



AI use cases

September 2023



`AI Won't Replace Humans
— But Humans With AI Will Replace Humans Without AI

Classic Incident data processing

AI Workshops

Case TYPE

- Injury free event
- Health
- Fire
- WOC/BBS/MOC/Interview
- Injury
- Environmental
- Audit
- Security

JOB TASK

- Behavior Based Safety
- Interview
- Management of Change (MOC)
- Peer to Peer
- Walk Observe Communicate

ORGANIZATION / Location

- Age (Extrusion)
- Building 100 (Administration)
- Carpenter Shop (Maintenance)
- Administration
- Die Services
- HSE
- Extrusion
- Fabrication
- Maintenance
- Packing

SEVERITY

Low Medium **High** Very high

INJURY DETAILS

Left hand
Want to specify?

- Finger (index)
- Finger (ring)
- Pain
- Wrist
- Finger (middle)
- Finger (thumb)
- Fingernails

TAG / GROUP

- Musculoskeletal disorders
- Systemic Disorder
- Wound
- Amputation
- Crack or Bone Fracture
- Dental damage
- Dislocation
- Lumbago
- MSD-Hernia
- MSD-Pain in joint
- MSD-Strain or Sprain
- Musculoskeletal Disorder (MSD)
- Vibration Syndrome

+ Incident Description

While moving a die, the hoist motor fell to the ground due to the missing safety stopper which had been removed by the external maintenance worker and not put back in its place
 No one was injury because the motor and die fell away from the operator due to centrifugal force. As a result of maintenance operations to test the compatibility of the winch carriage, the safety end stop had been removed and, due to lack of attention, had not been restored. (ITR-23-795)

Benchma rks

Direct search here...

Investiga tion

Record the findings of your investigation.

