CONTENTS

INCIDENT, REPORTING AND INVESTIGATION

1. INCIDENT

An incident is defined as, an undesired event, which may result in:

- Harm to people (Work related injury, fatality)
- Damage to environment (pollution)
- Damage to property or
- Process loss (Breakdowns)

It also includes breaches of security such as piracy and stowaways.

Thus, wherever the words accident, injury, damage, pollution, or process loss has been used in any manual, it must be deemed to refer to a type of Incident.

1.1. Injury incident

This is an uncontrolled or unplanned event, or sequence of events, that results in a fatality or injury to a seafarer onboard ship or whilst ashore on company business.

Note: This excludes;

- suicide or attempted suicide.
- criminal or terrorist activity.
- a deliberate act on the part of another individual; and,
- incidents which occur off the ship but where the consequences appear onboard at some later time.

1.2. Lost Workday Case (LWC)

This is an injury which results in an individual being unable to carry out any of his duties or to return to work within 24 hours following the injury unless caused by delays in getting medical treatment ashore.
Note: An injury is classified as an LWC if the individual is discharged from the ship for medical treatment.

1.3. Restricted Work Case (RWC)

This is an injury which results in an individual being unable to perform all normally assigned work functions during a scheduled work shift or being assigned to another job on a temporary or permanent basis on the day following the injury.

Note: The following come into the category of "less than normal assigned work functions"

- performing all duties or normal assigned work functions but at less than full time schedule.

- performing limited duties at normally assigned job at fulltime schedule; and,
- transfer to other duties.

1.4. Lost Time Injuries (LTIs)

Lost Time Injuries are the sum of Fatalities, Permanent Total Disabilities, Permanent Partial Disabilities and Lost Workday Cases.

(LTIs = Fatalities + PTD + PPD + LWC)

1.5. First Aid Case (FAC)

This is any treatment and subsequent observation or injuries such as bruises, scratches, cuts, burns, splinters, etc. The first aid and treatment may or may not be administered by a physician, or registered professional.

FACs include:

- follow-up visits to a physician or nurse for observation ONLY, or for routine dressing change.
- negative X-ray results.
- cleaning abrasions/wounds with antiseptic and applying dressing.
- irrigation of eye and removal of non-embedded foreign objects using a cotton swab.
- one time administration of oxygen after exposure to toxic atmosphere and resumption of normal (but not restricted) work the following day.
- soaking, application of hot-cold compress and use of elastic bandage on sprains and strains immediately after injury.
- applying one-off cold compress or limited soaking of a bruise.
- use of non-prescriptive medicines.
- use of elastic bandages,
- treatment of First-Degree burns.
- injuries which result in loss of consciousness, even if the individual resumes work after regaining consciousness (N.B. this does not cover loss of consciousness due to ill health).
- sutures for non-cosmetic purposes.
- use of casts, splints or other means of immobilisation.
- any general surgical treatment.
- removal of embedded objects from eye by surgical means.
- use of other than non-prescriptive drugs or medications.
- use of a series of compresses for treatments of bruises, sprains or strains

1.6. Total Recordable Cases (TRC)

The sum of all work-related fatalities, lost time injuries, restricted work injuries and medical treatment Injuries.

TRCs = LTIs + RWCs + MTCs.

2. INCIDENT CATEGORY

Note: General guidance only and may be decided by DPA or Head of Risk depending on gravity of the incident. In order to be able to address each incident with the correct category and speed of response the decision on the category must be made as early as possible.

2.1. High Severity

An incident or series of incidents that results in:

- One or more fatalities
- Multiple serious injuries to personnel
- Catastrophic financial loss or property damage including third party damage.
- Imminent and substantial endangerment to public health
- Property damage or loss of more than 1 million USD
- Significant environmental damage (Oil spill in water more than 1.0 m3)

2.2. Medium Severity

An incident, other than a high severity incident, that involves:

- A single serious injury to personnel
- Major impact to public health
- A major financial loss or property damage including third party damage.
- Material or equipment damage affecting the seaworthiness or efficiency of the vessel.
- Property damage or loss of 100,000 - 1 million USD
- Major environmental damage (Oil spill in water less than or equal to 1.0 m3)

2.3. Low Severity

Any incident other than a medium severity accident e.g., an incident that:

