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INCIDENT MANAGEMENT IN OCCUPATIONAL HEALTH AND SAFETY	1.0	11/07/2023

Linked to the Occupational Health and Safety Policy of Eletrobras Companies

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1 INTRODUCTION

1.1 INTRODUCTION

Eletrobras, a leading company in electricity generation and transmission in Brazil, committed to promoting the occupational health and safety at work of its employees and based on principles of excellence, social responsibility and best practices in people management and sustainability, establishes Occupational Safety and Health (OHS) as primary, inseparable and excellent values in all its processes, activities and services.

Many of the accidents that occur in work environments can be easily avoided by adopting preventive actions, which depend mainly on the engagement and commitment of all parties.

1.2 OBJECTIVE

To establish guidelines for the classification, recording, investigation and analysis, documentation, incident communication, sharing of lessons learned, as well as monitoring actions to control risks and avoid the repetition of similar occurrences or those of the same type as the identified causes.

1.3 SCOPE

The criteria and methodologies for classification, registration, investigation and analysis, documentation, incident communication and sharing of lessons learned described in this standard and in the documents that comprise it must be implemented at Eletrobras and observed by its employees, including service providers.

This applies to typical accident events, commuting accidents, occupational illnesses, near-accidents and critical deviations.

2 REFERENCES

- 2.1 Law No. 8,213/91 – sets out the Social Security Benefit Plans and other provisions.
- 2.2 NBR 14280 – Occupational accident registration – Procedure and classification.
- 2.3 Occupational Health and Safety Policy of Eletrobras Companies.
- 2.4 Standard Commitments for Life in Occupational Health and Safety

3 CONCEPT

3.1 ACRONYMS

- 3.1.1 **CAT** – Work Accident Report
- 3.1.2 **CIPA** – Internal Accident Prevention Commission
- 3.1.3 **DDS** – Daily Safety Dialogue
- 3.1.4 **SESMT** – Specialized Services in Work Health and Safety

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3.1.5 OHS – Occupational Health and Safety

3.2 CONCEPTS AND DEFINITIONS

3.2.1 Accident – unforeseen and undesirable event, instantaneous or not, that resulted in bodily injury (work safety) or damage to health (occupational health).

3.2.2 Accident with lost time – accident that causes bodily injury (work safety) or damage to the health (occupational health) of the worker that prevents the worker from returning to work on the day following the event, even if this subsequent day is not a working day – weekends, holidays and other days when the worker would not normally be working.

3.2.3 Serious accident – accident that caused injury or serious bodily harm or organic disturbance that requires hospitalization or that leads to the risk of death or major functional impairment.

3.2.4 Failure Root Cause Analysis – systematized and disciplined methodology for determining the contributing causes and basic physical, human and systemic causes that led to the incident.

3.2.5 Cause – factor or circumstance that contributed to the occurrence of the event (in cases of accidents and near-accidents) or the action or condition (in cases of deviations).

3.2.6 Basic causes – the basic or fundamental cause(s) that allow an incident to occur, usually found at a physical, human and systemic level. Basic causes are those that, if eliminated, would prevent the event from occurring. Also known as root causes.

3.2.7 Contributing causes – the causes that, by themselves, would not have caused the event, but are associated with the other basic causes that resulted in the incident.

3.2.8 Employee – for the purposes of this standard, it is equivalent to the term “worker”, described in the ISO 45001 standard – person who carries out work or work-related activities that are under the control of Eletrobras.

Note 1: Persons performing work or work-related activities, according to various procedures, whether paid or unpaid, such as on a regular or temporary basis, intermittently or seasonally, casually or part-time.

Note 2: Employees include Senior Management, people at managerial and non-managerial levels.

Note 3: Work or work-related activities performed under the control of the organization may be performed by employees employed by the organization, employees of external suppliers, contractors, individuals, agency staff and other persons, to the extent that the organization shares control of their work or work-related activities, in accordance with the context of the organization.

3.2.9 Deviation – any action or condition that has the potential to lead, directly or indirectly, to bodily injury or damage to the health of people, which disregards work standards, procedures, legal or regulatory requirements, management system requirements or good practices.

3.2.10 Critical deviation – deviation with the potential to result in a serious accident (high potential).

3.2.11 Occupational health deviation – any evidence, occurrence or personal condition that, related to the environment and/or working conditions, may lead to damage to physical and/or mental integrity.

3.2.12 Systemic deviation – set of equivalent or similar deviations, which occur repetitively and frequently (recurrent), with causes also residing at a systemic level.

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3.2.13 Eletrobras – Involves the holding company, its wholly-owned subsidiaries (Eletrobras Furnas, Chesf, CGT Eletrosul, Eletronorte and Eletropar) and companies over which it has direct and indirect corporate control.

3.2.14 Event – undesirable incident or situation that occurs in a specific location during a specific time interval. The event involves the release of energy or exposure to danger/risk.

3.2.15 Impact (effect/consequence of the dangerous condition) – result of an event or situation expressed qualitatively or quantitatively, which implies injury or damage to the person.

3.2.16 Permanent incapacity – result of assessment of physical and/or mental health status in which the worker is considered incapable of rehabilitation to carry out work activities.

3.2.17 Incident – unforeseen and undesirable event that resulted, or had the potential to result, in injury or harm to a person. The term “incident”, for the purposes of this standard, encompasses:

- a) accident: event that resulted in injury or damage to health;
- b) near-accident: event with the potential to result in injury or damage to health; and
- c) critical deviation: deviation with the potential to cause a serious accident (“high” and “very high” loss potential).

3.2.18 Systemic incident – set of the same or similar incidents that occur repetitively and frequently (recurrently), with causes also residing at a systemic level.

3.2.19 Incident investigation and analysis – process consisting of:

- a) investigation – act of seeking information and general data about the event, in order to enable the reconstruction of the facts that led to the incident (accident, near-accident, or critical deviation); and
- b) analysis – act of searching for the root causes of the incident (accident, near miss, or critical deviation) that is under investigation.

3.2.20 Non-conformity – anomaly characterized by failure to meet a requirement defined in standards, procedures, legislation, policies, internal documents, among others.

3.2.21 Loss – effect/consequence of an accident.

3.2.22 First aid (case) – refers to medical care at the site of the injury, usually administered immediately after the injury occurs. First aid often consists of a one-time, short-term care measure that requires little technology or training to administer. This includes minor cleaning, scraping, treatment of minor/superficial burns, application of bandages, use of drugs that do not require a prescription, etc. (as defined by the Occupational Safety and Health Administration – OSHA).

3.2.23 Probability – description of possibility or frequency, in relation to the chance that something will occur. The probability considers how likely the incident would be to result in injury or damage to the health of people.

3.2.24 Medical treatment (case) – occupational injury or illness that requires medical treatment, but which does not prevent the employee from working normally on the following shift;

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accident that requires medical monitoring more than once and/or the administration of medication, which does not cause restrictions on the employee's work duties.