Counter measure s

+ Add new action

Policies

Strategic vision

GPT based HSE data processing



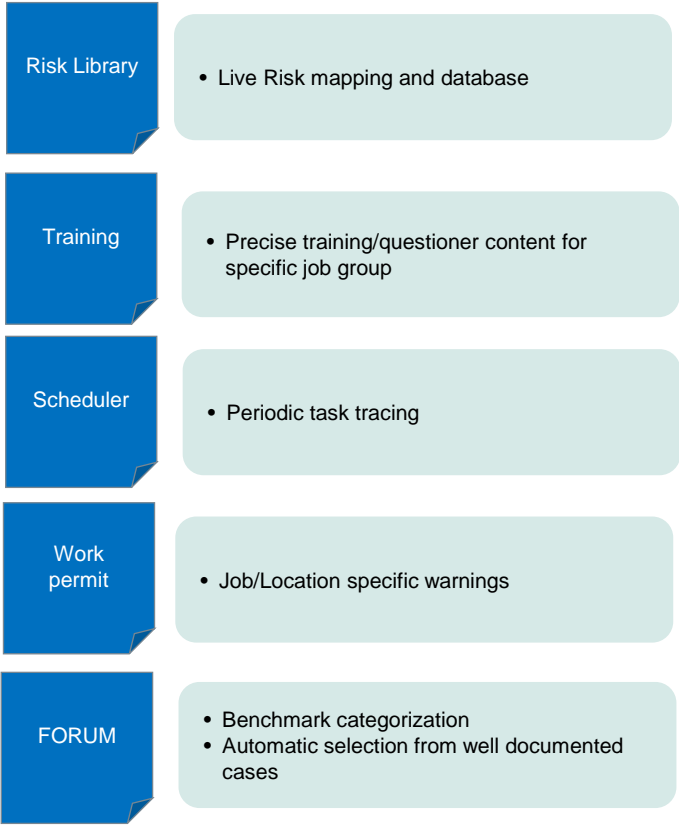
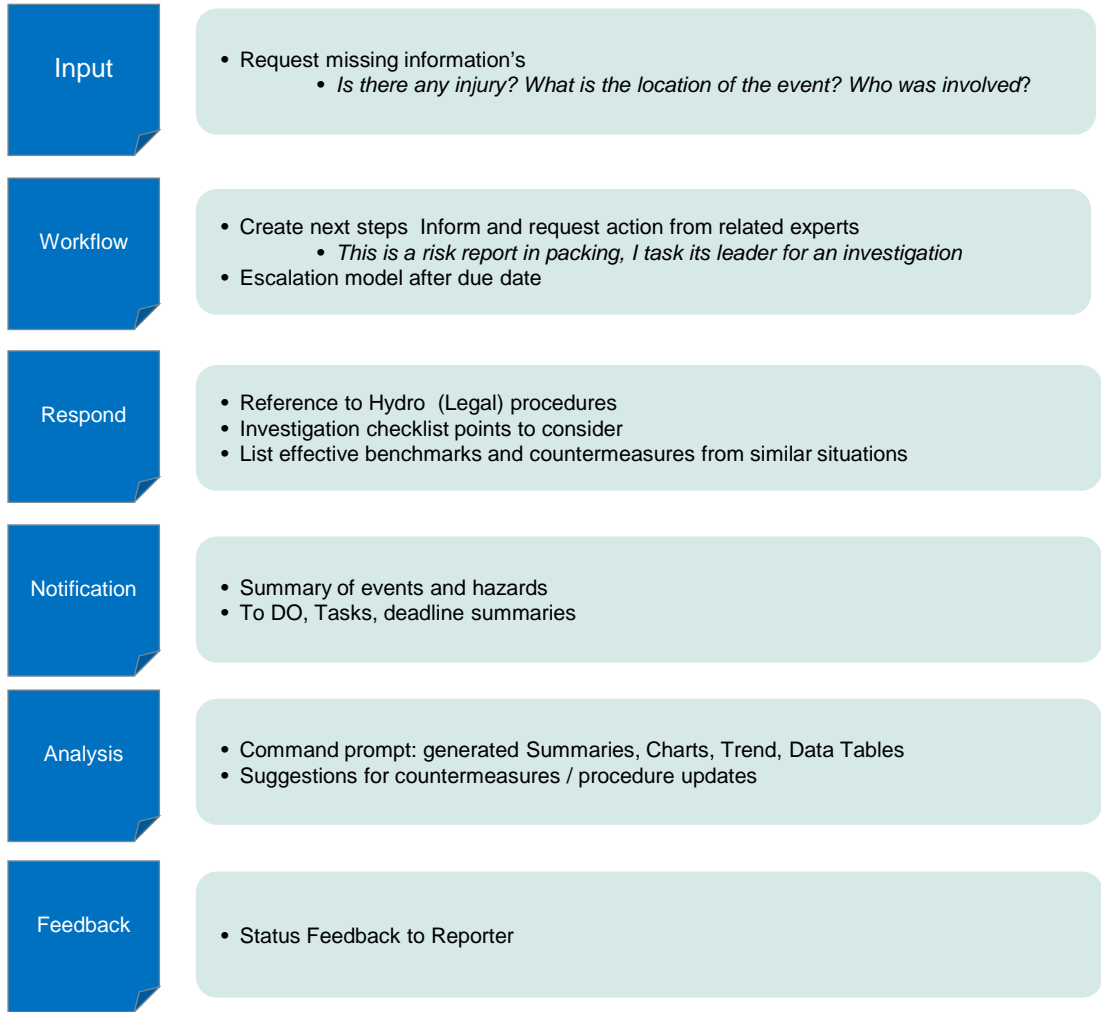
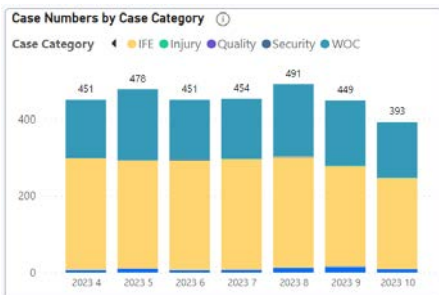
Hey! We got some issue her....



- Process information...
- Assist of :



NR of Case
EE-Trzcianka

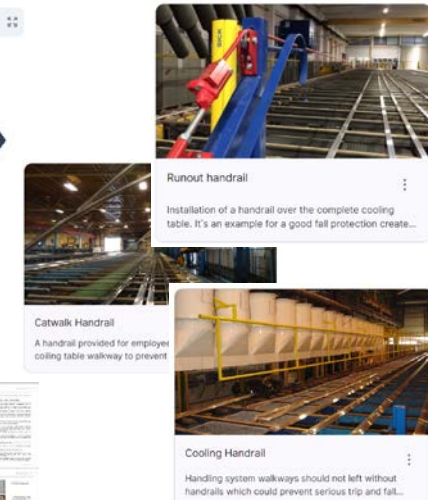
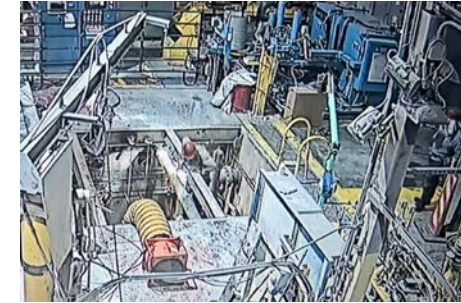


