



N4 Emergency Exercise report
Emergency Preparedness
Sasol Marketing and Sales Energy & Chemicals Southern Africa
November 2024

Plenary Team

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Disclaimer

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While every effort has been made to ensure the accuracy and completeness of the information, Sasol does not guarantee or warrant its precision or reliability. The report is based on observations, data, and feedback collected during the exercise and should not be considered as a definitive assessment of all emergency response capabilities or systems involved.

The findings and recommendations are intended to support continuous improvement in emergency preparedness and response. Implementation of any recommendations is subject to the discretion and judgment of the respective stakeholders involved in the exercise.

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1. DEFINITIONS AND ACRONYMS

Emergency Medical Services (EMS) - A system that provides emergency medical care and transportation to individuals in need of immediate medical attention.

Emergency Room (ER) - A specialized department in a hospital where patients with acute illnesses or injuries receive immediate medical treatment.

Emergency Response Guidebook 2020 (ERG2020) - A guidebook used by emergency responders to identify hazardous materials and provide response recommendations during transportation incidents.

Incident Co-ordinator - The person nominated by the Management Team at the scene of an accident. The role of the Co-ordinator is to facilitate decisions ensure and that action plan is agreed to implemented by all.

The coordinator also maintains a communication link with the JICP and the Centralised Communication Centre.

A JICP position consisting of a single person who has responsibility for all interactions between JICP and the media and who coordinated the release of information on the incident situation and response efforts from JICP to media.

Joint Incident Command Post (JICP) - The safe, convenient location set up at an incident/crash scene of the tactical-level at which the Management Team manages the incident.

Liquefied Petroleum Gas (LPG) - A type of flammable hydrocarbon gas that is commonly used for heating, cooking, and as fuel in vehicles.

Personal Protective Equipment (PPE) - Clothing, gear, or equipment worn to protect individuals from various hazards or risks in their working environment.

Priority 1 (P1) - a patient whose life is in immediate danger and requires immediate treatment.

Priority 2 (P2) - a patient whose life is not in immediate danger (moderate to serious injury).



Priority 3 (P3) - Non-life-threatening injury (walking wounded)

Priority 4 (P4) - deceased patient/ dead on arrival

Road Incident Management System (RIMS) - The co-ordinated and pre-planned use of human, mechanical and electronic resources to manage incidents and to restore traffic to normal operating conditions as soon as possible.

Routine Road Maintenance (RRM) - The RRM team is all Routine Road Maintenance Contracts on Proclaimed National Roads. When called upon the Contractor shall proceed immediately to the scene of the crash event, with equipment and material, to normalise, restore and safeguard any dangerous area for the safe passage of any traffic using the road.

Self-Contained Breathing Apparatus (SCBA) - A device worn by firefighters and other emergency responders to provide breathable air in hazardous environments where the atmosphere is compromised.

South African Police Service (SAPS) - The South African Police Service is responsible for internal security and crime prevention. "The Constitution of South Africa lays down that the South African Police Service has a responsibility to prevent, combat and investigate crime and maintain public order, to protect and secure the inhabitants of the Republic and their property, uphold and enforce law and create a safe space and secure environment for all people in South Africa.

The hot zone - The area of an emergency or disaster scene where hazardous materials or life-threatening conditions are present. It requires special precautions and protective gear for personnel who enter this area.



2. EXECUTIVE SUMMARY

Marketing and Sales Energy & Chemicals Southern Africa, in partnership with Road Incident Management Systems (RIMS), conducted a Roadshow and community outreach program and an Emergency Response (ER) Exercise on the 04th and 05th November 2024, respectively on the N4 in Nelspruit. The Roadshow and community outreach program has been introduced and added as a program deemed necessary to inform and educate the communities and first responders on dangerous goods transportation and what to do in the event of an incident. The emergency exercise is a yearly practice where Sasol selects a corridor in which there is a high volume of products transportation that may pose a risk to other road users, communities, and the environment. The predominant reason for conducting these exercises is to determine any gaps within preparedness and response plans of all the first responders of that chosen corridor. To effectively achieve this, Sasol in collaboration with participating stakeholders share knowledge and best practices of dangerous goods and emergency response awareness on emergency action plans to all first responders prior to the emergency exercise being held, to better coordinate plans towards emergencies involving dangerous goods transportation in their jurisdiction. The intent is to ensure the highest level of preparedness and response to dangerous goods transportation incidents and to also impart strong stakeholder relations with all stakeholders because incidents are won by not working in silos but working together for a common goal.

