
 GOVERNMENT OF DUBAI	Organization Unit:	Public Health & Safety Department	الوحدة التنظيمية:	 بلدية دبي DUBAI MUNICIPALITY
	Form sheet title:	Technical Guideline for Accident Investigation and Reporting	اسم النموذج:	
	Doc Ref.	DM-PH&SD-P7-A-TG <u>xx</u>	رقم النموذج:	

TECHNICAL GUIDELINE FOR ACCIDENT INVESTIGATION AND REPORTING

I. INTRODUCTION

This document establishes the procedure and guidelines for the proper understanding and implementation of accident investigation and reporting within the Emirate of Dubai.

II. OBJECTIVES

The primary objectives of this Technical Guideline are the following:

- Establish the common definition of the terms used in accident related cases - from investigation to reporting;
- Establish a uniform reporting format for workers exposure, accident reporting and investigation in the Emirate of Dubai to be used by all premises
- Ensure that all work related accidents and injuries shall be investigated and reported.
- Ensure compliance of reporting for any occupational and work related injuries, accidents and ill- health within the Emirate of Dubai

III. SCOPE



This Technical Guideline shall be applicable for all types of **Occupational** and **Work Related Accidents** and **Illnesses** in the workplaces in the Emirate of Dubai – including but not limited to *government and private offices, construction and project sites, hotels and recreation facilities, commercial establishments.*

IV. DEFINITION OF TERMS

Accident An event that cause harm, illness or injury or damage to the property or fatality.

Near Miss An event that could/had the potential to cause harm, illness or injury or damage to the property or fatality.



Occupational Illness A condition that results from exposure in a workplace to a physical, chemical or biological agent to the extent that the normal physiological mechanisms are affected and the health of the worker is impaired thereby and includes an industrial disease. (Art. 37-9,

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Victim/s	<i>Local Order 61-91)</i> Party/ies directly involved in an incident
Witness/es	Party/ies at the receiving end of the accident Party/ies who saw the actual event that led to an incident and/or accident
Corrective Action	Action to eliminate the cause of a detected incident and/or accident
Preventive Action	Action to eliminate the cause of a potential incident and/or accident
Time Lost	The code of practice defines loss of working time as " lost days counted from and including the day following the day of the accident, measured in calendar days, weekdays, work shifts or working days ". Calendar days are preferable as a measure of accident severity, while working days are preferable as a measure of economic impact.

V. ROLES AND RESPONSIBILITIES



Factory /Department Committee	<ul style="list-style-type: none"> Reviews corrective and preventive action plans and its effectiveness
Investigation Team	<ul style="list-style-type: none"> Investigates the incident or accident and identify all possible causes using the Basic Causes and Symptoms Guide. Recommends corrective and preventive action plans
Safety Officer/Safety Representative.	<ul style="list-style-type: none"> Helps coordinate investigation of incidents and accidents Records incidents and accidents Validates the Incident/Accident Report whenever necessary Communicates incidents, accidents and decisions on corrective and preventive actions Evaluates the effectiveness of corrective and preventive actions Reports the accident record summary to Department of Public Health and Safety (Occupational Health and Safety Section) using the attached forms
Line Managers/ Section Heads/ Direct Superiors	<ul style="list-style-type: none"> Form and lead an Investigation Team Prepare the preliminary incident/accident report and submit it to the Safety Officer or Safety Contact Person. Implement initial corrective action to contain the extent or damage, injuries or non-conformities
Victim/s and/or Witness/es	<ul style="list-style-type: none"> Report incidents or accidents to immediate supervisor

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VI. INVESTIGATION AND REPORTING PROCEDURE

- 1.0 Witness/es or the victim (if he is able) to immediately report the incident or accident to Immediate Supervisor.
- 2.0 Immediate Supervisor to mitigate the hazard or hazardous event that led to the incident or accident.
- 3.0 Immediate Supervisor to investigate the incident or accident
 - 3.1 Form and lead an Investigation Team, composed of the victim, if available, witness, and Safety Officer or Coordinator
 - 3.2 Invite other party/ies, whenever necessary, to help identify possible causes of the incident or accident
 - 3.3 Identify all possible causes using the Basic Causes & Symptoms Guide
 - 3.4 If the victim is not available, proceed with the investigation and validate the result of the investigation with the victim at the appropriate time
 - 3.5 Recommend corrective and preventive action plans
- 4.0 Prepare the report using the Incident/Accident Report Form in Annex 1 ,and submit it through the E-service of the Dubai Municipality.
- 5.0 Secure concurrence of the report from the members of the Investigation Team
- 6.0 Sign the Incident/Accident Report
- 7.0 Submit Incident/Accident Report to the management within:
 - 7.1 **24 hours** after a fatal or lost time accident.
 - 7.2 **48 hours** after a first aid or near miss-miss accident.
 - 7.3 Two copies to be retained by the factory, department section concerned
 - 7.4 One copy to be provided to the Site Safety Officer
 - 7.5 **For FATALITY or multiple injury cases, a copy shall be submitted within 24 hours to Dubai Municipality – Occupational Health and Safety Section.**

***Failure to submit, the company may be subjected to strict prosecution..*
- 8.0 Validate the Incident/Accident Report whenever necessary
 - 8.1 Advise the Factory Manager or the Department Head
 - 8.2 Convene the Safety Committee
 - 8.3 Call the victim to narrate the event/s that led to the incident or accident
 - 8.4 Validate the victim's learning
 - 8.5 Validate the corrective and preventive action plan/s
 - 8.6 Advise the Investigation Team on the most appropriate action plans to take
- 9.0 Update Incident/Accident Report and close when all action plans are completed and complied

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10.0 Update the relevant government agency (DM – Department of Public Health and Safety – Occupational Health and Safety Section) using the prescribed report format.