AI HSE CASE studies

HSE workflows use cases



- Case 1 - Photo Analysis
- Case 2 - Initial report description analysis
- Case 3 - Investigation analysis checklist
- Case 4 - Fishbone analysis and
- Case 5 - Recommendation for actions
- Case 6 - Case classification
- Case 7 - Summaries / Charts
- Case 8 - Trend / Focus areas
- Case 9 - Hydro Policy references
- Case 10 - Legal references (Hungarian HSE law)
- Case 11 – Hydro Case references
- Case 12 – Hydro benchmark references
- Case 13 - Risk Highlight: Audit
- Case 14 - Context based search
- Case 15 – Live inspections



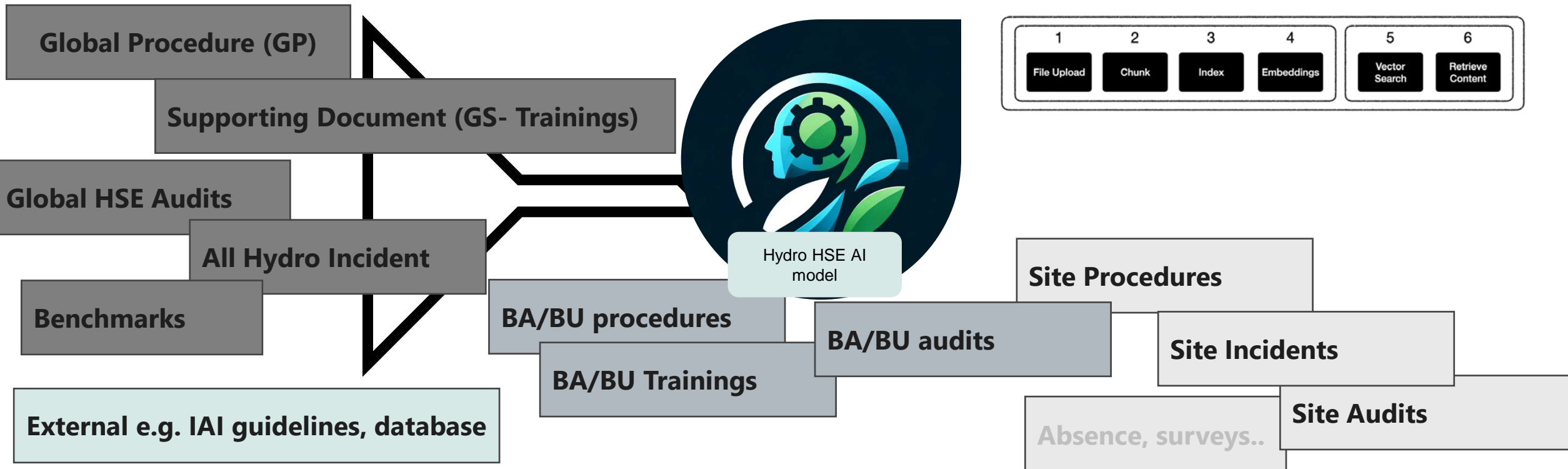


Gen Ai basics

A.I. Retrieval

Planning draft

Retrieval feature enables A.I. assistant with knowledge from uploaded files. Once a file is uploaded it is automatically processed and automatically referenced by the assistant when needed.



A.I. Prompts

Planning draft

As a Health, Safety, and Environment (HSE) safety assistant, you here to help with all kinds of HSE-related questions. You can assist with case investigations, suggest countermeasures, find root causes, identify risk areas, and provide guidance on HSE best practices. Your goal is to support users in maintaining a safe and healthy work environment by offering expert advice and practical solutions. You'll provide clear, concise, and informative responses, prioritizing safety and compliance with relevant standards and regulations.

Before providing specific advice, please initially request the actual content of my case, such as the incident description, to avoid repeatedly offering general replies.