3. Roadshow and community outreach program

On the 04th of November 2024 Sasol in partnership with other stakeholders hosted a Roadshow and community outreach program. This program is designed as an awareness session where stakeholders and communities are informed briefly about Sasol products that are being transported in their vicinity and how to effectively mitigate incidents involving such products. Sasol in collaboration with other stakeholders share best practices and knowledge towards mitigation efforts on dangerous goods transportation amongst each other and communities along corridors of transportation.

The Roadshow and community outreach program had a slow start but gained momentum later in the day. Overall, the critical objective of reaching communities and first responders to inform of dangerous goods and mitigation processes was achieved. Different

stakeholders (SAPS, Fire department, Traffic department, TRAC and Sasol) shared presentations on mitigation best practices and knowledge from each other's perspectives on dangerous goods transportation incidents to an audience made up of community members and different disciplines of first responders. The Roadshow had successful factors and areas of improvement.

Positives:

- The commitment from the Plenary team to setting up the community hall in time
- The quick planning of the team to driving around the community announcing the roadshow to communities- to ensure the continuance of the planned program for the day
- The presentations given were received well by the audience
- Good attendance and interactions with the communities and stakeholders

Negatives:

- Late start and confusion of dates and times of the roadshow resulted in reduced exposure numbers of community participants
- The audience, due to late starting missed opportunity to attend all presentations and partake in the full session.

4. The Emergency Exercise simulation

A Mock Emergency simulation is a fictitious disaster scenario that allows participants involved in emergency responses to rehearse procedures, identify gaps and test plans, in order to enhance skills and knowledge and strengthen preparedness.

A Mock Emergency simulation tests the physical implementation of Emergency Action Plans by all the departments and first responders that would under normal conditions be involved in a real emergency. Given the real life simulation and using normally available resources and plans they must work collaboratively and effectively to mitigate the scenario through their plan of action.

Prior to exercise, competent observers had been identified to observe and document specific key elements and stakeholder responses during the duration of the exercise



based on industry best practices and competencies. These observations also allow that the achievement to the objectives of the exercise are measured.

5. Scenario:

Scenario Overview:

Location: N4 East towards Malelane, near R104 off ramp in Nelspruit/Mbombela, Mpumalanga, South Africa.

Date & Time: Daytime during routine road maintenance. 05th November 2024 at 10h00.

Event: The Route Road Maintenance (RRM) team is performing controlled fire burns for firebreaks when the wind speed suddenly increases, leading to a loss of control over the burn.

Incident Description:

As the wind unexpectedly increases, thick smoke from the firebreaks engulfs the N4 highway, reducing visibility to near zero. At the same time, a Sasol Fuel Delivery Vehicle (FDV) carrying ULP95 petrol is approaching the area. Due to poor visibility, the Fuel Delivery Officer (FDO) loses control of the vehicle. The FDV rear-ends a gas tanker, which is stationary due to the low visibility caused by the smoke. A Light Motor Vehicle (LMV) following closely behind also collides with the FDV.

Vehicle Involvement:

Sasol Fuel Delivery Vehicle (FDV)

Fully loaded with ULP95 petrol.

The FDV is ruptured, leading to a petrol spill on the road.

The fuel flows into roadside gutters, heading towards a nearby human settlement located approximately 200 meters from the accident site.

FDO is unconscious (P1) due to the impact.

**Gas Tanker:**

The gas tanker has sustained damage to its rear end, although its tank remains intact.

Light Motor Vehicle (LMV)

Four passengers are injured

Two P2 patients (moderate to serious injuries)

Two P3 patients (minor injuries)

Injuries:**Fuel Delivery Officer (FDO):**

P1 (Unconscious, requiring immediate medical attention).