4 GUIDELINES

4.1 Incident management

4.1.1 Regardless of the type of analysis used, before starting the investigation stage, it is essential to use knowledge management techniques. In this context, the use of brainstorming to solve problems is recommended, especially if:

- a) the causes of the problem are difficult to identify; and
- b) the direction to be followed or options for resolving the problem are not apparent.

4.1.2 The following brainstorming steps must be followed:

STAGE	METHOD	CONDUCTION
1 – Introduction	Start the session by clarifying the objectives, incident or problem to be discussed.	Check that everyone understands the incident. Go over the incident description again, if necessary.
2 – Generation of ideas	Give participants time to think about the problem. Then, ask each participant for ideas, recording them afterwards.	Record everything the way it was said, including as many details as possible and populating the timeline.
3 – List review	Answer questions among the investigation committee.	Clarify points of divergence.
4 – Selection analysis	Filter the ideas and discuss those with the most relevance with the committee.	Group common points.
5 – Ordering of ideas	Prioritize ideas according to relevance.	Mediate any conflicts (committee leader).

4.2 Incident classification

4.2.1 The incident classification must be carried out using the potentiality matrix according to the Communication Flow and Incident Classification (appendix III).

4.2.2 Incidents classified as having low and medium risk potential must be analyzed according to the Failure Root Cause of Analysis Methodology (ACRF) (appendix V); for high potential incidents, the analysis methodology must be carried out according to the Action + Condition Methodology (appendix IV).

4.3 Incident Investigation and Analysis Committee

4.3.1 The leader responsible for investigation and analysis must designate a coordinator and, along with them, appoint the Investigation and Analysis Committee based on the incident classification, according to the *Communication and Classification Flow of the Incident (Occurrence)* (appendix III).

4.3.2 The leader and coordinator in charge must be people from the area where the incident occurs.

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The appointment of the members who will make up the committee must be carried out immediately after the occurrence.

4.3.3 The committee must prioritize the incident analysis process and consolidate the report within a maximum period of five working days. This period may be extended when the investigation depends on an analysis, evaluation or information that cannot be obtained within the above period. In this case, the issuance of interim reports is recommended.

4.3.4 According to the organizational structure and human resources, the committee may have a larger composition than the one recommended in the table in subitem 4.3.5.

4.3.4.1 Other participants (experts) may be appointed and invited, at the discretion of the committee leader and/or coordinator.

4.3.5 The definition of the leader and composition of the Investigation and Analysis Committee depends on the classification of the incident, defined in the *Incident (Occurrence) Communication and Classification Flow* (appendix III), and must follow the table:

Position / Role ¹	Incident Classification		
	Low	Medium	High
Officer ²			X
OHS Officer			X
OHS Manager Suppliers ³			X
Executive Manager ²		X	X
Manager ²		X	X
Division Manager ²	X	X	X
Coordinator ⁴	X	X	X
SESMT	X	X	X
CIPA	X	X	X
People involved in the incident ⁵	X	X	X

- Any adjustments can be made with the aim of adapting the position/function to the company's organizational structure.
- Leader of the Incident Investigation and Analysis Committee.
- Call to participate in the investigation of incidents with high potential for injury occurring with suppliers.
- Coordinator appointed by the leader of the Investigation and Analysis Committee.
- If the incident occurred with third parties, the participation of the administrative and technical supervisor of the contract is mandatory, in addition to the supplier's representative, if applicable;

4.3.6 For incidents with a high potential for fatalities, an external expert specializing in the subject must be hired to be part of the committee.

4.4 Initial report and communication flow

4.4.1 Immediately after ensuring that the remaining risks of the event are controlled, as detailed in Initial Measures (appendix I), the initial communication of the event must be sent.

4.4.2 Initial description of the incident

4.4.2.1 Immediately after an incident has been controlled, a statement must be issued, in accordance with the *Incident (Occurrence) Communication Model* (appendix II).

4.4.2.2 The description of the occurrence must be restricted to the fact that occurred, based on existing objective evidence; no inferences or speculations should be made about the causes, which should only be identified at the analysis stage, using an appropriate method.

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4.4.2.3 The initial description must follow the following structure: context + fact + consequence
+ photos, including:

- a) context: describe the activity, situation or condition that precedes the fact;
- b) fact: description of what happened;
- c) consequence: result, effect or damage caused by what happened; and
- d) photos: photographic record of the incident

4.4.2.4 For instance: while moving from point A to point B, an employee lost control of the vehicle and collided with a tree, suffering injuries.

4.4.2.5 In cases involving accidents with people, information must be included on the measures taken regarding health treatment (referral to hospital, imaging tests etc.)

4.4.3 Incident reporting

4.4.3.1 Reporting must be routed through the hierarchical line, according to the communication flow defined in the *Incident (Occurrence) Classification and Communication Flow* (appendix III) and must ensure:

- a) dissemination: send to all focal points of the units;
- b) registration: register immediately in existing formal communication systems; and
- c) other necessary actions: define actions to be taken, including the formation of an incident investigation and analysis committee.

4.4.3.2 After an accident occurs in a unit, the leaders of the other units, upon receiving the communication, must carry out a comprehensive analysis, that is, assess whether a similar incident may occur in any area under their responsibility and, if so, take the applicable preventive measures.

4.4.3.3 The distribution of this communication must reach the same hierarchical levels exposed in the incident communication flow.

4.4.3.4 Records and communications to official bodies, such as forwarding the Work Accident Report (CAT) to the National Social Security Institute (INSS), among others, must follow the requirements of regulatory and legal standards.

4.4.3.5 Records and communications to company areas: Specialized Services in Safety and Occupational Medicine (SESMT), medical services, social services, people management, legal, institutional relations, etc., must follow the guidelines determined in the company's specific regulatory documents.

4.4.3.6 The incident report must follow the standard established in this rule, according to the *Final Incident Report* (appendix VII). The results of the investigation and analysis must be attached to the *Final Incident Report*, including the methodologies used, determined according to the potential and the validated and approved action plan (as established in subitem 4.5.4 of this standard).

4.5 Incident analysis

4.5.1 Survey and data collection

4.5.1.1 The Investigation and Analysis Committee must be assured complete freedom to survey and collect all data, facts and information necessary to carry out its duties.

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4.5.1.2 The Investigation and Analysis Committee must document all data, facts and information to facilitate subsequent review of the investigation, analysis and issuance of the report, as necessary.

4.5.1.3 In the case of an accident with serious injury, the medical care provided and the assistance given to the victim's family must be analyzed.

4.5.1.4 Information such as photos, videos, testimonies and interviews, data, operational conditions, planning and analysis of risks/controls for carrying out the activity, etc., must be collected.

4.5.1.5 Survey and data collection must begin immediately after taking all actions to minimize the consequences of the event.

4.5.1.6 All documents mentioned as part of the dossier in the Final Incident Report (appendix VII), which are applicable to the occurrence, must be collected and considered in the analysis.