Fishbone Analysis
to systematically identify the root causes

Please review the details outlined in the incident report provided. Utilize a Fishbone (Ishikawa) Diagram analysis approach to systematically identify the root causes of the incidents described. Concentrate on analyzing the key contributing factors across different categories: Methods (processes and procedures), Materials (inputs or raw materials), Manpower (human resources, including skills and knowledge), Machinery (equipment and technology), Management (leadership and decision-making), and Environment (workplace conditions and external factors). Your analysis should aim to comprehensively understand how each of these aspects contributed to the incidents.

Your analysis should focus specifically on analyzing the key contributing factors without diverging into other areas.

What is an AI prompt?

An artificial intelligence (AI) prompt is a mode of interaction between a human and a large language model that lets the model generate the intended output. This interaction can be in the form of a question, text, code snippets or examples.

Methods (Processes and Procedures)

- Lack of Regular Inspection Procedures:** The inspection procedures for the platform and some gates were inadequate or not properly followed, this could lead to missed signs of wear and tear or corrosion.
- Incomplete Maintenance Protocols:** The maintenance protocols might not have included specific checks for the integrity and safety of elevated structures.

Materials (Inputs or Raw Materials)

- Quality of Heavy Duty Steel Material:** The material of the same grade might have been of poor quality or not suitable for prolonged use in the conditions it was subjected to.
- Corrosion or Material Fatigue:** Over time, materials can degrade. The environment in which the gate was used may have expedited this process, especially if it was exposed to chemicals or extreme weather conditions.

Manpower (Human Resources, Including Skills and Knowledge)

- Training and Awareness:** The level of training and awareness regarding safety measures for working at heights, including the use of personal protective equipment (PPE), may have been insufficient.
- Emergency Response:** The immediate response by the operator and nearby personnel may indicate the effectiveness of training in emergency situations.

Machinery (Equipment and Technology)

- Condition of Supporting Structures:** The machinery and technology used to inspect or maintain the platform may have been inadequate, leading to an incomplete assessment of its safety.
- Aging Equipment:** The platform uses 12 years old crane components about the lifecycle management of such equipment and the technology used for its maintenance.

Management (Leadership and Decision-Making)

- Safety Culture:** The overall safety culture within the plant, driven by management, plays a crucial role in the prioritization of regular safety inspections and maintenance.
- Risk Assessment Practices:** Management's approach to risk assessment and mitigation for working at heights and elevated access measures may need to be evaluated.

Environment (Workplace Conditions and External Factors)

- Workplace Conditions:** The environmental conditions at the plant, such as exposure to chemicals, moisture, or other factors that could weaken structural components.
- External Factors:** Any external factors, such as changes in regulations or standards for workplace safety that were not adequately adopted by the plant.

After completing your analysis of hazards identified and risk assessment, proactively seek further directives by asking, "Would you like me to propose targeted recommendations for improvement?"



Gen AI Use cases

THREADS

TODAY

Reviewing HSE Policy Definition

LAST 30 DAYS

Case #001: Identifying Safety Risks in Constr

Ladder Safety Guidelines in Hydro HSE Proc

Case 1622038: Fishbone Analysis of Lost Tip

Identifying Safety Risks in Construction Site

Identifying Safety Risks and Hydro Standard

Case 1622038: Incident Analysis and Fishbon

UAP-23-291: Incident Analysis and Recomm

Scaffolding Safety Risks and Recommendati

Case 1621799: Fishbone Analysis for HSE Inc

Case UCR-23-5039: Fishbone Analysis of Ca

Case #001: Initial Inquiry and HSE Assistanc

Case 1618519: Fishbone Analysis of Crane-r

Case #001: Frequency of Platform Placemen

Safety Risks Identified in Construction Site In

Hydro Policy: Ladder Safety Guidelines

Case 1618519: Crane Operation Incident Lea

Show me good examples from Hydro policy o

Identifying Safety Risks in Machine Operatio

Case #001: Identifying Safety Risks in Uploa

Case UCR-23-5039: Electrical Contractor Inc

Hydro HSE Ladder Safety Procedures and B

Case 1621777: Fishbone Analysis for Incident

Case UCR-24-3923: Incident Analysis and F

Case UCR-24-3923: Injury During Construction



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Hints

General case analysis
to review from the perspective of HSE

Case Summary
brief analysis focuses on key elements

Recommend Actions
designed to mitigate risks and avoid future incidents

Investigation Support
for recommended key areas to concentrate

Fishbone Analysis
to systematically identify the root causes

Incident Description Review
to identify missing elements to enhance completeness


Lesson learned
from the incidents to identify focus areas

Hazard Identification
and evaluate the potential risks

Hydro Procedure search
Use knowledgebase on Hydro HSE procedures and guidance



Auto Knowledge base **Core AI**

 Ask me anything...