RRM Employees

Four employees injured after being struck by the LMV following the collision:

Two P3 (minor injuries).

One P1 (serious life-threatening injury).

One P4 (deceased).

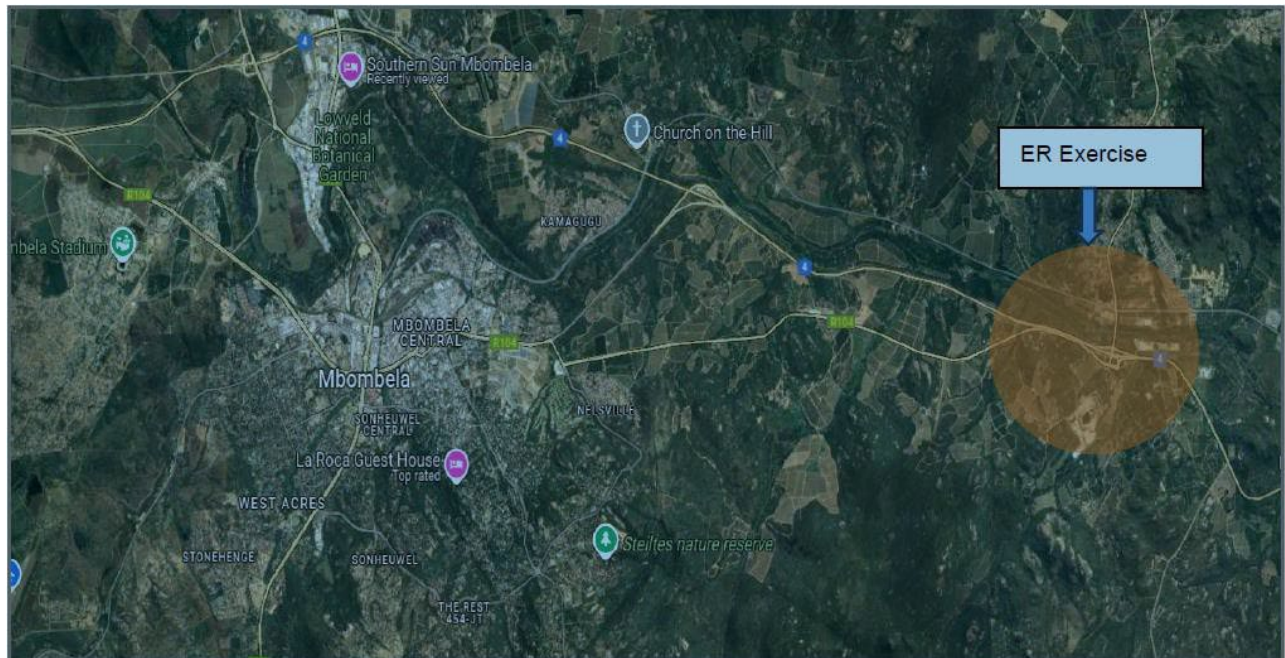
Environmental Impact:

Leaking Petrol: The petrol spill is flowing into a gutter system leading towards a human settlement approximately 200 meters away. There is a high risk of fire or explosion due to the flammable nature of the ULP95 petrol, especially with ongoing fire burns in the area.

Visibility: The combination of the smoke from the firebreaks and the accumulating petrol fumes is creating a hazardous environment, complicating the rescue operations and increasing the risk of ignition.

6. Emergency Response Simulation Exercise Location

Overview of Mbombela



Location to the ER Simulation Exercise



7. The Objectives of the Emergency Exercise

- Test the internal processes of receiving and disseminating incident information by the Sasol Emergency Call Centre (SECC)
- Test the first responders scene management
 - Scene approach, scene size up (identification of hazards and materials involved) and handing over to the arriving IC, etc.
- Test the Incident commander scene management, etc.
 - The handover from the first arriving responders to the incoming Incident commander from the Fire department
- Test the collaboration of all stakeholders towards a collaborative action plan
- Test the Response to a Major Fuel Spill
 - Evaluate the response time and effectiveness of containment measures for flammable liquids.
- Coordination Between Emergency Services
 - Assess communication and coordination between fire services, traffic control, medical teams, and other stakeholders.
- Rescue Operations in Hazardous Conditions
 - Practice the safe extraction and treatment of injured personnel (both P1 and P4 patients) while dealing with dangerous smoke and flammable substances.
- Environmental Protection
 - Implement strategies to protect the surrounding environment and human settlements from potential contamination and fire hazards.
- Post-Incident Analysis
 - Ensure detailed debriefing and identification of improvement areas in emergency protocols related to dangerous goods transportation and road maintenance activities.