4.5.2 Event chronology

4.5.2.1 A sequence of collected facts/data must be proposed in order to chronologically describe all the steps that preceded the event, the event itself and the subsequent steps.

4.5.2.2 If there is disagreement between the evidence and the chronology of the event, new and deeper investigations must be carried out until there is coherence between the evidence and the chronology.

4.5.2.3 In the most serious events, it is recommended, when possible, to reconstruct them, with photographic records and/or film, taking into account all the data collected.

4.5.2.4 You should always choose the most appropriate technique for assembling the event chronology, depending on the type of event that occurred. For example: the *Timeline* technique visually represents a chronological sequence of the event.

4.5.3 Identification of the causes of the incident

4.5.3.1 The investigation and analysis process must determine the causes (contributing and basic) of the incident, this determination being essential for the effective development of recommendations to correct and prevent similar or similar occurrences, and also generate understanding and learning.

4.5.3.2 The method to be used for incident analysis must use the following table:

Potential	Method
High	Action + Condition (appendix IV)
Medium and Low	Failure Root Cause Analysis – ACRF (appendix V)

4.5.4 Action Plan

4.5.4.1 For each cause found, one or more corrective, preventive and/or continuous improvement actions must be proposed to avoid the occurrence of similar events or events of the same nature.

4.5.4.2 The search for causes should not be limited to identifying “human errors”, as such causes do not allow actions to be taken to prevent the occurrence of a similar event or

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of the same nature.

4.5.4.3 Actions must be consistent with the causes identified to be assertive and effective in controlling, correcting and preventing the occurrence of a similar event or an event of the same nature that gave rise to the incident.

4.5.4.4 The Action Plan, together with the investigation method adopted, must be an integral part of the final incident report.

4.5.4.5 In order to be implemented, actions must be validated by the Investigation and Analysis Committee and approved by the leader in charge.

4.5.4.6 Proposals for rejected actions must be documented, accompanied by the reasons why they will not be implemented.

4.5.4.7 For accidents involving injuries, a social support plan for the employee must be presented alongside the report, which must contain, at least:

- a) deadline within which the occurrence was communicated to the family (the communication should take place immediately after confirmation of the occurrence);
- b) which family member was contacted (contact information, such as address and telephone number, and degree of kinship);
- c) who was the company's interlocutor (his/her position/role);
- d) what benefits are provided by the company to the injured person and their family members (degrees of kinship); and
- e) for how long (e.g.: psychological support, extension of the health plan, funeral assistance, etc., proof of payment of any funeral expenses and evidence of provision of psychological support).

4.5.4.8 In the event of the employee's death, counseling and information related to termination of the employment contract, life insurance and private pension must be provided within 48 hours after the death, with the priority being to make family members feel welcome.

4.5.5 Documentation of results

4.5.5.1 The results of the investigation and analysis, including the "Why" tree/determined causes and the validated and approved action plan, must be documented and attached to the *Final Incident Report* (appendix VII).

4.5.5.2 Documentation of approved corrective and preventive actions can be done in computerized systems to monitor recommendations and must allow their traceability in relation to the event (accident, near-accident or critical deviation) that gave rise to them.

4.6 Disclosure of results and final incident report

4.6.1 The results of the final incident report must be presented and discussed in the occupational health and safety management committee or forum of the operational unit where the event occurred.

4.6.2 The results must also be presented and discussed with the workforce at the location where the incident occurred, through a DDS, safety meeting, or similar activity.

4.6.3 The results of the Final Incident Report must be shared with other branches and areas of the company.

4.6.4 The results of the final incident report, classified as "high" potential, must be presented and discussed in corporate committees or corporate governance meetings.

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4.6.4 Occupational Health and Safety Alert

4.6.4.1 In cases of serious incidents, classified as “high” potential, or in cases in which the investigation leads to relevant facts (lessons) that can help other units avoid similar occurrences, the leader responsible for the investigation and analysis, with support from the SESMT, must prepare the Occupational Health and Safety Alert, according to the *Alert Card* (appendix VI), and forward it to the holding's occupational health and safety area for dissemination.

4.6.4.2 SESMT is responsible for storing all safety alerts issued by the units, and also for distributing each health and safety alert to the units. Each area/unit must ensure that alerts reach all of managements.

4.6.4.3 The Occupational Health and Safety Alert must not identify the place where the event occurred or the people involved. The fundamental information for the alert to fulfill its objective is: what happened, why it happened, how to avoid it and photographic records.

4.6.4.4 Health and safety alerts must be disseminated to contracted service providers, preventing similar events or events of the same nature from occurring. This disclosure must be made by the respective contract managers, with prior authorization from the unit manager.

4.7 Control and critical analysis of incidents (actions)

4.7.1 The leader of the unit where the incident occurred, with support from SESMT, must lead a monthly critical analysis meeting to monitor the status and verify the effectiveness of the corrective and preventive actions implemented.

4.7.2 The unit leader must define a team and flow to analyze the effectiveness of the implemented actions, taking into account the following items:

- a) comparison of results obtained after implementing the actions;
- b) checking for side effects, such as whether new risks have been added; It is
- c) repetition of the problem (for corrective actions).

4.7.3 If the actions are considered effective, the verification process must be concluded.

5 RESPONSIBILITIES

5.1 President and vice-presidents

5.1.1 Lead and participate in governance meetings, sponsoring and promoting the application of the incident management process within the company.

5.2 Officers

5.2.1 Lead and participate in governance meetings, sponsoring and promoting the application of the incident management process within the company.

5.2.2 Lead the investigation and analysis of incidents, in the case of an accident classified as high potential and designate the coordinator for the Investigation and Analysis Committee.

5.2.3 Ensure compliance and application of this standard.

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5.2.4 Ensure an environment of transparency and freedom for recording, communicating and investigating and analyzing incidents.

5.2.5 Provide human, financial and technological resources necessary to implement corrective and preventive actions resulting from the investigation and analysis of incidents occurring in its area of responsibility.

5.2.6 Approve the investigation and incident analysis report in cases of accidents classified as high potential.

5.3 Managers

5.3.1 Lead the investigation and analysis of incidents, according to the accident potential classification.

5.3.2 Communicate and report the occurrence of incidents, as defined in the communication flow.

5.3.3 Ensure compliance and application of this standard.

5.3.4 Ensure an environment of transparency and freedom for recording, communicating and investigating and analyzing incidents.

5.3.5 Provide the human, financial and technological resources necessary to implement corrective and preventive actions resulting from the investigation and analysis of incidents occurring in their area of responsibility.

5.3.6 Approve the incident investigation and analysis report according to the accident potential classification.

5.4 Work health and safety areas

5.4.1 Communicate to leaders about incidents occurring in the unit, according to the *Incident (Occurrence) Communication and Classification Flow* (appendix III).

5.4.2 Validate the classification of incidents, when they involve injuries and/or damage to people (accidents).

5.4.3 Issue the CAT to company employees for occurrences characterized as workplace accidents and, in the case of service providers, monitor its issuance.