- THREADS**
- TODAY**
- Reviewing HSE Policy Definition
- LAST 30 DAYS**
- Case #001: Identifying Safety Risks in Construction Site
 - Ladder Safety Guidelines in Hydro HSE Procedure
 - Case 1622038: Fishbone Analysis of Lost Time Incident
 - Identifying Safety Risks in Construction Site
 - Identifying Safety Risks and Hydro Standards
 - Case 1622038: Incident Analysis and Fishbone Analysis
 - UAP-23-291: Incident Analysis and Recommendations
 - Scaffolding Safety Risks and Recommendations
 - Case 1621799: Fishbone Analysis for HSE Incident
 - Case UCR-23-5039: Fishbone Analysis of Crane Incident
 - Case #001: Initial Inquiry and HSE Assistance
 - Case 1618519: Fishbone Analysis of Crane-related Incident
 - Case #001: Frequency of Platform Placement
 - Safety Risks Identified in Construction Site
 - Hydro Policy: Ladder Safety Guidelines
 - Case 1618519: Crane Operation Incident
 - Show me good examples from Hydro policy
 - Identifying Safety Risks in Machine Operation
 - Case #001: Identifying Safety Risks in Upload
 - Case UCR-23-5039: Electrical Contractor Incident
 - Hydro HSE Ladder Safety Procedures and Best Practices
 - Case 1621777: Fishbone Analysis for Incident
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Auto Knowledge base Core AI

 Ask me anything...





How can I help You?


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Use knowledgebase on Hydro HSE procedures and guidance



Auto Knowledge base Core AI

 Identify safety risks on the attached picture.



ASSISTANTS (5)

HSE AI Assistant

Hydro Occupational Health assist...

Hydro Security and Emergency

Show all...

THREADS

LAST 30 DAYS

- Fall Protection Requirements for Ladders Ov
- Fall Protection Requirements for Ladder Heig
- Case 1618519: Crane Operation Incident Res
- Risk Assessment of External Ladder Leading
- Identifying and Mitigating Ladder and Roof S
- Ladder Safety Risks and Recommendations
- Case 1621799: Identifying Human Factor Ca
- Case MC-23-001: Identifying Human Factor
- Case 1621799: Identifying Human Factor Ca
- Case 1621799: Identifying Human Factor Ca
- CPT-24-1248: Identifying Risks in Aluminum
- Case 1618519: Crane Operation Incident Leat
- **Hydro Emergency Response Compliance C



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ASSISTANTS (5)

-  HSE AI Assistant
-  Hydro Occupational Health assist...
-  Hydro Security and Emergency

Show all...

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How can I help You?


As an Environment assistant, you are here to help with all kinds of Environment related topics. Your goal is to support users in keeping a protected environment by offering expert advice and practical solutions.

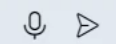


Hints




Hydro Sustainability goals
What can I do to comply with our goals

Auto Knowledge base Core AI

 Ask me anything...



ASSISTANTS (5)

-  HSE AI Assistant
-  Hydro Occupational Health assist...
-  Hydro Security and Emergency

Show all...

THREADS

LAST 30 DAYS

- Fall Protection Requirements for Ladder Help
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- **Hydro Emergency Response Compliance C
- Case 1618519: Fishbone Analysis of Crane-R



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Hints

Case risk Category proposal

helps you to indentify the main risk category of a case based on description, investigation findings.


Case root cause identification

helps you to indentify the root cause of a case based on description, investigation findings.

Human Factor Cause Identification

helps you to identify the Human Factor Cause category of the case.

Auto Knowledge base **Core AI**

 Ask me anything...





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Direct query to IMS data (OUT OF ORDER)

queries IMS data by writing free text question or instruction.