- Does not involve a serious injury, e.g. personal injury requiring first aid, and not quantified as a Lost Time Incident
- Equipment failure which results in time loss

- Results in a minor financial loss or property damage or Consequences undesirable or unexpected outcomes that result in negative effects for an organization.
- Property damage or loss of less than 100,000 USD
- Inconsequential impact on the environment (Oil spill contained on board)[1]

3. INCIDENT REPORTING PROCEDURE

a. Master is responsible for reporting all incidents to the company with the objective to improve safety, health and pollution prevention systems of the company, to avoid the re-occurrence of similar accidents and reduce the risks of operations.

b. Initial Notification of all high/medium severity incidents including oil spill contained on board[2] must not be delayed. This should be done as soon as practicable after the occurrence of the incident and should contain as much information as is available through a preliminary investigation.

c. The Company must be notified immediately by telephone and then e mail of any incident resulting in death, serious injury, pollution, damage to the vessel or its equipment, damage to other vessels or property, or if the vessels seaworthiness is compromised.

d. Subsequently incident data entered in CFM[3]. Any supporting documents, statements of witnesses and photographs should be forwarded to the office and added to the Document section of the accident report in CFM[4].

e. Damage caused to buoys, beacons, other aids-of-navigation, quay walls, locks, bridges, must be reported immediately to proper local authority.

f. Reference is made to the legal requirements. If any legal reporting is required, same shall carried out as soon as possible by the office or directed to the vessel as appropriate.

g. Injuries to Visitors, Contractors, Company staff or any person not part of the Crew, and Damages caused by Vessel to Third Party Property must also be reported to office.

h. Photographs play vital role in incident analysis. Photographs where possible must be forwarded with the reports. If the camera has a date/time function, this should be used

i. All listed field in the incident report form must be completed.

j. All cases of injury incidents, however minor it may be, are to be reported to office. Refer OCIMF Marine Injury Reporting Guidelines while reporting injury incidents.

k. Refer Contingency Plans Manual for actions to be taken if incident involves emergency like collision, fire, grounding etc.

l. Master also has an obligation under law to make reports of Oil Spills, details of which are provided in the SOPEP/SMPEP and VRP.

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[1] W 26 / 2020
[2] W 26 / 2020
[3] W 03 / 2025
[4] W 03 / 2025

m. Flag State regulations require reporting of serious incidents and injuries to the Flag Administrations. The Designated Person Ashore or Marine Superintendent shall assess all reports and ensure compliance to legal /regulatory reporting requirements for various authorities like flag state.

n. If evidence shows that the incident has either occurred due to or resulted in a breach of regulatory requirements, the DPA shall report it to the appropriate authorities.

o. Company shall also inform P&I club/ H&M and other relevant parties depending on the gravity of the incident.

p. No verbal or written statements concerning any accident are to be made by the Master or any of the ship's staff, to anyone other than a Company Representative, which may be the P and I representative.

q. Questions asked by official investigators at the scene of an accident are not to be answered unless legal council is present or unless authority is given by the company. If the Master or any Officer or Rating is required to answer questions and the authorities do not permit time for reference to the Company, local legal advice must then first be obtained through the ship's agent or P and I representative and the Company informed as soon as possible thereafter. It is accepted that these procedures may cause delay to the vessel.

r. Should the Master or any crewmember be forced by the authorities to make a statement, their statement should be endorsed with the following "This statement is made in contemplation of legal action". The Master shall notify the Company as soon as possible thereafter and a scanned copy of the written statement is to be sent.

s. All communications must be preceded by the words "THIS DOCUMENT IS PRIVILEGED AND WITHOUT PREJUDICE AND CONFIDENTIAL FOR ADDRESSEE ONLY".

t. Reference should be made to Fleet Procedures Manual, Section 12.0, Insurance and Claims.

u. Once an investigation is completed, and the report is closed. The final report must be shared with the ship management department, including the CEO.

3.1. Safety Flash

Within 24 hours of an incident or accident, a Safety Flash must be sent to the entire fleet and the Ship Management Department. This communication should outline the nature of the event, indicate whether there were any casualties, and confirm that an investigation is underway, no details of the vessel or personnel involved to be share at this stage. Additional details and findings will be shared once the investigation is complete.