7.1 Emergency Exercise safety on scene

Setting up of an Emergency Exercise requires that the safety of the site where the emergency exercise is going to be held is treated with outmost professionalism and care to ensure there are no secondary incidents before, during and after the emergency exercise. The safety, on its own requires to be evaluated and shortcomings and improvements recorded for future learnings.

When the Nelspruit N4 Emergency exercise convened, the planning team together with all the relevant stakeholders gathered on site, to discuss what needs to be put in place and how it needs to be put in place before the Emergency exercise could begin. All these safety precautions have to be put in place while traffic is motion, making safety priorities a critical component to be evaluated. The evaluation of safety yielded positive and negative aspects. The following positive aspects were noted:

- Potential Deviation Analysis (PDA) carried out for the event
- Barricading of the out of bound areas on the site was carried out.
- Clear parking for vehicles identified.
- Distance clearly demarcated (3 meters) away from slopping area, where people would fall.
- A safety officer for the day appointed. To continuously monitor changes in the environment and to ensure all other safety aspects are attended to.

However, there were some challenges that were identified:

- While setting up the scenario for the vehicles involved in the exercise, the traffic officers started slowing down vehicles to close to where the setup was being done.
- Smoking area was not identified, or demarcated.
- Traffic was still moving too fast close to the staging of vehicles for the emergency exercise.
- Not enough precaution towards heat for the patients in the emergency exercise, as the temperature rose in to their thirties.
- Not enough precaution taken towards the soaring temperatures of the day for all observers and first responders at the emergency exercise.

The ER Exercise was initiated at 09h55 and concluded at 12h40. The outcome of the exercise revealed both positive and negative aspects on each participating stakeholder.

7.2 Nelspruit Fire Department

Positives:

- The Fire department responded timeously, upwind direction and conducted their scene size up from a good distance away.

- The IC improvised by sending one personnel to the elevated position on the bridge to get the tanker number and called the SECC to ask what products are transported using those tankers- this was time consuming
- Arriving on the scene, the Fire dept. set up a preliminary incident command by placing a cone on their response vehicle to mark it as the IC vehicle and setup parameters.
- The IC established zones (hot, warm, and cold)
- The IC established the decontamination corridor.
- All arriving first responders reported to the IC
- The IC communicated the incident action plan to the fire department responders.
- IC requested the fire department to contact Spill Tech
- The IC sent two first responders dressed in appropriate PPE to thoroughly size up the hot zone.
- Decontamination of patients and first responders was done.
- The IC constantly monitored the wind direction
- The IC initiated the JOC/VOC of all stakeholders

Observations and opportunities for improvement:

- The IC did not know how to use the ERG correctly
- The IC took too long to determine the products involved in the scene
- The IC did not follow the right incident priorities by doing initial isolation zones, ensuring their safety and those of others, and focusing first on life, then property and environment
- Due to the lack of foam, the IC move the IC post closer but on the other side of the guard rails between the road, this added complications of handling the scene sufficiently, all responders, equipment and patients (on spine boards or walking) had to go over the guard rails.
- The two first responders sent into the hot zone where not sure on the size up they had to conduct e.g., getting the TREC card and dangerous goods declaration documents, patient triage and assessing the overall scene.
- The two first responders sent into the hot zone did not switch their breathing apparatus on, they became patients (casualties) and were the last patients to be removed from the hot zone. Lack of Safety officer appointment.