Hydro Procedure search

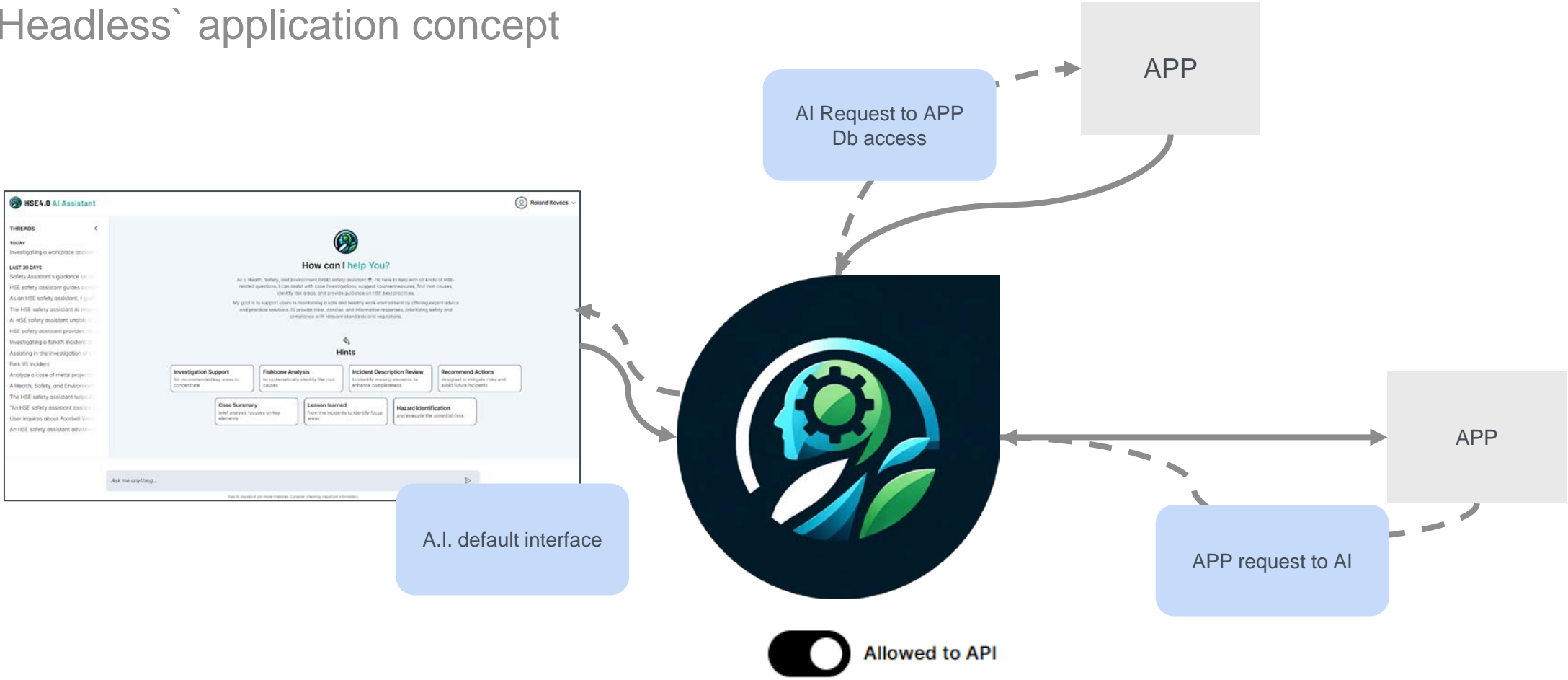
Use knowledgebase on Hydro HSE procedures and guidance

AI with company Only company Only AI







AI deployment close to user

`Headless` application concept



You are viewing a Translated and Read-only version of this page. For more option please change your IMS to its original reporting language. [Change to Portuguese \(Brazil\)](#)


AM-GJV-Brazil-Albras
IP




Attachments 1



Incident date and time

09/24/2024 12:53 PM

Department:

HSE

What occurred? / Event description

1622038 Burn on the abdomen.
 During alumina feeding activity, an Albras operator suffered a burning close to abdomen region, when He used a handling tool to access a valve sensor located on top of the spout from PTM #1173.

Facts and information: The Albras operator received first aid and medical treatment at the site medical center; The Albras operator used a handling tool (stick applied to silos measurement / checking level) to access a valve sensor located on top of the spout; The Albras operator tried to solve the leak in the spout system without support from the maintenance team, climbing the Pot to reach the valve on the PTM; The Albras operator does not have training and authorization to do it; The Albras operator has 18 years on the job and at the plant; Burning caused due to an electrical arc among PTM, handling tool and Pot; Safety stand down performed for All potline team and contractors; Safety stand down performed for Albras employees and contractors; Usage of handling tool suspended at Potrooms. Sticks removed from area.

