BSBWHS505

Investigate WHS incidents

ASSESSMENT FOR BSBWHS505

Student name	MOHD NUJAIMI BIN ABU BAKAR
Date of assessment submission	5/02/2018

Trainer/Assessor's name	
Date of assessment marking	Click here to enter a date.
Outcome for unit	☐ Competent ☐ Not Yet Competent

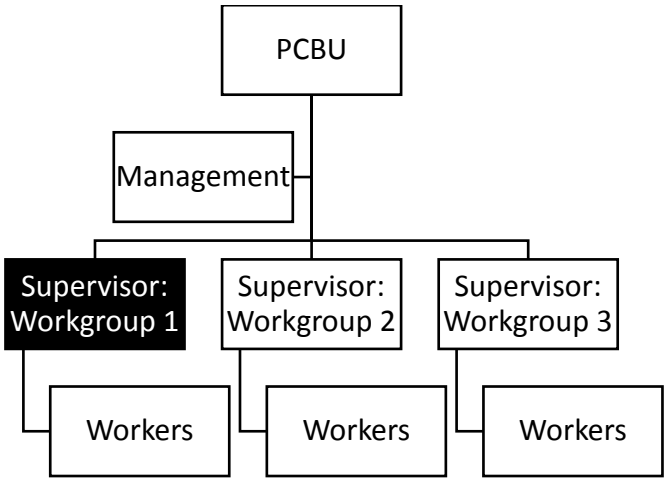
TASK INSTRUCTIONS

- The assessment for this unit of competency consists of the following:
  - **A series of activities:** Some of these activities will require you to provide a response within this document, others will require you to gather evidence to demonstrate your knowledge and skills (overview below)
  - **Quiz:** You will be required to complete a series of questions to demonstrate your knowledge and skills.
  - **Practical task:** You will be required to have an observer attest to your knowledge and skills and sign a report to this effect.
- At times, you will be provided with a specific business context to which you must respond, otherwise it is anticipated that you will use a workplace of your choosing (your own, or hypothetical) to provide the context to the task.
- At all times, the responses in your assessment must reference **Australian** (Queensland or Federal) documentation, including legislation, regulations, codes of practice, standards and guidance publications.

ACTIVITY OVERVIEW	REQUIRED FOR SUBMISSION
1. Initial responses to incidents	• Workbook response (below)
2. Planning the investigation	• Workbook response (below)
3. Collecting and analysing information and data	• Workbook response (below)
4. Completing investigation report	• Workbook response (below)

ACTIVITIES

For the following activities, you will assume the role of a workgroup supervisor in a workplace of your choosing (see example organisational chart below).



Name a workplace and workgroup that you are (or hypothetically are) the supervisor for. Also, identify a likely incident to occur within this workplace which requires investigation. It may have actually happened or could hypothetically happen.

Name of workplace	REFINERY AND PETROCHEMICAL INTEGRATED COMPLEX (RAPID) PENGERANG
Workgroup	FITTER
Describe incident	At 0940 a.m. after positioning the stair case at the final position, the fitter team de-rigged the slings from the stair case. One of the fitters then signaling (by shouting) to the signalman slings were clear and to hoist up. The signalman was positioned approximately 15 metres above the final staircase position, he was standing on scaffold at level 3. The signalman gave instruction to the crane operator to hoist up, while hoisting up the crane block, the block got caught with a scaffolding bolt securing a puncheon to the scaffold midrail that held the toe boards in place. It is assumed this caused the 4 foot toe board to come lose and fell. It is assumed the plank struck the I.P and caused him to lose balance and fall through an opening in the structural steel.