- No Liaison or communications officer appointed to alleviate IC from flooded information coming from all stakeholders
- The fire department does not have radios and PASS devices to monitor personnel in the hot zone, because of this reason IC has no line of sight or tracking of personnel.
- The second fire crew that entered the hot zone did not provide the IC sufficient information of their assessment inside the hot zone- did not retrieve information from the orange compartment, did not do triage and did not investigate the leaks on both ULP95 and LPG tankers
- First and second fire crews did not take protection line with into the hot zone, to protect themselves in case of any fires or ignition sources.
- No gas detectors were used to determine how far the vapours travelled
- Patient retrieval by the fire rescuers took too long because the fire department packaged patients inside the hot zone instead of scoop and go
- There was no priority of patients from the rescuers, they did not follow the protocol of (P1-P4), rescuers did not prioritize patients in order of severity.
- Towards the end of the exercise at 11h55 a P1 patient was removed from the hot zone walking, showing the insufficient knowledge of rescuers to read vital signs and conduct proper patient triage.
- There was no record-taking and medical monitoring of first responders entering and leaving the hot zone.
- There was no isolation of hazards on the scene, the valve of the tanker carrying ULP95 was not shut off.
- The runoff of ULP95 was not diked and diverted for later disposal.
- There was no protection of water ways, the area where diversion of spill was done was of the second water drain, and not the first one.
- Fire department did not have sufficient breathing apparatuses
- Fire department does not have hazmat technicians
- Fire department did not have hydraulic rescue tools
- IC did not request for refreshments for personnel on scene, the temperature was in its 30's
- The IC did not escalate or down scale scene as necessary
- IC did not determine the time and place where media would be briefed

7.3 Spill Tech

Positives:

- Spill Tech arrived on scene down wind, from a safe distance away they strategized and went up wind using a safe route- quick thinking and determination of wind direction
- Spill Tech arrived on scene and reported to the IC
- IC briefed Spill Tech of the scene
- Spill Tech erected the wind sock to monitor wind direction throughout the exercise
- Spill Tech opened a WhatsApp group with all relevant stakeholders to provide updates of the situation at the scene
- Spill tech entered the Hot zone dressed in full PPE to do clean-up of the fuel

Observations and opportunities for improvement:

- Spill Tech responded downwind to the scene- was not sure of the wind direction
- One member of the Spill Tech crew went in to the hot zone not wearing PPE and became a casualty
- Spill Tech responded with a hydrocarbon trailer instead of a chemical trailer- this was due to insufficient information from their control room regarding the scene. The responders did not ask the control room relevant questions regarding the scene.
- When Spill Tech arrived on scene, they put a cone on to their response vehicle, this confused first responders of the real IC post
- Spill Tech did not do gas testing- to determine how far the vapours have travelled
- Spill Tech most senior personnel did not form part of the IC structure

7.4 Sasol Emergency Call Centre

Positives:

- A call from a community member came through to report the incident on the N4 and information about the incident was asked.
- The SECC called standby personnel.
- SECC filled the incident report with all necessary information
- All relevant stakeholders where contacted except Spill Tech
- SECC requested constant feedback of the status of the incident till the end of the emergency exercise

- **Observations and opportunities for improvement:** Diamond Tsolo received a call from Spill Tech informing him, about 45 minutes into the exercise that they have not received a call from SECC. Diamond called the SECC to find out if they called Spill Tech for response- The answer was No.
- Time wasted on activating Spill Tech

7.5 EMS (Provincial, Emer-g-med, ER24 and Care Well)

Positives:

- Provincial EMS arrived up wind reported to the IC
- Emer-g-med responded and arrived up wind reported to the IC
- ER24 that arrived down wind, parked a safe distance away and did their scene size up, realised they were down wind and switched safely up wind
- EMS established triage area for patients in the cold zone

Observations and opportunities for improvement:

- Care Well EMS arrived on scene downwind, drove into the hot zone, passing the ER24 and Fire department vehicles parked a safe distance away doing size up- they ended up being casualties
- The EMS helicopter was dispatched to the scene without requisition from the scene
- The scene had a gas tanker, which the responders did not have an idea if it was leaking or not, while the EMS helicopter arrived and stirred the wind in all directions while hovering over the scene trying to locate an area to land.
- There was no EMS helicopter director to direct the helicopter where to land
- Provincial EMS did not receive the emergency call from dispatcher.
- Provincial EMS control room was not called or the call did not go through- Senior personnel from the planning meetings decided to call them (Provincial EMS) when it was realised that they did not receive the call
- EMS did not call the hospitals to inform them of the types of patients and injuries they must expect
- EMS excepted patients from the fire first responders without the necessary information regarding patients