4. MEDIA AND PUBLIC INTEREST

a. No statements are to be given to the News Media, Agents or anyone other than officials entitled to have the information. (Refer Fleet Procedures Manual, Section 10.2, Press and Media communication

b. Claims made by outside agencies that they have consent of the Company to represent it are to be first checked and confirmed by the Company.

5. LOGBOOK ENTRIES

a. Particulars regarding accidents, damage must be entered in the Official Logbook, the Deck Logbook and, if appropriate, the Engine Room Logbook.

b. These particulars should at all times be confined to the date, place and time of the accident/near-miss, and the nature and extent of damage or injury sustained, as well as measures taken to protect the safety of the vessel and crew.

c. Detailed narratives or statements in the vessel's logbooks describing the accident / near-miss are unnecessary and are to be avoided.

6. DRUG AND ALCOHOL TESTING

The possibility of effect of drugs and alcohol must be investigated. For drug and alcohol testing procedures, following an incident, refer to company Drug Alcohol policy.

6.1. Post Incident Test Procedure

These guidelines are based on the USCG Regulations. Samples must be taken in case of Accidents or Incidents (as defined above)

6.2. Collection of samples

The regulations do not set a specific time limit but require collections "as soon as practicable." They also state that the regulations shall not prevent a person from performing duties in the aftermath of an accident to protect lives, property, or the environment. Each case will be different. However, it should be noted that evidence of alcohol can leave the body quite quickly.

6.3. "Directly involved" in a serious marine incident

An individual whose order, action, or failure to act is determined to have, or cannot be ruled out as having caused or contributed to a serious marine incident is "directly involved". A law enforcement officer, such as a Coast Guard officer, Port State officer, or a state or local police officer may also determine that a person was directly involved in a serious marine incident. If this happens, the Master shall then take all practicable steps to collect a sample.

6.4. Specimen Collection Equipment

Urine collection and shipping kits are maintained aboard vessels. Breathalysers are also carried aboard vessels. Blood sampling equipment is not carried aboard.

6.5. Breathalyzer testing and results

Breathalyzer results are to be witnessed, taken and recorded as laid down in the Drug and Alcohol Policy.

6.6. Urine Sample Results and Blood Sample Results

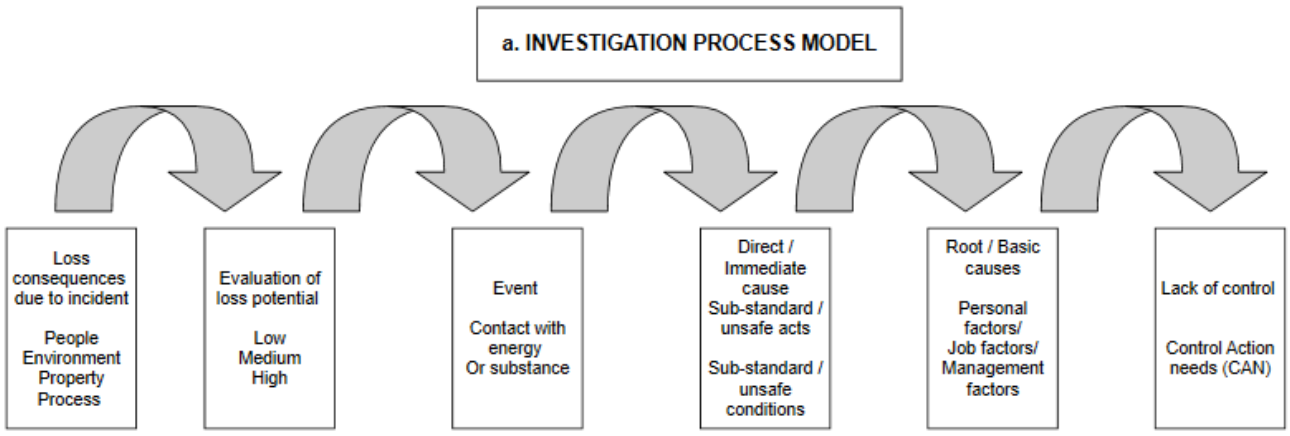
Vessels carry Testing kits aboard be used as per manufacturer's instructions, and as when required. Testing and custody of transfer must be in accordance with of the Drug and Alcohol Policy. Blood Samples may only be drawn by a qualified individual.