ACTIVITY 1

Consider the initial responses to the incident, in preparation for an investigation:

a) How would you ensure the incident site is safe and secure?
   - Describe how you would address the immediate needs of those involved in the incident

b) Outline the WHS legislative requirements for your workplace regarding incident response (i.e. duty holders, notification/reporting, preserving incident sites) as outlined in:
   - WHS Acts
   - WHS Regulations

c) Outline the your workplace's requirements regarding incident response as outlined in:
   - Policies
   - Processes
   - Procedures
   - Systems

Ensuring safety and security of site

The incident area will be identified and confirmed according to the witnesses. The area been barricaded and NO ENTRY sign will be installed. The tools and equipment involved in the accident were also recognized. Pictures were taken from different view just in case the site being compromised. Initial statement taken from the witnesses as it still fresh in their mind. Supervisor was informed not to enter the area or resume the job till further instruction.

WHS Acts

38 Duty to notify of notifiable incidents

(1) A person who conducts a business or undertaking must ensure that the regulator is notified immediately after becoming aware that a notifiable incident arising out of the conduct of the business or undertaking has occurred.

Maximum penalty:
(a) in the case of an individual—$10 000; or
(b) in the case of a body corporate—$50 000. Note Strict liability applies to each physical element of this offence (see s 12A).
(2) The notice must be given in accordance with this section and by the fastest possible means.
(3) The notice must be given— (a) by telephone; or (b) in writing.
(4) A person giving notice by telephone must— (a) give the details of the incident requested by the regulator; and (b) if required by the regulator, give a written notice of the incident within 48 hours of that requirement being made.
(5) A written notice must be in a form, or contain the details, approved by the regulator. Note If a form is approved under s 277 for a written notice, the form must be used.
(6) If the regulator receives a notice by telephone and a written notice is not required, the regulator must give the person conducting the business or undertaking— (a) details of the information received; or (b) an acknowledgement of receiving the notice.
(7) A person conducting a business or undertaking must keep a record of each notifiable incident for at least 5 years from the day that notice of the incident is given to the regulator under this section. Maximum penalty: (a) in the case of an individual—$5 000; or (b) in the case of a body corporate—$25 000. Note Strict liability applies to each physical element of this offence (see s 12A).
(8) Despite anything else in this section, if a notifiable incident for which notice is required to be given is reported in accordance with the Dangerous Substances Act 2004, the reporting under that Act is taken to be adequate notice of the incident for the purposes of this Act.

39 Duty to preserve incident sites

(1) The person with management or control of a workplace at which a notifiable incident has occurred must ensure so far as is reasonably practicable, that the site where the incident occurred is not disturbed until an inspector arrives at the site or any earlier time that an

inspector directs. Maximum penalty: (a) in the case of an individual—$10 000; or (b) in the case of a body corporate—$50 000. Note Strict liability applies to each physical element of this offence (see s 12A).
(2) In subsection (1) a reference to a site includes any plant, substance, structure or thing associated with the notifiable incident.
(3) Subsection (1) does not prevent any action— (a) to assist an injured person; or (b) to remove a deceased person; or (c) that is essential to make the site safe or to minimise the risk of a further notifiable incident; or (d) that is associated with a police investigation; or (e) for which an inspector or the regulator has given permission.

WHS Regulations

South Australia Work Health and Safety Regulations 2012
Part 6—Provision of information to regulator.
675V—Duty to notify regulator of certain incidents (1) The mine operator of a mine must take all reasonable steps to ensure that the regulator is notified as soon as possible after becoming aware of an incident arising out of the carrying out of mining operations at the mine. Maximum penalty:
(a) in the case of an individual—$6 000; (b) in the case of a body corporate—$30 000. (2) The notification must— (a) be in writing; and
(b) be in a form required by the regulator; and
(c) in the case of an incident that results in an illness or injury, contain the details specified in Schedule 23.

Policies

Technip HSE Policy stated all reported incident will be investigated where the report will be accurate and transparent.

Processes

Witnesses or the injured person shall notify his/her Supervisor regarding any incidents. Supervisor will triggered emergency alarm and the area to evacuated if necessary. If not, the first line responder i.e. fire fighting team or first aider or medic to response to the incident. Injured person to be evacuated. Supervisor shall notify the incident to HSE personnel who will then barricade the area and preserve the scene. Investigation will take place where report will be issued and necessary action item will be taken to prevent recurrence.