5.4.4 Validate, together with the unit where the incident occurred, the classification of the accident potential.

5.4.5 Train unit leaders in the incident investigation and analysis process.

5.4.6 Technically support and participate in the investigation process and analysis of the occurrence of all safety incidents – accidents, near-accidents and critical deviations – and monitor the investigative process.

5.4.7 Validate the Final Investigation and Occurrence Analysis Report of all safety and health incidents – accident, near-accident and critical deviation.

5.4.8 Monitor the quality of classification, investigation and analysis processes and incident records.

5.4.9 Monitor the quality of investigations and the effectiveness of proposed correction and prevention actions.

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5.4.10 Monitor and analyze incident trends and propose improvement actions.

5.4.11 Monitor compliance with applicable local legislation related to the processes of classifying and recording incidents with an impact on health and safety.

5.4.12 Monitor compliance with this standard in the company, including service providers in the inspection.

5.4.13 Maintain records and control of all incidents related to work health and safety and issue periodic incident control reports.

5.4.14 Prepare statistics relating to all incidents occurring in the company for control and for use in critical analysis meetings.

5.4.15 Support the issuance of formal initial incident communication, in accordance with the *Incident (Occurrence) Communication and Classification Flow* (appendix III) and deadlines established in this standard.

5.4.16 Disclose the results of the incident investigation and analysis report, as described in subitem 4.6 of this standard.

5.4.17 Participate in the control and critical analysis of incidents, in the evaluation and verification of the effectiveness of corrective and preventive actions.

5.5 Health and well-being areas

5.5.1 Support SESMT in classifying incidents involving injury and/or damage to people.

5.5.2 Monitor the development of the situation of incident victims.

5.5.3 Carry out social support for employees involved in an injury accident and their family members, including preparing a social support plan.

5.6 Internal Accident Prevention Commission (CIPA)

5.6.1 Participate in the investigation and analysis process of all occupational health and safety incidents occurring in the unit.

5.6.2 Participate in the control and critical analysis of incidents, in the evaluation and verification of the effectiveness of corrective and preventive actions.

5.7 Employees and contract managers/inspectors of service provider companies

5.7.1 Immediately inform their immediate superior and SESMT of all incidents, regardless of classification.

5.7.2 Make themselves available for clarification when they are involved in incidents and/or have suffered consequences from this event, regardless of classification.

6 GENERAL PROVISIONS

6.1 The legislation related to the topic and the specific legal provisions and agreements in force at the company must be observed.

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6.2 Situations not foreseen in this standard must be analyzed by the areas involved, being justified through a technical note. The conclusions must be ratified by the head of the senior management executive body to which the area is subordinated or, at its discretion, by the Eletrobras Executive Board (DEE), observing the provisions of the current legislation and Eletrobras' Bylaws.

6.3 In order to meet the specificities of each process, this standard can be broken down into specific normative documents, always aligned with the principles and guidelines established here.

6.4 The normative documents and provisions contrary to this rule are hereby revoked.

7 APPENDICES

- Appendix I – Initial Measures
- Appendix II – Incident Communication Model (Occurrence)
- Appendix III – Communication Flow and Incident Classification (Occurrence)
- Appendix IV – Action + Condition Methodology
- Appendix V – Failure Root Cause Analysis Methodology (ACRF)
- Appendix VI – Alert Card
- Appendix VII – Final Incident Report

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APPENDIX I

INITIAL MEASURES (of the management of the area in which the incident occurred)

After ensuring that the remaining risks of the event are managed and controlled, the person responsible for the location where it occurred must:

- Take actions to ensure the minimization of the consequences of the event, such as: assistance to victims, control of sources of danger, evacuation and isolation of areas, etc.
- paralyze the service front where the event occurred to preserve the scene and location with all relevant evidence and information, for as long as the Investigation and Analysis Committee deems necessary.
- make the necessary records and collect data and information for incident analysis.
- in the specific case of fatal accidents, it is mandatory to pay attention to the legal requirements regarding the isolation of the location and the length of time for which the location must be kept isolated/blocked.
- Start collecting data and information immediately after taking all actions to minimize the consequences of the event.
- When applicable, the following additional steps must be followed:
 - surround and isolate the location of the incident, protecting it from bad weather (rain, wind, etc.), if necessary;
 - record the names of those involved and witnesses, in order to be able to locate them later (especially in external accidents);
 - operational units must provide criteria and responsibilities for safely stopping and restarting the operation or activity related to the incident.
 - operations or activities should only be restarted after carrying out a risk assessment and implementing actions indicating that there is no possibility of the incident recurring.
 - in the case of incidents that involve isolating an area or stopping activities or operations, as provided for in legislation or determined by a competent authority, the suspension of isolation or the resumption of activities or operations must only occur after authorization by these authorities.

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APPENDIX II

INCIDENT (OCCURRENCE) REPORT MODEL

OCCURRENCE REPORT: <company name>

SEVERITY (ACTUAL): <low, medium, high>

POTENTIAL (HYPOTHESIS): <low, medium, high>

Occurrence Report:

Basic Data

- Type:
- Leave:
- State:
- City:
- Site:
- Date:
- Time:
- Name:
- Age:
- Company: <holding, Furnas, Chesf, CGT Eletrosul, Eletronorte>
- Employee: <direct hire or contractor>
- Supplier: <if applicable>
- Contact number: <if applicable>
- Technical contract inspector: <if applicable>
- Activity:
- Role:
- Admission date:
- Registration:
- Leader:
- OU:
- Segment:
- Immediate Actions:
- Updates:
- Photographic record:

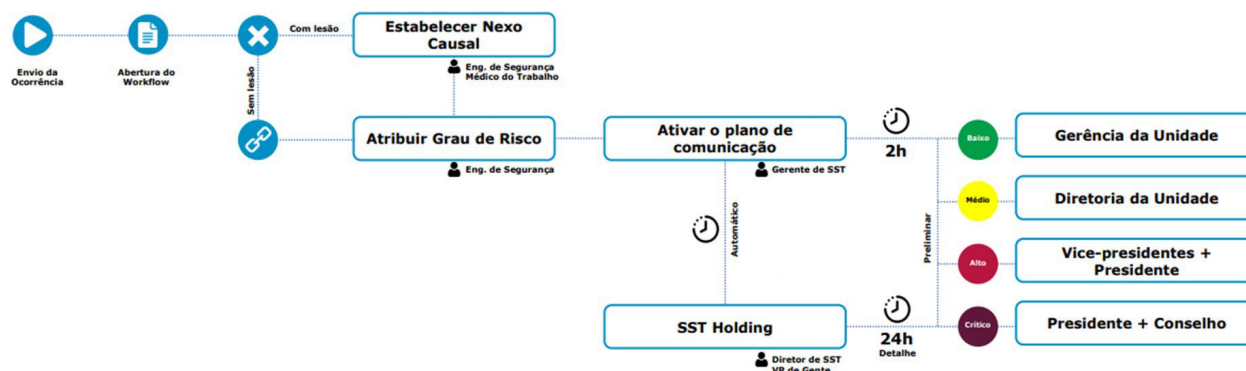
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APPENDIX III