6.7. Post-Accident Reporting Requirements in the USA

A Coast Guard form CG-2692B, Report of Required Chemical Drug and Alcohol Testing Following a Serious Marine Incident, must be submitted to the appropriate Officer in Charge, Marine Inspection following any serious marine incident. This form should be submitted along with a form CG-2692, Report of Marine Accident, Injury or Death. The drug test results will not always be available when the CG-2692 and CG-2692B are submitted. The marine employer must report the test results, positive or negative, when they receive them.

7. INVESTIGATION PROCESS MODEL AND EXPLANATION OF LOSSES

The cause-and-effect sequence of an accident is expressed in an 'Investigation Process Model'



7.1. Why investigate Incidents?

Incident investigation has the primary purpose of preventing further incidents by identifying the causes and lessons learned to allow safeguards to be put in place to prevent recurrence. If the investigation is only concerned with the actual injuries and losses associated with the incident, then some potential causes and lessons may be missed.

In a simpler incident, the causes may be more readily apparent than in a High Severity Incident. In a High Severity Incident, there will probably be complex multiple causes and

error chains which will take time and effort to identify. In essence, the more serious an incident the more potential there may be to identify causes and lessons.

All incidents must be investigated to identify and control safety, health or pollution hazards before they cause a more serious incident.

7.2. An Investigation helps to:

- Identify immediate and basic root causes.
- Establish preventive strategies to avoid similar incidents from recurring in the future.
- Establish trends in incident causes and establish training needs.
- Identify any new hazards.
- Satisfy industry / legal requirements.

Frank and open investigations that concentrate on lessons that can be learnt help in creating a good safety culture in the organization.

Preventing incidents also improves the profitability of a business.

We therefore request the cooperation of all our ships staff in reporting each and every incident.

7.3. Who should investigate?

This will depend on the type of incident and its seriousness of the incident and the potential for or actual loss, damage or injury involved.

The person appointed to lead the investigation shall not be connected with the incident and shall be trained in incident investigation.

The company provides training in incident investigation techniques, including root-cause analysis, to key shore-based staff. The Master and Chief Engineer is responsible for Incident investigation and will be suitably trained/certified for this.[5]

Ship Officers are trained in incident investigation on board using Karco Training Module (refer Fleet Procedure Manual, 5.0 Training).

Where possible trained personnel shall be given opportunities to participate in investigations (and practice the relevant skills) so that practical experience is obtained before being expected to lead an investigation.

Company has access to sufficient resources and personnel who can assist in investigation; this may include independent contractors. Investigator is decided as following:

[5] W 52 / 2017

- **Low severity incidents:**

  Incident investigation shall be done by Master / Chief Engineer / Chief Officer / Second Engineer

- **Medium severity incidents:**

  The investigation team will include Marine Superintendent or DPA or Ship Manager as appointed by Head of Risk

- **High Severity accidents:**

  The investigation team will include DPA or other Senior personnel, or an external qualified investigator appointed by CEO.[6]

7.4. When to Investigate?

The investigation should be conducted as soon as reasonably possible, after the immediate steps, required for the safety of the people or vessel, have been completed.

7.5. How to Investigate?

Publications such as Mariners' Role in Collecting Evidence (Nautical Institute), Code of Safe Working Practices (MCA), Marine Injury Reporting Guidelines (OCIMF) etc assist with conducting an incident investigation.

Following are six major phases of effective investigation, with key point guidelines for each:

7.5.1. Respond to the emergency promptly and positively:

i) Take control at the scene.
ii) Implement ship's emergency procedure.
iii) Ensure first aid and call for emergency.
iv) Control potential secondary accidents.
v) Identify sources of evidence at the scene.
vi) Preserve evidence from alteration or removal.
vii) Investigate to determine loss potential.
viii) Decide who should be notified.