Procedures

In the Incident Reporting Investigation and Reporting, all incident shall:
Be reported in 24 hours
HSE Alert to be issued within 24 hours
Investigation report with Root Cause analysis technique within 7 days
HSE Lesson learnt to be issued within 7 days
All action item to be closed in timely manner.

Systems

In Technip process, all incident shall be notified through the Synergy system. Recordable case require notification to Authority. Standard form of information to be filled in and the system will issue an Alert to the related personnel. Next, the team shall conduct an investigation where the report to be uploaded into the system. For high risk activity, the management shall be briefed and the action item to be agreed to prevent recurrence. Each action item were tracked in Synergy system where the status to be closed in timely manner or the notification will keep appearing in the email.

Outcome for Activity 1	☐ Satisfactory ☐ Not satisfactory
Trainer/Assessor comments	

ACTIVITY 2

You are required to develop an investigation plan to address the incident:

a) Define the scope and purpose/objectives of the investigation
   - Ensure this reflects the scope and nature of the incident
   - Explain which individuals/parties you would consult with in planning the investigation, including deciding between options (e.g. internally, external advisors)

b) Outline the requirements of the investigation in the form of an action plan
   - Identify resourcing requirements, and allocate roles and responsibilities
   - Prioritise tasks and specify timelines for the investigation
   - Identify how the outcomes of the investigation will be documented

c) Identify factors that may impact on the investigation and how they might be addressed. Consider the impact of:
   - Workers with specific needs and limitations (e.g. cultural background and diversity, low language, literacy and numeracy levels)
   - Structure and organisation of the workforce (i.e. part time vs casual vs contract workers; shift rosters; geographical location)
   - Workplace culture relating to gender

Ensure that the requirements from Activity 1 are met through your responses to Activity 2.

Scope and purpose/objectives of the investigation

To prevent repetition of the same work related injuries, ill health, diseases and incidents by identifying the root causes and taking appropriate action.
To meet legal requirement
To maintain accurate record (for insurance, legal prosecution, public enquiries)
To comply with organisation's own policy and business reasons
In order to find the root causes, the fact shall be right or otherwise wrong root cause will lead to wrong corrective action which will made the investigation ineffective. Investigation team of experience people will be formed and a leader will be appointed. A lifting expert would be part of the team who understand the task. An expert of incident investigation technique will also be part of the team.

Action plan

The investigation team shall start with a briefing among the team members based on the fact from initial interview conducted on site. The team shall be provided with a dedicated room and not to be interfered with. The team shall be divided into three groups:
Group 1 visited the incident scene and performed re-enactment based on witnesses information. Witnesses could be part of the re-enactment process for better understanding.
Group 2 reviewed any kind of documentation that found related to the incident.
Group 3 performed the interview to the key witnesses from the surrounding area, the Supervisor and their colleague from the same team.
These activities shall be completed in one day. At the end of the day, the team will gather again to share what they have and a timeline pre and post incident developed based on sequence. Findings that contribute to the incidents will be revealed and it will be used to develop the incident investigation technique to identify the root cause. Action item will be proposed on each of the root causes.

Impacting factors

Language barrier– Use simple language. It will be easier for the witness to explain. Use translator of you have to.
Self defence – The witness might not tell you the whole truth to protect their interest. Investigation team shall make them at ease and promise no consequence management apply though they might have broken some rules. Initial statement right after the incident is very important because they do not have the time to manipulate the stories.
Cooperation to the investigation team – Investigation team have schedule to meet. Therefore the support team to provide the necessary document as required as soon as possible and prepare witnesses for interviews according to the timing.

Inexperience team – The investigation team shall be familiar with the worksite and the activity associated with the incident. The expert should deliver and assist as expected. Interference from management – in order to protect company interest, the management might influence the investigation that could resulted inaccurate and non transparent report.