INCIDENT (OCCURRENCE) COMMUNICATION AND CLASSIFICATION FLOW

A) Communication Flow

Incident communications must be forwarded through the company's hierarchical line, following the Communication Flow below:



Submit occurrence

Open the Workflow

- ➔ With injury -> **Establish Causal Nexus [Safety Engineer/Occupational Physician]**
- ➔ Without injury -> **Attribute Risk Level [Safety Engineer]**

Activate communication plan [**SST Manager**]

Automatic -> **SST HOLDING [Director of SST/People VP]**

2h – Preliminary – 24h Detail

Low – Unit Management

Medium – Unit Directors

High – Vice-presidents + President

Critical - President + Board of Directors

Communication channels and deadlines:

Action	Channel	Deadline
Communication of the Occurrence	Whatsapp/ System	2h
Prior Report	e-mail	24h
Investigation Report	e-mail	5 working days
Alert Card	e-mail	5 working days

B) Incident (Occurrence) Classification

The classification must be carried out as follows:

1 Severity Classification:

Use the risk matrix to classify the **severity** (low, medium, high or critical) of the accident that occurred (ACTUAL).

- Assess the probability of the accident occurring;
- then evaluate the impact caused by the accident that occurred; and
- finally, in the risk matrix, classify the **severity** of the accident that occurred (low, medium, high or critical).

2 Classification of Potentiality and Degree of Risk:

Use the risk matrix to classify the **potential** (low, medium, high or critical) and the **degree of risk** (1,2,3...) that the type of accident can cause (**HYPOTHESIS**).

- Assess the probability of that type of accident occurring;
- then assess the impact that type of accident can cause; and
- finally, in the risk matrix, classify the **potential** for that type of accident (low, medium, high or critical) and the respective level of risk (1,2,3...).

Remark: Potentiality will always be greater than or equal to severity.

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4x4 Risk Matrix

Mapa de Riscos						
Probabilidade ^ ^ ^	Muito Provável (A)	Médio 12	Médio 9	Crítico 3	Crítico 1	
	Provável (B)	Médio 13	Médio 10	Alto 5	Crítico 2	
	Possível (C)	Baixo 15	Médio 11	Alto 7	Alto 4	
	Remoto (D)	Baixo 16	Baixo 14	Alto 8	Alto 6	
		Baixo (IV)	Médio (III)	Alto (II)	Crítico (I)	
		Impacto >>>				

Risk Map
 Probability >>>
 Very Likely (A)
 Likely (B)
 Possible (C)
 Remote (D)
 Low (IV)
 Medium (III)
 High (II)
 Critical (I)
 Impact >>>

Probability Table

Probability	Frequency
Very Likely (A)	There are no control measures implemented; occurs frequently or is highly likely to occur; the unwanted event may occur more than once a month.
Likely (B)	Control measures with low efficiency; aggravating conditions favor the occurrence; the unwanted event may occur as often as less than once a month, but more than once a year.
Possible (C)	There are efficient control measures; technically possible for it to occur, but it depends on a 2nd cause for it to occur; the unwanted event may occur as often as once every five years.
Remote (D)	There are highly efficient control measures; the occurrence is remote and depends on several causes to occur; the unwanted event can only occur in exceptional circumstances or is unlikely to occur and is outside management levels.

Impact Table

Impact	Health and safety
Critical (I)	One or multiple fatalities
High (II)	Injuries that generate permanent disability
Medium (III)	Injuries that cause employee leave
Low (IV)	First aid, injuries without employee leave

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APPENDIX IV "ACTION +

CONDITION" METHODOLOGY

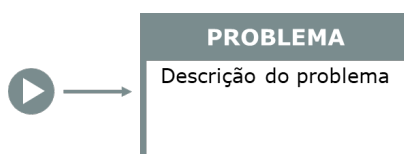
High potential events or fatalities must be handled with the utmost rigor, using methodologies that support the identification of all possible variables for the occurrence of an incident. Their occurrence is often linked to several root causes or a combination of small causes. Therefore, only methodologies that involve the association of actions and direct conditions are acceptable.

The Action + Condition Diagram demonstrates how a problem can be analyzed in its individual causes by asking "why". This is a powerful communication tool that provides a visual "dialogue" of the problem and simplifies complex issues, breaking them down into lines of reasoning that are connected to the problem. This methodology forces participants to abandon inferences and focus on the causes of a problem, which can occur as actions or conditions.

The elaboration of the analysis of an incident using the Action + Condition methodology must begin by defining the problem, which is nothing more than the object of study for which one wishes to avoid recurrence, such as the accident.

Any **problem** can be defined as a difference between the (desired) goal and the current condition, and these must be defined in the context of the organization's overall goals and objectives.

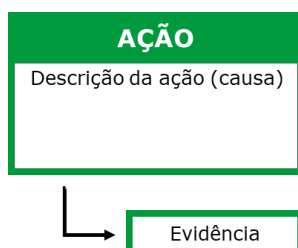
A clear definition of the problem is extremely important for identifying the causes that contributed to the occurrence of the problem, which is why the participation of both the Investigation Committee in this definition and the organization's specialists who have different points of view are extremely important.



PROBLEM

Description of the problem

Action: All causes that derive from human attitude (or failure); anything that requires human movement. The action is represented in the diagram with green color.
Ex: Failing to use PPE, not carrying out risk analysis, not tying down ladders; pulling, pushing, etc.

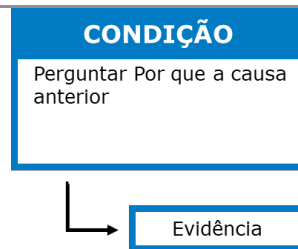


ACTION

Description of the action (cause)
Evidence

Condition: All causes that derive from the work environment. The condition is represented in the diagram with blue color.
Ex.: Lack of procedure, lack of training, poor signaling, powered cords, etc.