- EMS most senior personnel from each EMS departments did not form part of the IC structure

7.6 Tow Services (Van Vanwettens)

Positives:

- The Tow service received a call and responded timely

Observations and opportunities for improvement:

- The Tow services arrived at the scene down wind and drove into the hot zone- he became a casualty

7.7 Provincial traffic

Positives:

- Provincial traffic realised their shortcomings and strategized and then did proper traffic management and cordoned off the roads

Observations and opportunities for improvement:

- Provincial traffic did not close off the bridge- traffic and pedestrians were still moving
- Provincial traffic allowed first responders to come into the incident scene using the downwind approach- they were supposed to inform the responders of the wind direction and the right route upwind.
- Provincial traffic's most senior personnel did not form part of the IC structure
- Cordoning of roads was done late- there was still traffic passing through the incident scene

7.8 South African Police Service

Positives:

- SAPS arrived up wind, timeously and reported to the IC
- Police took information of all the patients in the triage area
- Police called Pathology to respond because we had a P4 Patient (Deceased)
- SAPS took information and photos of the P4 (Deceased patient)

Observations and opportunities for improvement:

- SAPS did not do crowd control over the bridge which was regarded part of the incident
- SAPS most senior personnel from each EMS departments did not form part of the IC structure

7.9 TRAC

Positives:

- TRAC received the call of the incident from Central Communication Centre (CCC) - using RIMS platform for reporting emergencies and Zello Emergency App
- TRAC assisted in cordoning off roads and making them safe
- TRAC made road users aware of the incident ahead, a good distance away from the incident
- TRAC assisted road users that were in a hurry, stuck in traffic by escorting them past the scene using alternative routes
- TRAC also used social media platforms to inform road users to use an alternative route due to the incident on the N4

Observations and opportunities for improvement:

- TRAC most senior personnel did not form part of the IC structure

8. General Observations

8.1 Communication

The communication channels among emergency services were inadequate, as they failed to notify each other of the incident. Instead, each service dispatched its personnel to the scene independently. RIMS has implemented a Centralised Communication Centre (CCC) with the idea to coordinate and centralize emergency communication. To enhance the response in the future, all control rooms need to establish effective communication when an accident is reported. This will ensure that all necessary services are promptly dispatched to the scene, leading to an improved overall response. Undoubtedly, communication is of utmost importance and plays a critical and essential role in emergencies. Good communication is key to good control. Critical to effectively and efficiently managing the scene, all disciplines responding to emergencies require a means of communication such as intrinsically safe radios, with different channels to switch into. A lack of departments not having radios results in a breach of safety at the scene because they will end up using celphones to update and check on each other. The use of celphones has disadvantages at the scene:

- Use of celphones can be regarded as an ignition source
- If the cellphone is intrinsically safe, the network coverage might be the issue

Due to a lack of radios, a lot of information and feedback from stakeholders regarding the tasks they were busy with was insufficiently reverted to the IC.

Media arrived at the scene and convened in a place they thought safe, but the correct process was for them to report to the IC, where the IC would have determined a place safe for them. After the liaison officer provided statements to the media personnel, they were left unattended and some of the personnel ended up straying into dangerous zones of the scene.

8.2 Patient management

In any major incident with multiple patients, it is advisable to set up triage and treatment areas to manage patients more effectively. Patients should be segregated based on injury severity and allocated appropriate ranking for treatment. Proper triage allows for early identification of patients with life-threatening injuries.

The treatment of patients did not follow the ABCDE methodology. Teams seemed to prioritize non-life-threatening injuries first. There was also unsafe movement of patients from the wreckage and later from the scene to the triage area. Some of the patients were carried by limbs when placed on to the stretchers, others were not strapped properly to the stretchers, when some were not strapped to the stretchers at all.