Outcome for Activity 2	☐ Satisfactory ☐ Not satisfactory
Trainer/Assessor comments	

ACTIVITY 3

Consider the collection and analysis of information and data:

a) Explain why and how you will inspect the incident site.
b) Explain why and how you will inspect the equipment used at the time of the incident.
c) Identify other evidence you would gather regarding the incident.
d) Outline how you would gather information and data in ways that ensure objectivity, confidentiality, validity and accuracy.
e) What reasoning would you give to the investigation team to justify using the conceptual basis for the analysis, namely:
   - Adopting an open-minded and objective approach
   - Analysing policies, procedures, processes and systems in place at the time of the incident
   - Focussing on the 'how', 'what' and 'why' of the incident
   - Not focussing on individual behaviour or fault
   - Using applicable models of causation and occurrence

Inspecting the incident site

The reason to inspect the incident site:
To look at the consequence from the incident – to look at the damage to the asset, impact of environment spill or the evidence of injury.
To look for deeper evidence – incident marks, distance and clearance, equipment condition, unsafe act or condition that lead to the incident.
To understand body position – It need to be ascertain the body position of the injured person before, during or after the incident. Re enactment would help.
To get the exact dimension – visiting on site allow the team to measure the length of the scaffold plank, the clearance in lifting area and the weight of the load.
To perform re enactment – Witness will demonstrate what had happened in the exact location using the same tool and the same body position.
To take pictures to incorporate into the report.

Inspecting equipment

Equipment was inspection for its functionality. The crane safety measures/sensor would be tested.
The method of scaffolding erection to be inspected whether its meeting the standard or not.
Equipment been inspected for defect or fatigue element that lead to the failure.
Interview on the witnesses on how the equipment being used. Any bypass, non compliance, or unfamiliarity with the equipment.
To see any evidence of inspection or calibration and ensure the equipment match the certificate/documents.

Other evidence

CCTV, medical records, Permit to Work, Job Hazard Analysis, certificate of equipment, training records, procedures, tool box talk meeting, discipline record, similar incident report, signage, safe work method statement.

Process for gathering information and data

Information gathered from:
Site visit to incident scene
Interview the witnesses
Document review

Briefing the investigation team

The team will be briefed pre investigation based on limited information that they have. After process of gathering information and data completed, the team will gather again to attend another briefing to report progress and share the findings that they have got during the investigation. The final investigation report to be agreed by all parties before issuance.

Outcome for Activity 3	☐ Satisfactory ☐ Not satisfactory
Trainer/Assessor comments	

ACTIVITY 4

Complete an investigation report of the identified incident for your PCBU in the following structure:

1.0 INTRODUCTION

- Outline the background of your company, its role and purpose
- Briefly describe the incident that has taken place
- Define the scope and purpose of the investigation

2.0 INVESTIGATION FINDINGS

- Construct a timeline of events leading up to the incident (e.g. who was involved, what happened, initial responses to meet legislative/organisational requirements)
- Describe the scope of the investigation (e.g. identify investigation team, sources of information and data, site/equipment inspections that took place, other evidence gathered, experts consulted)
- Outline how information and data was gathered using objective, confidential, valid and accurate methods.
- Highlight the root causes of the incident:
  - Note the key events, conditions and/or circumstances that together resulted in the incident
  - Consider the effectiveness of workplace policies, procedures, processes and systems

3.0 RECOMMENDED PREVENTION MEASURES

- Highlight points at which the incident could have been prevented
- Outline actions, interventions and practical measures that would prevent reoccurrence of the incident, which address the root causes identified
  - Evaluate between alternative strategies to identify the best option(s) for the workplace, identifying the criteria used for this decision
  - Identify resourcing requirements, and allocation roles and responsibilities
  - Prioritise tasks and specify timelines for implementation
  - Outline how the effectiveness of these solutions will be measured and evaluated

4.0 CONCLUSION

- Explain the importance of WHS to your company, and the value of addressing and avoiding incidents

TIPS:

- Use the report template (below) and elaborate on the points above.
- Write in simple English. Remember that people from a range of backgrounds and abilities would be reading this document.
- Be sure to reference evidence to back up your conclusions and recommendations, providing sufficient detail so that the reader can look into it further.