VII. HANDLING OF LOST TIME ACCIDENTS

- Only the Company Physician (or retained medical consultants) or his representative can decide when an injury requires the employee to take a leave.
- The Company Physician should coordinate with the immediate Supervisor before granting a leave.
- If an accident leave is necessary (unless hospitalized) the Company Physician shall initially grant a one day leave and require the employee to report to the clinic the following day for further examination.
- Should further leave be required, the Company Physician should coordinate with the Department Head of the employee on his granting the number of days as factory accident leave.
- The employee is only allowed to return to work when a **“Fit to Work notice”** is issued by the Company Physician.

VIII. BASIC CAUSES AND SYMPTOMS GUIDE



Lack of Knowledge <ul style="list-style-type: none"> ▪ Employee not qualified to perform task ▪ Safe method not known or understood ▪ Improper use of equipment ▪ Inadequate equipment for the task ▪ Employee not properly trained to perform the task 	Employee Placement Issue <ul style="list-style-type: none"> ▪ Physical overexertion ▪ Task exceeded medical restrictions ▪ Recurrence of a previous illness ▪ Not physically fit or able to continuously perform the task
Unsafe Method <ul style="list-style-type: none"> ▪ No established procedure ▪ Existing procedure did not recognize the hazard 	Not Enforcing Safe Practices <ul style="list-style-type: none"> ▪ Inconsistent enforcement of safe practices ▪ Similar unsafe/wrong behavior not confronted ▪ Written practices and/or procedures not followed (using short cuts)
Inappropriate Design/Substandard Construction <ul style="list-style-type: none"> ▪ Unsafe or wrong design/construction ▪ Inadequate guarding ▪ Difficult to perform the task safely ▪ Exposed pinch point or other hazards 	Inadequate Personal Protective Equipment <ul style="list-style-type: none"> ▪ Necessary safety equipment not available ▪ Inadequate protection for task performed ▪ Inadequate eye protection ▪ Inadequate respiratory protection ▪ others
Inadequate Inspection and Maintenance Program <ul style="list-style-type: none"> ▪ Defective tools and equipment 	Inadequate Feedback System <ul style="list-style-type: none"> ▪ Safe behavior is "punishing" while unsafe behavior is "rewarding"

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<ul style="list-style-type: none"> ▪ Inoperative safety device ▪ Inadequate/wrong chemical labelling ▪ Hazard created by normal wear and tear ▪ Equipment / device used needed repair ▪ Equipment / device failed during use 	<ul style="list-style-type: none"> ▪ Task completion is emphasized over safe completion ▪ Inadequate feedback given on similar unacceptable behavior ▪ Production or other factors implied over safe performance
Inadequate / Inferior Equipment <ul style="list-style-type: none"> ▪ Required safety features and interlocks not provided ▪ Frequent maintenance required ▪ Complicated and not user-friendly operation 	Others <ul style="list-style-type: none"> ▪ Performance Error (similar accident) ▪ Absent-mindedness ▪ Gross Negligence ▪ Deliberate Action, etc.



XI. ATTACHMENTS

- *Attachment 1 - Incident/Accident Report Form*
- *Attachment 2 – Employers' Accident / Illness Report*