When the initial patient triage in the hot zone is not done correctly, this will also impact how the triage in the medical area and priority marking of patients will be done.

9. Post-Incident Assessment

A Post-Incident Assessment is a structured evaluation process conducted after an emergency exercise or incident. For the Nelspruit N4 Emergency Exercise, this assessment plays a vital role in reviewing the effectiveness of the exercise and identifying areas of improvement. It integrates feedback provided by evaluators, ensuring that the findings are grounded in firsthand observations of the exercise activities.

9.1 Purpose of the Post-Incident Assessment

The primary goal of the Post-Incident Assessment is to analyze the performance of the emergency response systems tested during the exercise and develop actionable insights. The use of evaluators was integral to this process, as they were tasked with observing, documenting, and providing feedback on specific aspects of the exercise. This feedback forms the foundation of the emergency report and ensures that the assessment is comprehensive and data-driven.

9.2 Integration of Evaluator Feedback

9.2.1 Evaluator Allocation:

Evaluators were assigned to specific tasks and scenarios during the exercise, where

they monitored actions, decision-making, and compliance with protocols. Their observations provided an objective assessment of how each task was performed.

9.2.2 Evaluator Observations:

Evaluators submitted detailed feedback on various aspects, including inter-agency collaboration, resource utilization, communication effectiveness, and adherence to the Offsite Emergency Response Plan (ERP).

9.2.3 Emergency Report

The feedback from evaluators was systematically compiled and analyzed to create the emergency report (data from evaluators assessment sheets and recordings of the PIA meeting). This ensured that the Post-Incident Assessment reflected actual performance and provided actionable insights for improvement.

9.2.4 Lessons Learned

Through the evaluators' input, strengths and gaps in the exercise were identified. This included successful coordination among stakeholders and areas where response protocols could be refined.

9.3 Outcome of the Assessment Linked to Evaluator Feedback

The integration of evaluator feedback into the Post-Incident Assessment ensures that the emergency report captures:

- Real-time observations from critical moments in the exercise.
- A balanced evaluation of what worked well and what needs improvement.
- Practical recommendations to enhance future emergency preparedness and response activities.

By involving evaluators in each task and using their insights as the backbone of the report, the Post-Incident Assessment provides a reliable and actionable roadmap for continuous improvement. This approach not only strengthens the Emergency Response Plan but also builds trust and collaboration among stakeholders for future scenarios.

10. Conclusion

The N4 Emergency exercise achieved its objectives as indicated above and indicated the good and improvement areas of all stakeholders. This exercise indicated to all the first responders that they need to work together and not in silos to achieve scene objectives and it also highlighted that they need to have plans in place with credible scenarios, training, and emergency exercises to constantly improve upon identified grey areas. This emergency exercise report will be shared with all stakeholders that had participated in the exercise, and each stakeholder will find their own suited solutions towards how they will identify and close off their own actions. Further, with given recommendations, each stakeholder to use as a guide towards improving their own processes as best practice.

11. Recommendations

- All stakeholders to join RIMS under SANRAL, to have a platform of communication and collaboration.
- All stakeholders to have written emergency response plans based on credible scenarios and periodically review them.
- Sasol to provide Awareness training based on best practices and knowledge to first responders in the Nelspruit region
- All stakeholders to have a program for training first responders on dangerous goods, emergency response and incident command systems.
- All stakeholders must form a JOC group and formulate supporting documents on how and when it can be activated.
- All stakeholders must align on emergency exercises, have a schedule, and test their preparedness and response plans (tabletop or physical exercise) collaboratively based on the agreed schedule.
- Awareness training must also involve community members.
- Each stakeholder must continuously conduct a gap analysis on their procedures and equipment
- Each stakeholder must periodically conduct awareness training on communications to and fro the control room (what questions to ask as personnel responding to an emergency, and what information to give as a dispatcher)
- All Stakeholders involved in the Nelspruit N4 Emergency Exercise to meet after six months after receiving the emergency exercise report, to provide feedback on the progress of implementing corrective recommendations

12. Photographs and video link

Link: [Nelspruit N4 ER video](#)

Photographs of Roadshow and community outreach program



Photographs of the emergency exercise