1.0 INTRODUCTION

Technip Asia Pacific (APAC) is the leading engineering technology solutions and turnkey contracting provider in Asia Pacific for the design and construction of hydrocarbon field development, oil refining, gas processing, petrochemicals and selected non-hydrocarbon projects. Technip APAC consists of country from Singapore, Vietnam, China, Brunei, Malaysia, Thailand, and Mymmar. And activities cover 3 business segments i.e. Subsea, Offshore and Onshore. Incorporated in 1982, the company participates in business activities internationally with Kuala Lumpur in Malaysia as the main operational centre.

A crane block got caught with a scaffolding bolt securing a puncheon to the scaffold midrail that held the toe boards in place. It is assumed this caused the 4 foot toe board to come lose and fell.

It is assumed the plank struck the I.P and caused him to lose balance and fall through an opening in the structural steel.

The investigation will investigate issues associated with, and leading up to, the drop object incident occurred during works being carried out on lifting and installing structural stairs case access shaft NW0. The investigation is to be as wide ranging as possible but limited within the management influences of RAPID Project management teams.

The investigation team will provide recommendations to prevent recurrence of such incidents.

2.0 INVESTIGATION FINDINGS

TIME (HRS)	DESCRIPTION
0750-0830	IP, with his fitter group attended morning tool box briefing and also registered as attending the risk assessment briefing that focused on resuming activity of stair case installation. Chargehand emphasised the importance of being 100% tied off he also indicated not to work under the suspended load.
	Another risk assessment briefing was performed by the rigger team for lifting of the remaining stair case from ground into the NW0 access shaft. The briefing was given by the rigger foreman and he emphasizes was on the barricade requirements and controlling the stair case while lowering into the access shaft because of the limited space.
0840	One rigger and his foreman started to rig up shackles and webbing sling onto the stair case. The signalman was already on the top column giving instructions to the 250 MT crawler crane operator, via walkie talkie since it was a blind lift.
0850	Lifting operation commenced.
	Rigging foreman left the activity to proceed with another lifting at NE column leaving the signalman and rigger to proceed with the stair case lifting operations.
	The fitter and group of scaffolder were standby inside the NW0 at the final installation area. They kept away and to one side while waiting for the stair case to arrive at the final location.

TIME (HRS)	DESCRIPTION
0910	The signalman final position during the lowing and hoisting operations was at scaffolding Level 3. This was approximately 15 metres from the final landing position. He was performing a signalman job and at the same time manually controlling the load due to clashing points of the structure support, scaffolding and pipes till the stair case arrived to the required location.
	Note: The lifting process ran at the slowest motion of the single line auxiliary hoist following the instruction of the signalman.
0915	The chargehand and his fitter group positioning the stair case to the final position using tag lines. Then, they proceed with fitup works by installing chain block and tacking to secure the stair case.
0930	The fitter group de-rigged the rigging gears and signalled to the signalman to hoist up the crane block.
	The signalman communicated with the crane operator to hoist up the block. The signalman was controlling the block when it come in contact with the scaffold bolt attached to the midrail puncheon, on the platform where he was standing. He instructed the crane operator to stop hoisting up.
	By the time he realised the block was hooked onto the scaffold clip and stopped the crane the scaffold was already damaged, It is assumed this is when the plank dropped but he did not see it fall.
0935-0940	Once he freed the block, the block spun and his first thought was to try and control the block, once the block was once again still he proceeded to hoist up the block till end of operation.
	While the signalman was hoisting the crane up the fitter group started their fit up activity, it was during this time the plank fell and bounced and hit others structures before hitting the IP. It is assumed the plank struck the I.P near the face and caused him to lose balance and fall. The distance he fell is approximately 1m as his D ring got caught on the pipe support below the opening, his lanyard was hooked on to a scaffold tube but the lanyard was not fully extended when he was retrieved. It is assumed this is when IP injured his left hand.