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Attachment No. 1

INCIDENT / INJURY REPORT FORM				
PART 1 GENERAL INFORMATION				
Name of Establishment (Dept./Section):				
Type/Nature of Business:				
Location:		License No.		
Email Add.		Tel. No./Fax No.		
Contact Person:		Mobile No.		
Designation:		Number of Employees:		
PART 2 INCIDENT INFORMATION				
Date/time of the Incident: _____		Place of the Incident: _____		
Where did the incident happened: <ul style="list-style-type: none"> <input type="checkbox"/> within the workplace <input type="checkbox"/> in the field work <input type="checkbox"/> during official business <input type="checkbox"/> during official travel 		Please describe the specific location of where the incident happened and whether he is working alone or with other workers.		
PART 3 INJURED EMPLOYEE DATA				
Name of Injured Person:		Employee. No.	Age:	Sex:
Date of Birth:				
Position:	Nationality:	Length of Service:	Duty/Time:	
PART 4 DETAILS OF THE INJURY				
What was the injury?				
What part of the body was injured?				
Was the injury (tick one box that applies) <ul style="list-style-type: none"> <input type="checkbox"/> Single <input type="checkbox"/> Multiple _____ (how many) <input type="checkbox"/> a fatality? <input type="checkbox"/> a major injury or condition? <input type="checkbox"/> an injury which require more than 3 days off from work <input type="checkbox"/> an injury which require out-patient hospital treatment (or less than 24 hours) <input type="checkbox"/> a first aid case <input type="checkbox"/> a near-miss accident 		Is there damaged to the machinery or equipment? <ul style="list-style-type: none"> <input type="checkbox"/> Damaged Machinery/Equipment: _____ _____ <input type="checkbox"/> Vehicle (Company-owned / Personal): _____ Please give additional details such as Plate No. and/or if there are other vehicles involved in the accident. _____ _____ 		
PART 5 DETAILS OF THE ACCIDENT (Please tick the box that best describes what happened and go to part 6)				
<ul style="list-style-type: none"> <input type="checkbox"/> Contact with moving machinery or material being machined <input type="checkbox"/> Hit by a moving, flying or falling object <input type="checkbox"/> Hit by a moving vehicle <input type="checkbox"/> Hit something fixed or stationary <input type="checkbox"/> Injured while handling, lifting or carrying <input type="checkbox"/> Slipped, tripped or fell on the same level <input type="checkbox"/> Fall from a height _____ meters <input type="checkbox"/> Trapped by something collapsing <input type="checkbox"/> Drowned or asphyxiated 		<ul style="list-style-type: none"> <input type="checkbox"/> Exposed to or in contact with chemical or harmful substances <input type="checkbox"/> Exposed to fire <input type="checkbox"/> Exposed to an explosion <input type="checkbox"/> Contact with electricity or an electrical discharge <input type="checkbox"/> Injured by an animal <input type="checkbox"/> Physically assaulted by a person <input type="checkbox"/> Road and/or traffic related accident <input type="checkbox"/> Other kind of accident (describe it in part 6) 		
PART 6 DESCRIPTION OF THE ACCIDENT - Please give as much details as you can such as: the event that led to				

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the accident, the name & type of machineries or equipment involved, name of the substance involved, contributing factor made by people that led to the accident, etc. Use separate paper and add sketch, photographs or other details if necessary.

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Name/Signature of Supervisor:

Name/Signature of Witness/es:

PART 7 ROOT CAUSE/S IDENTIFICATION (What are the main reasons leading to the incident?)

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PART 8 CORRECTIVE & PREVENTIVE MEASURES (What are the corrective actions and preventive measures to prevent similar incident)

Root Cause/s	Action Plan/s	Who	When



Name & Signature of Immediate Superior:

Date:

Name & Signature of Safety Officer:

Date:

Note: Please submit a filled-out copy of this form to Occupational Health & Safety Section (Department of Public Health & Safety) through the E-service and if you need any help please call 800900 or contact the following numbers: [04-606-6063](tel:04-606-6063) or to [046066890](tel:046066890) for all accidents/incidents which require the presence and investigation of Dubai Municipality, Dubai Police, Dubai Civil Defense and/or other relevant Government Office.

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Attachment No. 2

WORK ACCIDENT & ILLNESS EXPOSURE DATA REPORT

1. Name of Establishment:					
2. Type/Nature of Business:					
3. Location:				4. License No.	
5. Email Add.			6. Tel. No.		7. Fax No.
8. Contact Person:			9. Designation:		
10. Mobile No.			11. Number of Employees:		
EXPOSURE DATA January to December _____					
Number of Employees: _____			Total Hours Worked (by all Employees during the year) _____		
INJURY SUMMARY	1 st Quarter	2 nd Quarter	3 rd Quarter	4 th Quarter	Year to Date
Total Reported Incidents					
Total Reported Fatalities					
Total Reported and recorded Disabling Injuries					
Total Reported Lost Time Injuries					
Total Reported Near Misses					
Total Reported and recorded Illnesses					
Frequency of Accidents					
Severity of Accidents					

Note: General Manager and Safety Officer

1. This report shall be accomplished whether or not there were accident/illness occurrences during the period covered and to be submitted to Dubai Municipality - Occupational Health and Safety Section (Department of Public Health and Safety) Fax No. 04-703-3595 not later than 30th day of the month following the end of each calendar year.

2. **Frequency Rate** is the total number of disabling injuries per million-employee hours of exposure.

$$\text{Frequency Rate} = \frac{\text{Total number of disabling injuries} \times 1,000,000}{\text{Employee-hours of Exposure}}$$



3. **Severity Rate** is the total number of days lost or charged per million-employee hours of exposure.

$$\text{Severity Rate} = \frac{\text{Total number of days lost or charged} \times 1,000,000}{\text{Employee-hours of Exposure}}$$

4. **Exposure** is the total number of hours worked by all employees in each establishment including employees of operating production, maintenance, transportation, electrical, administrative, sales and other departments.

5. **Disabling injuries** - work injuries, which result in death, permanent total disability, permanent partial disability or temporary total disability.

6. **Non-disabling injuries** (Medical Treatment) - injuries which do not result into disabling injuries but required first aid or medical attention of any kind.

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Further information is available from:

Occupational Health and Safety Section
 Public Health and Safety Department
 Dubai Municipality
 Tel: 046066890/046066063 Fax: 2270160