[6] W 09 / 2024

7.5.2. Collect pertinent information

i) Get the 'Big Picture' first. Have a look at the scene of the incident and try to identify the people, equipment, materials and conditions present at the scene of the incident.

ii) People evidence – Interviewing

- Interview all witnesses separately as quickly as possible after the incident so that people do not forget the details.
- Interview each person separately.
- Interview on-site whenever feasible.
- Put the person at ease and explain that the purpose of the investigation is to find the cause to prevent the incidents and is not for blaming any individual.
- Get individual's version.
- Ask question at the right time.
- Give the witness feedback of your understanding.
- Record (in writing) critical information quickly.
- Use visual aids.
- Use re-enactment sparingly and carefully.
- End on a positive note.
- Keep the communication line open.
- If required, re-interview witnesses to clarify any doubts.

iii) Any personnel directly involved with the operations leading to incident, should be asked about their routine working schedule and rest periods immediately preceding the incident to confirm if they were adequately rested or could be suffering from fatigue at the time of incident.

iv) Allow the witnesses to speak freely and express it in their own words. Do not give your opinions regarding the possible causes! Do not allow your past experiences affect your judgment or lead to pre-conceived opinions on the causes.

v) Avoid asking questions, which are answered in just a "YES" or "NO". They do not help in prompting the person's memory. Ask open ended questions such as "Can you describe in your own words what happened?"

vi) Repeat what you have understood to the witness to confirm that you have understood the meaning correctly.

vii) Don't re-enact an incident unless absolutely necessary and under strictly-controlled conditions.

viii) For capturing Position evidence, use sketches, maps and photography to show relative position and before-and-after details. Take photos, video recordings of the site. This helps in aiding to memory.

ix) Collect and safeguard important Parts such as equipment, tools, damage areas and fluid samples. Consider if any equipment, material needs to be sent ashore for testing or may be required as evidence. If so, label it and preserve it carefully.

x) Check inspection reports, checklists, logs, maintenance records, log books etc. to substantiate evidence. Examine Records to identify basic causes such as training, maintenance or scheduling problems.

xi) After collecting the evidence, read it carefully and co-relate the evidence to ensure that evidence received from different sources and individuals is fitting together; e.g. do the timings of the course recorder tally with the timings given by the persons interviewed? If required, re-interview witnesses to clarify any doubts.

xii) Breach of requirements: The investigation requires identifying any possible breach of Company, flag or International requirements, rules and or regulations. In this respect please consult Company's SMS manuals, circulars, SOLAS, MARPOL, SOPEP - Flag regulations, notices, advisories and requirements

xiii) Consult makers for unusual failure of an equipment[7]

Analyse and evaluate all significant causes:

a. Use the cause-and-effect sequence.

b. Make a casual factor outline.

c. Cover immediate cause or symptoms (sub-standard acts/practices and conditions).

d. Cover basic or underlying causes (personal factor and job factors).

e. Determine the critical few specific causes.

f. Cover deficiencies in the management system (inadequate system, inadequate standards, inadequate compliance with standards).

Analyse the facts carefully. It is important to base judgments on facts and not on pre-determined views.

Drawing a timeline of the events helps in analysing the incident. ASK WHY. A simple technique to reach the "root cause" or "basic cause" is to keep asking WHY?

7.5.3. The Five "Whys" Technique

i) 5 Why's is a simple tool for determining the root cause of a problem. It is a method of asking "Why" till the root cause is reached. Very often, 5 iterations of asking why is sufficient to determine the root cause and hence

[7] W 35 / 2020

the name “5 Why’s” however it is not mandatory. Determining the root cause may take less or more than 5 iterations of why.

ii) The 5 Whys strategy is an easy and often-effective tool for uncovering the root of a problem. Because it's simple, you can adapt it quickly and apply it to almost any problem.

iii) So Why Use 5 Whys: Its beauty is in its simplicity. It is a tool which everybody can readily apply. It also ensures that you don’t move to action straight away without fully considering whether the reason you've identified really is the cause of the problem.

iv) An example of implementing the ‘5 Why’s Technique”:

a. My car will not start. (The problem)
    i. Why? - The battery is dead. (first why)
    ii. Why? - The alternator is not functioning. (second why)
    iii. Why? - The alternator belt has broken. (third why)
    iv. Why? - The alternator belt was well beyond its useful service life and has never been replaced. (fourth why)
    v. Why? - I have not been maintaining my car according to the recommended service schedule. (fifth why, a root cause)
    vi. Why? - Replacement parts are not available because of the extreme age of my vehicle. (sixth why, optional footnote)
b. I will start maintaining my car according to the recommended service schedule. (Solution)

v) To validate those potential root causes that are under your control, you can apply the following validations to your answers or root causes. Ask the following questions for every possible root-cause you identify at all levels of the 5 Whys:

- Is there any proof (something you can measure or observe) to support this root-cause determination?
- Is there any history or knowledge to indicate that the possible root-case could actually produce such a Problem?
- Is there anything "underneath" the possible root-cause that could be a more probable root cause?
- Is there anything that this possible root-cause requires in order to produce the Problem?
- Are there any other causes that could possibly produce the same Problem?