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CONDITION

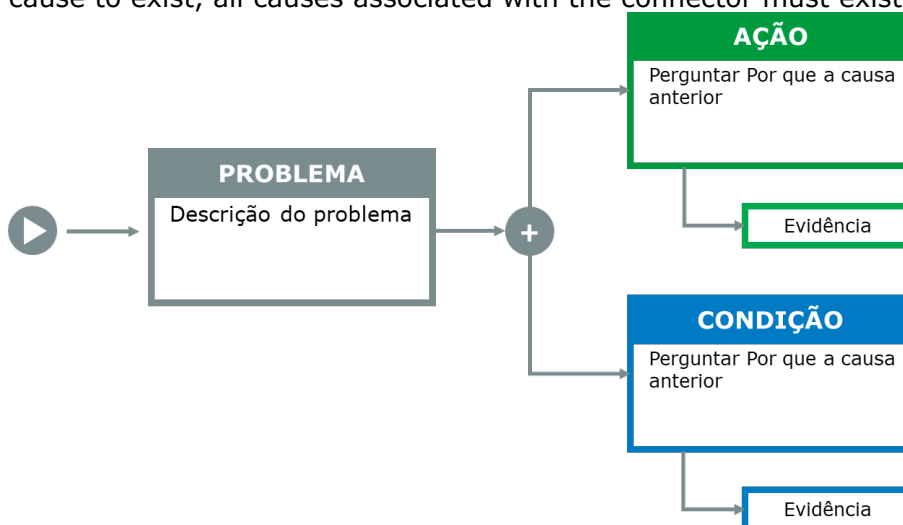
Ask reason for the previous cause

Evidence

When the causes-conditions are not determined, it is often possible to fail to determine creative and effective solutions to the problem.

Typically, there are at least two causes for every effect, an action and one or more conditions. People are very good at identifying causes of action, but they often need help perceiving cause-conditions.

When there are two or more causes for the problem or previous cause, the connector must be used. This represents that the causes are associated and that for the problem or previous cause to exist, all causes associated with the connector must exist.



PROBLEM

Description of the problem

ACTION

Ask reason for the previous cause

Evidence

CONDITION

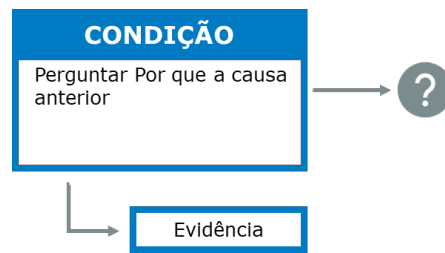
Ask reason for the previous cause

Evidence

The Action + Condition investigation methodology requires that all causes presented be supported with evidence. If no evidence is identified to support a cause, it should be identified with a question mark.

This icon in the diagram is an action item for seeking more information and a warning flag for solutions.

Question marks  in an investigation are valuable as they indicate that there is some missing information.

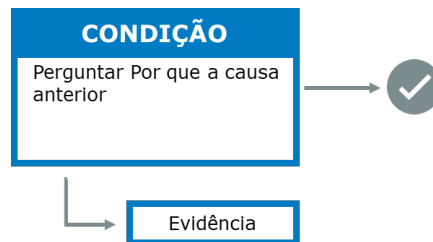


CONDITION

Ask reason for the previous cause

Evidence

The *check* icon  in the investigation diagram is used when the root cause of the problem is identified and there are actions to be taken so that this cause is eliminated or reduced, thus preventing the problem from recurring.



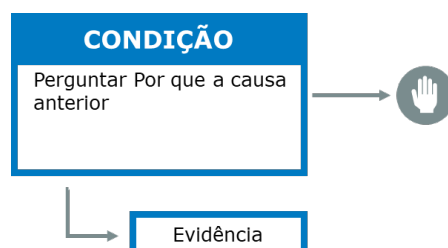
CONDITION

Ask reason for the previous cause

Evidence

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The hand icon  in the investigation diagram is used to signal that although the root cause of the problem has been identified, there are no possible actions to be taken to eliminate or reduce the cause.

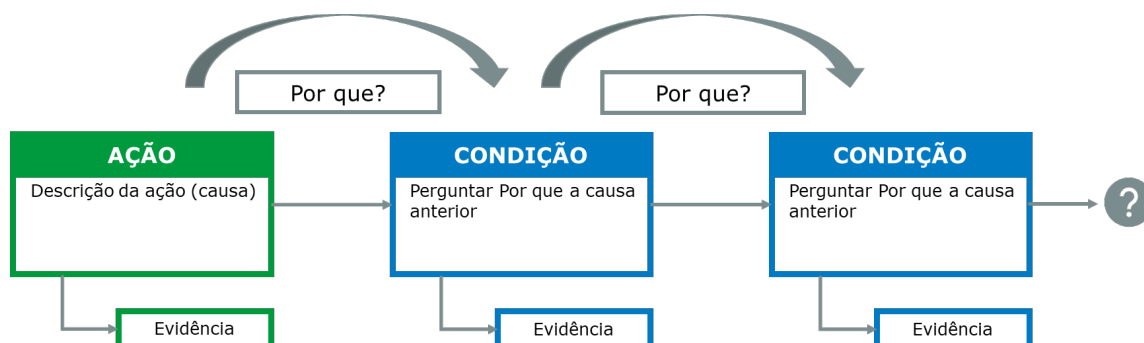


CONDITION

Ask reason for the previous cause

Evidence

Starting from the problem, one must ask "Why?" the problem happened, and, based on the answer, keep asking until it is no longer possible to answer or until there is not enough evidence for the hypotheses raised to be understood as fact.



Action

Description of the action (cause)

Evidence

Why?

Condition

Ask reason for the previous cause

Evidence

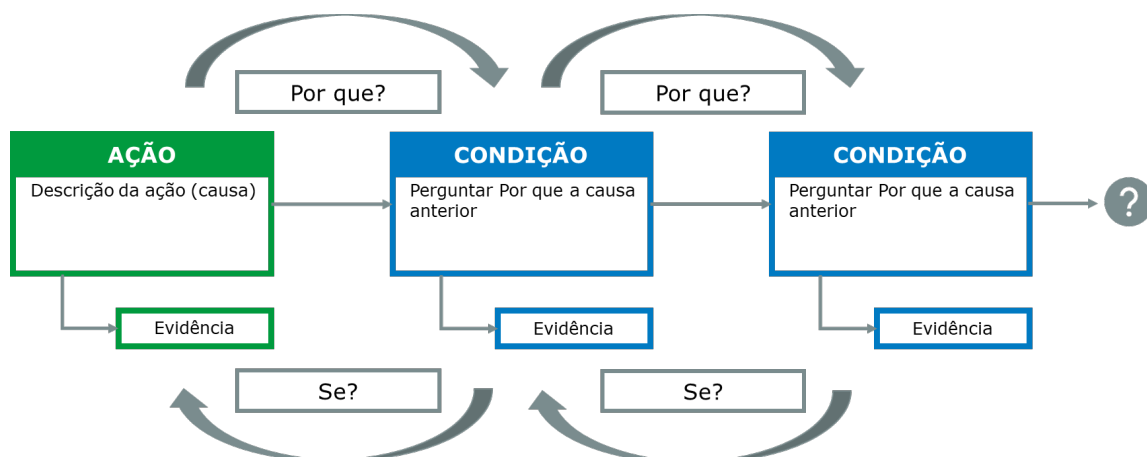
Why?

Condition

Ask reason for the previous cause

Evidence

To check whether the line of reasoning is adequate, one must return by asking "If?". If the response obtained is not coherent, the defined cause is incorrect and the diagram must be revised.



Action

Description of the action (cause)

Evidence

Why?

Condition

Ask reason for the previous cause

Evidence

If?