An investigation team consist lead by Project Manager and supported by HSE Manager with few other team members was formed and assigned to investigate the incident, identify the root cause and provide recommendations to prevent recurrence. An external lifting and scaffolding specialist were also invited for their expertise.
Information were gathered through site visit, interview the witnesses and review related documentation i.e. competency, inspection record and material certificates. A re-enactment been developed for better understanding.
Using the Tripod Beta and Kelvin Topset incident investigation technique, below are the root

causes identified by the team:

Poor planning and preparation of work

- Change in installation method (no rigger inside access shaft to assist the signalman)
- Multi disciplines being allowed to work while lifting activities were being done
- Inadequate inspection / supervision inside access shaft, relying on charge hands and 100% tie of principle
- Man power allocation and resourcing (was 6 rigger, only 4 on the incident day)

Lack of understand of the Risk

- Risk assessment did not identify all the risk (lifting activity once the hook is released from the load)
- JSA did not identify and include all the risk (lifting activity once the hook is released from the load)
- No specific method of work, considered general lifting
- Change in work process, without considering potential risk. (Installation of stair cases in SE and NE Hull columns was carried out using 2 riggers and 1 signalman. Rigger inside access shaft receiving and placing the load.

3.0 RECOMMENDED PREVENTION MEASURES

- Reinforce message that lifting competent person can only execute one job at a time; rigging or signalman.
- To treat unloaded lifts in restricted areas as crane under load, and ensure no person is in the line of fire during any lifting activities
- Improve scaffolding platform inside the access shaft and improve general housekeeping.
- Area Supervisor / superintendent to increase frequency visiting the area, to ensure chargehands and teams are working in a safe environment. A structured program to be established to review the risk assessment verification process in the inner shaft.
- Introduce an air horn warning system for clearing areas and notify lifting activities are about to commence and completed.
- Review standard operating procedures, JSA and work methods for lifting activities to ensure
  risk assessment have considered all the risk such as working in cluttered / restricted areas
- Review and change general project HSE induction to include specific areas covering lesson
  learnt from this incident. To reinforce message on hierarchy of control that PPE is the last line of defense and its function is to reduce the severity of injury. Emphasize on PIC requirement.
- To train site Supervisor in Front Line Supervisor training.

4.0 CONCLUSION

Further to this and as a result of the incident findings Technip would like to emphasize the importance of complying with HSE rules and regulations. Project Management also need to increase control over the daily construction activities in the Site, by enhancing supervision (encouraging supervisors to take the leadership towards the Subcontractors; ensuring better communication this applies to both construction and HSE supervision) and strengthening the implementation of specific control tools (PTW, MS/JSA, risk awareness training and daily task talks). Safety of the workers especially in Technip project is our paramount commitment. It reflects Technip core value in taking care of safety health and welfare of the workers. Therefore, we shall learn from the incident and take step forward in implementing the recommendations to safeguard the workforce on site.

Outcome for Activity 4	☐ Satisfactory ☐ Not satisfactory
Trainer/Assessor comments	