7.5.4. Develop and take corrective actions:

i) Consider alternative controls.

ii) Lower the likelihood of occurrence.

iii) Reduce the potential severity of loss.

iv) Take temporary actions immediately.

v) Take permanent actions as soon as possible.

vi) Document with written report.

Prepare report using sketches, photos and descriptions. Clarity of the report is important as people reading the report have not seen the incident site and have not heard the evidence. The readers should be able to clearly understand the facts through the report.

7.5.5. Review findings and recommendations

i) Have every report reviewed by the next higher-level manager.

ii) Measure the quality of the reports and coach for improvement.

7.5.6. Follow through

i) Conduct investigation review meetings.

ii) Monitor timely implementation of remedial/preventive actions.

iii) Analyse data for trends.

iv) Profit from prompt and positive changes based on reviews, analysis and experience.

8. FOLLOW UP AND CLOSING OUT OF INCIDENT REPORT

a. Corrective actions for an incident shall be taken immediately.

b. Any shore assistance required shall be reported to company.

c. Any delays shall be immediately notified to office.

d. In case, any breach of regulations or Company procedures considered critical is identified during investigation, necessary measures shall be taken and all vessels shall be informed.

e. The report sent by the vessel shall be reviewed by the company to confirm that the incident has been adequately investigated.

f. The investigation report shall be completed as soon as possible with all the facts and relevant information. Statements from participants and witnesses should be used to establish the facts.

g. The final investigation report shall normally be completed within 30 days from the date of the incident unless a different time scale has been decided by the investigation team.

h. Company shall ensure that the investigation has fully explored the possible causes and identified appropriate actions to prevent recurrence.

i. All investigations shall be closed within 3 months by company. DPA / Head of Risk shall review this timescale until all issues are resolved.

j. If unable to close within 3 months, Head of Risk is to be informed and extension to be obtained stating reasons for the same.

k. Marine Superintendent / DPA / Ship Managers shall ensure effective implementation of the subsequent corrective action and recommendations of the incident investigations.

l. Preventive actions identified during investigation shall be implemented at the earliest Additional or refresher training shall be provided to personnel involved in an accident as appropriate.

m. The effectiveness of the corrective and preventive Actions shall be reviewed during subsequent Safety meetings, Master's review and internal audits.

8.1. Analysis

Company shall ensure that incident investigation findings are retained and periodically analysed to determine where improvements to management systems, standards or practices are required.

Company ensures that the root causes and factors contributing to an incident are identified and that steps are taken to reduce the risk of a recurrence.

When determining root cause, reference to possible breaches of company and legislative requirements shall be considered.

The objective of the analysis is to identify the trends from incidents. From these trends, aim and objectives will be produced for agreement at the management review. This will enable the most effective actions to be carried out to reduce the losses in the future.

The recommendations should be as far as possible made to address the lapses in HSQE management system rather than on individuals.

All incidents shall also be reviewed by DPA and top management during annual management review.

Company may make necessary amendment to existing HSEQ procedures or develop new procedures if required as part of preventive action.

Contingency Plan Manual shall also be reviewed as required after medium or high severity incident.

8.2. Sharing lessons learnt

- Fleet shall be immediately notified of the safety related information from the incidents.
- The Company shall send summary of the important incident reports and lessons learnt to all the ships, with a view to prevent similar incidents on other ships. Masters shall discuss the incident reports with all crew so that similar incidents are prevented.
- In case of high severity incidents and where appropriate, Company shall share the lessons learnt with appropriate industry groups, e.g., Classification Societies, charterers, P&I clubs, professional institutes, equipment makers, shipyards, industry associations etc to avoid similar incidents on other vessels.
- Major incidents would form a part of case studies for officer seminars.
- Quarterly HSQE performance statistics including incident statistics shall be provided to the fleet.

Company shall use the conclusions from the investigation to reduce the risk of any recurrence or related incidents.

The lessons learnt shall be used to drive improvements in HSQE performance and reduce the risk of any recurrence or related incidents.