Why?

Condition

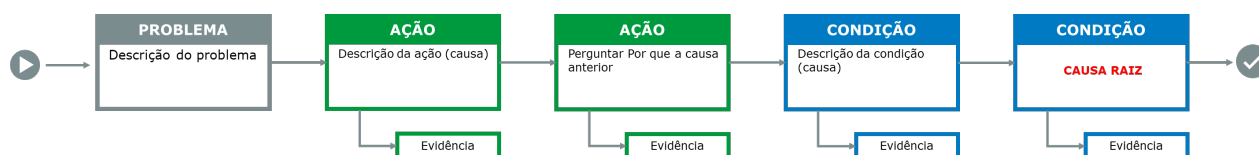
Ask reason for the previous cause

Evidence

If?

After completing the preparation of the Action + Condition Diagram, the root causes that led to the initial problem must be identified. Using this methodology, the root cause will be the last cause (Action or Condition) identified in each line of the diagram, as shown in the following figure:

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PROBLEM

Description of the problem

ACTION

Description of the action (cause)

Evidence

ACTION

Ask reason for the previous cause

Evidence

CONDITION

Description of the condition (cause)

Evidence

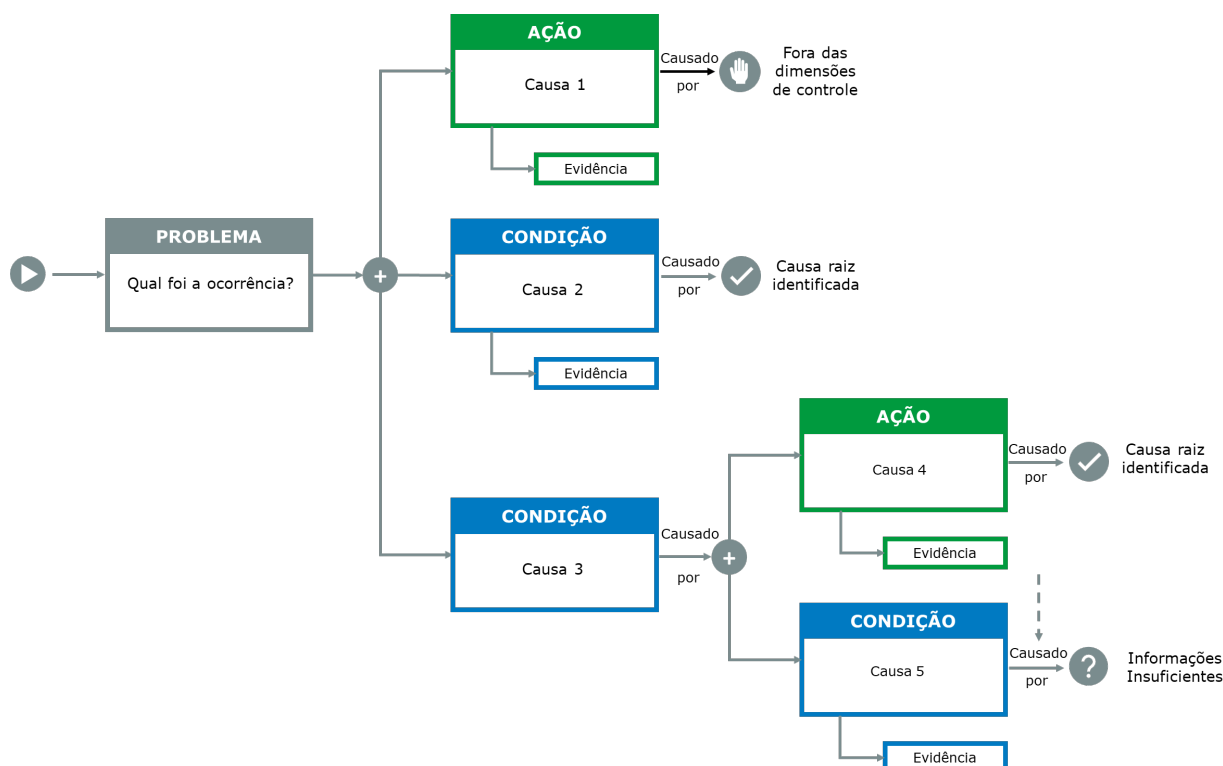
CONDITION

ROOT CAUSE

Evidence

If there is no evidence to support a cause, it should be identified with a question mark (?). Question marks in an investigation are valuable because they indicate there is information missing. A question mark in a cause and effect diagram is an action item for seeking more information and is also a warning flag for solutions.

Action + Condition Diagram Template



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PROBLEM What was the occurrence?	ACTION Cause 1 Caused by -> Outside of control dimensions Evidence	
	CONDITION Cause 2 Caused by -> Root cause identified Evidence	ACTION Cause 4 Caused by -> Root cause identified Evidence
	CONDITION Cause 3 Caused by ->	CONDITION Cause 5 Caused by-> Insufficient information Evidence