QUIZ

QUESTIONS	CORRECT
1. Which of the following matters are considered as initial responses to an incident? Select all that apply. ☒ First aid ☒ Evaluation of response ☒ Preserving the incident site ☒ Evacuation	☐
2. Under Part 3 of the *Work Health and Safety Act 2011* (Qld), a PCBU must notify Work Health and Safety Queensland about all incidents that occur in the workplace, even if there is no injury or damage caused. ☐ True ☒ False	☐
3. Which of the following should be considered when developing an investigation plan? Select all that apply. ☒ WHS legislation ☒ Workplace policies, procedures, processes and systems ☒ Appropriate selection of a team for the scope of the investigation ☒ Consultation and participation of individuals/parties with planning ☒ Obtaining necessary resources for investigation, including expert advice	☐
4. Under Part 9 of the *Work Health and Safety Act 2011* (Qld), which of the following rights and powers does a WHS inspector possess? Select all that apply. ☒ To provide information and advice about WHS compliance ☒ To assist in resolving WHS issues in the workplace ☒ To inspect a workplace, including investigation of WHS incidents ☒ Enter a workplace with or without the PCBU's permission	☐
5. Which of the following factors would be considered barriers to an incident investigation? Select all that apply. ☒ Availability of witnesses due to organisational structure (e.g. casual employees, shift work) ☒ Differences in understanding due to diversity (e.g. cultural background, low language, literacy and numeracy levels) ☒ Attitudes of investigators (e.g. negative views of opposite gender) ☒ An extended time passing since the incident occurred	☐

6. Under Part 10 of the *Work Health and Safety Act 2011* (Qld), which of the following types of notices may be issued by a WHS inspector? Select all that apply. ☒ Improvement notices ☐ Non-disturbance notices ☒ Prohibition notices ☐ Time out notice	☐

Outcome for Quiz	☐ Satisfactory ☐ Not satisfactory
Trainer/Assessor comments	

PRACTICAL TASK

You are required to have a suitable observer verify your ability to complete the following tasks. These tasks may be simulated or real.

TASKS		VERIFIED
A.	Work with others to carry out initial responses to a notifiable incident: • Ensure incident site is safe and secured, addressing the immediate needs of those involved • Ensure workplace policies, procedures, processes and systems are followed (e.g. evacuation procedures, providing support, requesting information from those involved) • Ensure WHS regulator is notified	☒
B.	Take a leadership role when consulting with others to develop and document an investigation plan: • Determine scope and purpose of investigation, including timelines • Form an appropriate investigation team and assign responsibilities and roles • Identify and evaluate alternative strategies and resources for investigation process • Obtain necessary resources for investigation • Ensure requirements of WHS legislation and workplace policies, procedures, processes and systems are met by the plan	☒
C.	Work in investigation team to collect information and data: • Inspect incident site, equipment and other evidence (e.g. witnesses) • Extract mathematical information, as required • Gather information and data in ways that ensure objectivity, confidentiality, validity and accuracy • Electronically document outcome of inspection	☒
D.	Work with others to analyse information and data: • Construct a timeline of events leading up to the incident • Analyse numerical data, key events, conditions and/or circumstances • Demonstrate and open-minded and objective approach • Analyse policies, procedures, processes and systems in place at the time of the incident • Focus on the 'how', 'what' and 'why' of the incident, using models of causation and occurrence rather than focussing on individual behaviour or fault	☒
E.	Consult with others to determine prevention measures: • Develop and detail actions, interventions and practical measures to address root causes and prevent the reoccurrence of the incident • Identify how solutions will be measured and evaluated to determine effectiveness	☒
F.	Prepare and verbally present an electronic investigation report to relevant parties (e.g. PCBU, Trainer/Assessor): • Identify the events leading up to the incident, immediate and underlying causes and points at which the incident could have been prevented • Explain recommendations arising from the investigation • Cite evidence and basis for conclusions and recommendations • Develop appropriate report for audience and use objective language	☒

Name of observer	Norezam Abdul Manan
Role of observer (Confirm their suitability to sign)	☐ Trainer/Assessor ☒ Other (specify): HSE Executive
Phone number of observer	+60126477089
Email address of observer	Norezam.amanan@rapid-ipmt.com
Signature of observer	
Date	12/02/2018
Comments	All tasks are successfully completed.

Outcome for Practical Task	☐ Satisfactory ☐ Not satisfactory
Trainer/Assessor comments	