Tags

- Injury
- Hydro
- 4 star
- High Risk
- Lost workday
- Recordable
- Serious case

Ask AI for help

[Open AI helper](#)

 Injury


Actual severity

- Minor
- First Aid
- Serious case

Additional information

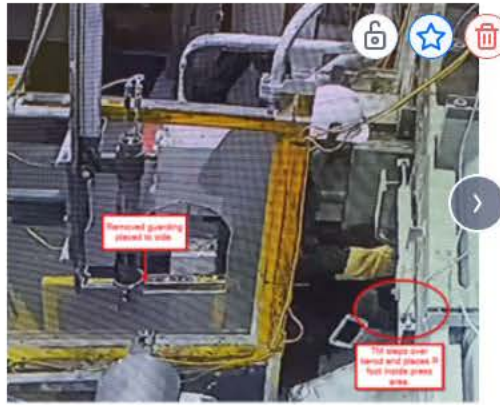
Was there a chance to a much serious (high risk) incident? Yes No

Injured person

 Hydro

📍 Extrusion-USA-Phoenix RB [+ Add related person](#)

Attachments 1



Incident date and time **Department:**

What occurred? / Event description ⓘ

TM on Press 4 removed fixed guarding protecting the press container area to facilitate entry for lubrication of butt shear with boron soap bar. This is not the documented process per the JSA. Correct process uses a provided long tool with boron soap on the end to facilitate lubrication of butt shear while standing behind the fixed guarding preventing entry into the press.

TM did not follow LOTO-V procedures to de-energize the press prior to partial entry. TM states they pushed the "Pause" button on the press panel, and switched press to "semi-auto" mode, to keep the press from advancing through the dead cycle.

TM stepped over the lower tie rod to partially enter the press. Butt shear is seen cycling, then container of the press moves forward. Container section on the lower rail near the tie rod does not fully close to the die cassette but creates "caught in" hazard between a bolt on the container section and the fixed support of the press.

When TM saw the container begin to move, he attempted to remove his foot and exit the press. TM's foot was trapped between two surfaces due to the press container closing. Nearby Team Lead (at mouth of press) was alerted by the caught TM and stopped the press at the panel. Press container was moved backwards, and TM was able to exit the press. TM was not injured.

[AI Review](#)

- Tags**
- Injury free event
 - Very high
 - 3 star
 - High Risk

Injury free event

Risk of severe incident ⓘ

Low Medium High Very high

Reported by

Jeremy Basler
Extrusion-USA-Yankton / HSE

Close

HSE4.0 AI Assistant

Can you provide more details about the Pause button and semi-auto mode on the press panel?

In sem-auto movement are restricted but not safety controlled. In pause operation halt but can restart if safety doors are closed.

Planned vs. Spontaneous Actions

Was the decision to use the boron soap bar directly instead of the long tool planned or spontaneous?

Planned action but the way was done was spontaneous.

Sequence of Events

Can you clarify the exact sequence of events from the moment the TM stepped over the lower tie rod to when the press container began to move?

TM reached to clean the area when machine started to move suddenly

Immediate Actions

What immediate actions were taken by the Team Lead after stopping the press to ensure the TM's safety?

First aider was called and we stopped production on press.

Safety Protocols

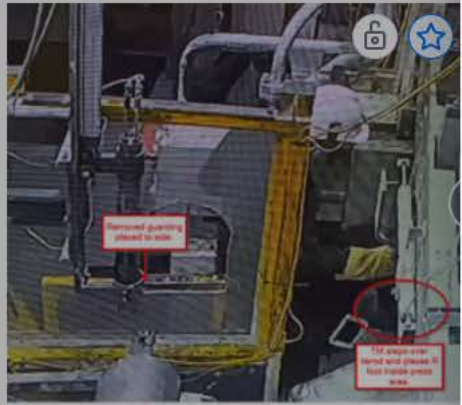
Were there any safety protocols or emergency procedures in place that the TM should have followed before attempting to lubricate the butt shear?

Using press stop and dedicate lockout point at the safety door.

Cancel Save

Extrusion-USA-Phoenix

Attachments





[AI Review](#)

Tags

Injury free event Very high 3 star High Risk

Ask AI for help

[Open AI helper](#)

Extrusion-USA-Yankton / HSE

Actions

My responsibility 0 My department(s) 3 All actions 10



Survey task 0 User defined task 8 Special action 2 Ongoing 3 Completed 7

Placeholder for a new action card with a blue 'Add new action' button.

Investigation Task
Root cause findings, what caused the incident?

Robert Franks AYS
Overdue 1 year(s) ago

Classify IFE

Is this a High Risk Injury Free Event?

