When conducting an incident investigation, there are some key fields that aid a successful SIF investigation and learning event. **OSA Participant Action 4: Implement a SIF Incident Investigation and Learning Program** asks participants to apply investigative and learning processes, tools or methods to identify root causes and latent factors and to confirm corrective actions are in place that prevents SIF events. The Onshore Safety Alliance provides flexibility in how a participant meets the objective of this action. The template below provides fields that typically support such investigation and learning events.

<table>
<thead>
<tr>
<th>FIELD</th>
<th>GUIDANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incident Reference #</td>
<td>• Provide a unique number that aids reference</td>
</tr>
<tr>
<td>Incident Title</td>
<td>• Short Description of Incident e.g.:</td>
</tr>
<tr>
<td></td>
<td>o T-401 Overflow Event</td>
</tr>
<tr>
<td>Location</td>
<td>• Specific location where incident occurred or originated</td>
</tr>
<tr>
<td></td>
<td>• Secondary locations may be included if the incident spread or occurred in multiple places</td>
</tr>
<tr>
<td>Incident Owner</td>
<td>• Typically, an Asset/ Operations / Drilling Leader</td>
</tr>
<tr>
<td></td>
<td>• Considered the customer for the investigation and learning event</td>
</tr>
<tr>
<td>Date</td>
<td>Specific date of incident occurrence</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Time</td>
<td>Specific time of incident occurrence</td>
</tr>
</tbody>
</table>
| Incident Classification | Participants classify incidents according to actual or potential severity on their risk matrix. Example classifications are (refer to OSA Risk Matrix): 
  - Severe 
  - Major 
  - Moderate 
  - Minor 
  - Incidental |
|                      | Incidents should also be classified as Actual or Near-Miss. |
| Incident Investigation Methodology | Participants should define the methodology required based on the incident classification defined above: 
  - 5-Whys (for incidental and minor) 
  - Root Cause Analysis (for moderate, major or severe incidents) 
  - Learning Teams (for any event involving human error) |
| Team                 | Define investigation team roles: 
  - Lead 
  - Subject Matter Experts 
  - Facilitator trained and competent in the methodology chosen 
  - Workers/Peers knowledgeable in the activity relating to the incident |
|                      | Leaders should If appropriate (maintaining safe environment) relevant leadership |
- Hierarchy of incident ownership may be assigned based on severity of incident
- The Lead and Facilitator role may be combined

### Deliverables
- Final report
- Presentation to leadership

### Timeline
- Timing for above deliverables

### Findings
- Based on investigation method
- List each finding
- Root Cause (if identified)

### Corrective Actions
Corrective actions should:
- Address root cause or identified causes
- Be specific, measurable, achievable, relevant and time-bound
- Be assigned to action parties who have agreed to action
- Be reviewed periodically for on time closure
- Require acceptance by incident owner prior to close out