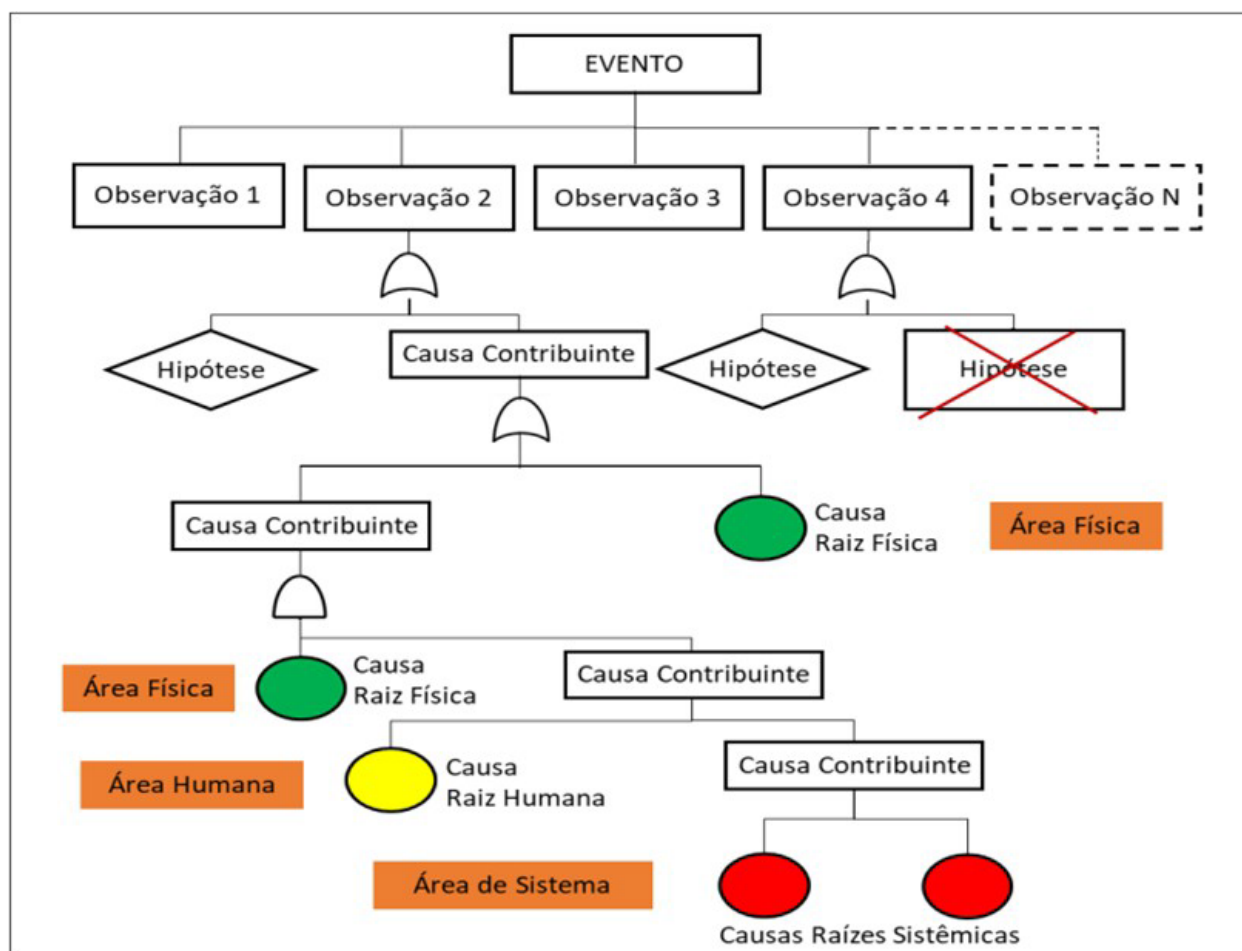
APPENDIX V

FAILURE ROOT CAUSE ANALYSIS METHODOLOGY (ACRF)

- 1 The Failure Root Cause Analysis methodology is a structured tool USED TO:
 - identify the different competing factors that resulted in the unwanted event (incident);
 - determine the contributing causes and root causes of an undesired event (incident);
 - direct the causes to physical, human and systemic categories (systems, policies, standards, procedures, documents, risk management and change management, culture, etc.);
 - based on the determined causes, establish an action plan with corrective and preventive recommendations to avoid recurrence; AND
 - generate understanding, learning and systematically avoid future recurrences of similar or equivalent nature.
- 2 The investigation and analysis should be based on the following questions, without, however, being limited to them:
 - Why did the initiatives and controls planned, adopted and implemented to control the risks not prevent the incident?
 - Are inspections carried out routinely considering the scenario/risk and applicable controls?
 - Were the employees involved in the activity trained, qualified, and had the knowledge to perform the task in which the incident occurred?
 - Did the activity have a risk analysis?

- Did the analysis include the risks that caused the incident and the applicable control means (preventive and/or mitigating)?
- Were the employees involved in the activity trained, qualified, and aware of the factors present in the task and their respective controls?
- What controls were applied by the team involved in the task?
- What are the contributing causes and root causes of the incident?
- What should have been done to avoid the incident?

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Observation 1 | Observation 2 | Observation 3 | Observation 4 | Observation N
 Hypothesis | Contributing Cause | Hypothesis | ~~Hypothesis~~
 Contributing Cause | Physical Root Cause | Physical Area
 Physical Area | Physical Root Cause | Contributing Cause
 Human Area | Human Root Cause | Contributing Cause
 System Area | Causes | Systemic Roots

Failure Root Cause Analysis - Typical "Why" Tree.
 Example: Flowchart for determining root causes and contributing factors.

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APPENDIX VI

ALERT CARD

The Alert Card must only contain relevant points (lessons) that may be useful to other units, that is, what was learned from the incident and which, if corrected and prevented, will prevent the occurrence of a similar event or event of the same nature.

1. Title: provide a summarized and explanatory title for the event.
2. Degree of risk: actual and potential of the incident.
3. What happened: insert brief description of the incident.
4. Why it happened: describe the root causes that allowed the incident to occur.
5. How to avoid: inform which corrective and preventive actions can be taken to eliminate the basic causes and prevent similar or equivalent incidents from occurring.
6. Photos: include relevant photos of the event.

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APPENDIX VII FINAL

INCIDENT REPORT

The final incident report must contain the information listed below:

1 – Incident Title

- General Data – ID, Name, Age, Position, Seniority, Company, CNPJ, Management, Board of Directors.
- Personal Data – Date of birth, Date of Admission; Function, Length of Experience in the Role, Training Completed, Marital Status, Number of Children.
- Data about the Site – (Occupancy, City, State), (Place of Occurrence, City, State, Coordinates: Latitude and Longitude), Date and Time.
- Data on occupational safety standards that are part of your work routine.
- Type of Incident – (Typical, Route, Material, Environmental and Near Accident).

2 – Summarized Description of the Event

3 – Information about the Company

- Line of Activity.
- Number of employees.
- Time of service provision for Eletrobras and in the role.

4 – Investigation Process

- Investigation Team (with identification of the investigation leader).
- Detailed description of the investigation.
- Chronology of the Event (Determination of the time variable in the detailed description).
- Interviews (of the victim, the person in charge, and others that may be involved).
- Research methodology used.
- Root Causes of the Accident.
- Technical Accountability.

5 – Investigation Dossier

5.1 For all accidents with injuries

- Registration form of the person involved in the incident.
- CAT – Work Accident Report.
- ASO – Occupational Health Certificate.
- Written instructions regarding precautions to avoid workplace accidents or occupational illnesses (Service Order).
- Legal training for those involved; (ex.: NR 10, NR 35, NR 33, Machine Operator)
- Police Report (when applicable).
- Work Permit (when feasible).
- Checklist (when feasible).
- Risk Analysis (when feasible).
- PPE sheet.
- Timesheet.
- Evidence of the call for meetings (emails, Teams report, minutes).
- Record of presence of the investigation committee (Teams report, photo of the forum, record in minutes).

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5.2 For fatal accidents, present the documentation listed in subitem 5.1, plus:

- Contract termination.
- Professional profile.
- CAT – Death.

5.3 Accidents with chemicals:

- MSDS of the product or products involved.
- Training those involved in the use of Chemical Products.

5.4 Accidents involving machinery and equipment or tools:

- Preventive maintenance control.
- Preventative Maintenance Report.
- Equipment record (when applicable. Ex. Occurrence with compressors, electrical panels, etc.).
- Report on the condition of the machine, equipment and tools from the manufacturer or a specialized professional (Ex.: ladder breakage; mid-span claw breakage, etc.).

5.5 Accidents involving building structures:

- Fire Department Inspection Report (AVCB) or Fire Department Inspection License.
- Conditions of the Fire Prevention and Fighting System.
- Site permit.

6 – Action Plan

7 – Attachments:

- Photos, illustrations, etc.