality	
Corrective Actions Assigned	
Lessons Learned Communicated	
Documentation Complete	

FORM K - INCIDENT PROGRAM REVIEW SUMMARY

Use this form to summarize trend review, program performance, and improvement actions.

Item	Details / Comments
Review Period	
Reviewer(s)	
Departments Included	
Top Incident Trends	
Top Near Miss Trends	
System Barriers Identified	
Program Improvements Needed	
Management Approval	

FORM L - INVESTIGATION TRAINING ACKNOWLEDGMENT

Use this acknowledgment to document employee or supervisor training on incident reporting and investigation expectations.

Item	Details / Comments
Employee Name	
Training Date	
Topics Covered	
Trainer / Supervisor	
Employee Signature	
Comments	

28. APPENDICES

APPENDIX A - INCIDENT INVESTIGATION REFERENCE SUMMARY

This program is intended to support incident reporting expectations, root cause evaluation principles, corrective action management practices, employee involvement, and continuous improvement requirements. Investigations shall focus on learning, prevention, and system improvement.

APPENDIX B - ROOT CAUSE EVALUATION EXPECTATIONS

- Evaluate environmental conditions, communication issues, procedure quality, equipment concerns, work planning, training, supervision, staffing, and management-system factors.
- Ask why the behavior or condition made sense at the time before concluding cause.
- Identify corrective actions that address system weaknesses rather than only retraining or reminding employees.
- Use management review for high-potential events, repeat findings, or failed corrective actions.

APPENDIX C - CORRECTIVE ACTION MANAGEMENT EXPECTATIONS

Corrective action management activities should include assignment tracking, target completion dates, completion verification, communication review, effectiveness evaluation, and documented management oversight. Corrective actions should be reviewed during safety meetings, management reviews, and audits until verified complete.