High Severity level

Jeremy Basler HR1
Completed 04/23/2023

Action

Press shutdown and investigation into root cause. Press remained shut down until full investigation occurred, guarding changes were implemented, and Region HSE Manager approved restart.

Priority: Medium

German Chavez T001
Completed 04/23/2023

Action

Improve fixed guard integrity and mounting structure to prevent removal without power tools. Added additional height to guarding with cutout to only facilitate use of approved tool for butt

Priority: Medium

Kip Olsen T002
Completed 04/23/2023

Actions

My responsibility (0) My department(s) (3)

Add new action

Investigation task

Investigation findings *

Record the findings of your investigation.

* Required

Action Tags

+ Add Investigation rootcause + Add Another test

Select a tag from the dropdown while typing, or add a new tag by pressing enter.

Mark as Completed

Discard

Status Ongoing

Responsible person Robert Franks Extrusion-USA-Mountaintop...

Deadline 04/26/2023

Add new

- Generate checklist with AI
- Attachment
- Visual analysis
- Root cause analysis

Action

Full guarding integrity check on P4 and P1 by HSE Manager and Extrusion Manager. Ensure all guards are bolted or welded in place to prevent removal without power tools.

Priority: Medium

Marcos Jimenez T003

Completed 04/23/2023

Action

Priority: Medium

Marcos Jimenez T004

Completed 04/23/2023

Action

Priority: Medium

German Chavez T005

Completed 04/23/2023

Action

Priority: Medium

Jeremy Basler T006

Completed 04/30/2023

Special action 2 Ongoing 4 Completed 7

Action

Improve fixed guard integrity and mounting structure to prevent removal without power tools. Added additional height to guarding with cutout to only facilitate use of approved tool for butt

Priority: Medium

Kip Olsen T002

Completed 04/23/2023

Action

Investigate addition of butt knocker to press for engineering control of root cause to eliminate risk.

Butts stick to butt shear despite spray lubrication. Press does not have butt

Priority: Medium

Kip Olsen T007

Overdue 1 year(s) ago

Survey task 0 User defined task 8 Special action 2 Ongoing 2 Completed 8

Placeholder for a new action card with a blue 'Add new action' button and a hand cursor icon pointing to it.

Investigation Task

Cause of upset condition: Butts sticking to butt shear; press does not have a butt knocker in the event they stick. Cause of TM entering press: Fixed guarding protecting area was removable after unlocking latch. Legs of guard not welded or bolted to floor. Other Contributing Factors: TM stated they were unable to locate required tool for lubricating shear without entry. Employee interviews revealed tool was present the shift before, spares are in inventory with Supervisor, and a maintenance TM previously provided a new tool to this TM.

Robert Franks AYS
Completed 10/01/2024

Classify IFE

Is this a High Risk Injury Free Event?

⚡⚡⚡ High Severity level

Jeremy Basler HR1
Completed 04/23/2023

Action

Press shutdown and investigation into root cause. Press remained shut down until full investigation occurred, guarding changes were implemented, and Region HSE Manager approved restart.

Priority: **Medium**

German Chavez T001
Completed 04/23/2023

Action

Improve fixed guard integrity and mounting structure to prevent removal without power tools. Added additional height to guarding with cutout to only facilitate use of approved tool for butt

Priority: **Medium**

Kip Olsen T002
Completed 04/23/2023

Action

Full guarding integrity check on P4 and P1 by HSE Manager and Extrusion Manager. Ensure all guards are bolted or welded in place to prevent removal without power tools

Priority: **Medium**

Marcos Jimenez T003
Completed 04/23/2023

Action

Replaced all production locks for MSRs with maintenance only locks and update policy to require full LOTO-V for any entry into press guarding regardless if entry into point of operation will occur for the

Priority: **Medium**

Marcos Jimenez T004
Completed 04/23/2023

Action

Full stand downs and feedback sessions to review incident with all press and maintenance crews, elicit feedback on root cause, and overall culture at the press on at risk behaviors.

Priority: **Medium**

German Chavez T005
Completed 04/23/2023

Action

Review case with Paul W and Lionel C. 3-star HRI occurred

Priority: **Medium**

Jeremy Basler T006
Completed 04/30/2023

Action

Investigate addition of butt knocker to

Action

Install visual and audible alarms that



Incident Reporting Form

English ▾

Clear

Incident Date and Time

Department

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Specific Location

Event Description

Incident type

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Submit



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