1.0 Purpose

The purpose of this document is to define the procedure to be followed by ALL departments if there is an incident, accident or near miss situation within the Nassau Cruise Port facilities.

The intent of any resulting investigation is to establish the facts and circumstances related to the event in order to determine the root cause and develop remedial action to control the risk.

2.0 Responsibility

This procedure applies to ALL departments. The OHSE Manager (OHSE Department) is responsible for ensuring that all accidents, incidents, and near misses that are associated with the NCPL Integrated Management System are actioned to mitigate any consequences that may arise, in accordance with the procedures that follow:

3.0 Procedures

3.1 Internal Reporting

- ALL injuries, illnesses, environmental concerns, and near-misses that occur on the job shall be reported immediately by the affected person to the responsible supervisor and forwarded to the OHSE Department.
  - Immediate appropriate action is required to address the incident and attend to people or environmental concerns.
  - The severity of the incident and its classification may change as more is learned about the incident.
- The reports shall be logged, and a root cause analysis is initiated when applicable as per the project investigation process.
  - An accident & incident report shall be logged with a log number by the OHSE Manager and Security Department.

3.2 Incident Management Process

The following activities shall comprise the critical aspects of the incident management process:

- Employees have a responsibility to promptly report incidents to their supervisor.
  - Supervisors are responsible for ensuring incidents are appropriately reported and investigated.
- To maintain reporting consistency, all incident investigation reports shall be done using the NCPL incident report forms, which are subjected to review and approval by the department managers.
  - All injuries, regardless of severity, shall be reported to the facility's OHSE Department.
  - All incidents and near misses shall be reported and initially investigated within 24 hours of occurrence.
- All injuries/incidents shall be reported within defined timescales by NCPL OHSE Manager to the CEO as soon as practicable.
- If injured workers require transport to an off-site doctor or clinic, the transport shall be coordinated by site medical personnel in conjunction with the NCPL HR manager and OHSE manager or designee.

3.3 Contractor Reporting

- Sub-Contactor supervisors shall be responsible for reporting and participating in the investigation of incidents and high-potential near-miss events.
- Subcontractors shall adhere to all accident/incident and near-miss notification, investigation procedures, and report documentation. They shall be required to report all incidents and near misses within established timeframes and local reporting requirements.
- Depending on the nature of the incident and the persons involved, subcontractor OHSE representatives may also be added to the incident investigation team.

3.4 Regulatory Reporting

NCPL complies with all statutory reporting requirements. These arrangements oblige the organization to report the details of certain accidents and incidents to the relevant enforcing authority. The types of incidents which shall be reported are usually:

- Incidents resulting in loss of life which are reported immediately.
- Incidents resulting in a worker taking several days off work due to injury.
- Incidents involving damage or potential damage to dangerous items of plant.

3.5 Investigations

Incidents/accidents/near misses shall be investigated by the OHSE Manager and appropriate Head of Department, and people connected to the incident.

The report shall be reviewed and signed by the identified Department Manager and OHSE Manager. It shall include details of the injury or incident, root cause, corrective actions taken, and recommendations to prevent reoccurrence.

3.5.1 Root Cause

A root cause analysis shall be conducted on all incidents (injury or environmental).

Accurate, clear, and complete information is needed from the investigation process.

It is important when investigating incidents not to allocate blame which may restrict the free flow of information.

The types of events and circumstances leading up to the incidents, which are relevant for the investigation, may include, but not limited to:

- The system of work currently in place and work instructions.
- Work conditions, such as lighting, floor surfaces, stair treads and handrails, warning signs.
- Condition of tools, equipment, materials, and fixtures directly involved.
- The experience of workers in the in the work being done.

In the investigation of the events the basic factors that determine root cause may be:

- Poor systems design, which may result in exposure to hazards such as unguarded dangerous parts of machinery, ineffective safety devices or inadequate ventilation.
- The work environment has a direct effect on safety behavior. The physical environment, especially sudden changes to that environment, are factors which need to be identified.
- Behavioral factors can result in exposure to hazards. Examples of behavioral factors are the misuse of safeguards, the improper use of tools and equipment, ignoring cautionary notices, failure to wear personal protective equipment, horseplay, or poor standards of housekeeping. Such behavior is not accepted within NCPL.

3.5.2 Interviews

Interviewing the person(s) involved and witnesses to the accident is of prime importance, ideally in familiar surroundings so as not to make the person uncomfortable.

- Interviewees should be separated to stop people from influencing each other.
- Questions when asked should not be intimidating as the investigator will be seen as aggressive and reflecting a blame culture.
- Written records of witness statements should be signed.

3.5.3 Inspections

The accident site shall be inspected and recorded (digital photographs/video recordings) as soon as possible after the accident and inspection findings included in the report.

3.6 Analysis

NCPL uses the information gained from accident and incident statistics to measure trends over a period of time so that the organization has an indication of whether it is improving, stable or deteriorating with regards to IMS safety performance.

The OHSE Manager is responsible for the collection, examination and analysis of all accident and incident data. The purpose of this exercise is to establish incident trends and near miss

situations to direct incident prevention activities to areas of concern. This process enhances risk and incident reduction across NCPL's organization.

3.7 Review

The accident and incident investigation process are reviewed from time to time to check that it consistently delivers information in accordance with the stated objectives and standards. This review may be incorporated with management Reviews.

3.8 Training

The OHSE Manager ensures that adequate training, is provided to staff to implement these procedures. The Human Resources Manager retains records of training received by staff.

3.9 Forms & Reports

Accident and incident reports are discussed NCPL's safety meetings so that corrective and preventive actions can be implemented, and other people benefit from the lessons learned and recommendations made. As a minimum, accident and incident reports are sent to the Department Managers for dissemination. In addition, copies of summaries are forwarded to all relevant worksites for posting on bulletin boards and for discussion at safety meetings.

All documentation and records generated by this procedure is retained and managed in accordance with the documented information procedure.

4.0 Definitions

- Incidents are classed into four types for reporting. They are:
  - Accidents
  - Near accidents
  - Non-conformity
  - Hazard observation

Accidents: An 'Accident' is an event with loss. Loss is harm to people, damage to property, the environment, or process.

Near Accidents: A 'Near Accident' (or near miss) is an event without loss. Near accidents are events that could have resulted in harm to people, damage to property, the environment, or process.

Non-conformity: A **'Non-Conformity'** is a non-fulfilment of a specified requirement.

Hazard Observation: A **'Hazard Observation'** is reporting of Unsafe Acts & Unsafe Conditions that have potential to harm the health, safety, and welfare of people.

- **Analyses & Causes:**

A detailed analysis should be done by the Head of Departments & OHSE Manager to derive lessons learned. This enables individuals to learn from experiences, identify & take preventive actions to prevent occurrence or recurrence & measure safety performance.

A **'Root Cause Analysis'** is an analysis that identifies the casual factors, immediate causes & root causes of an incident and develops recommendations to address each level of analysis.

Causes can be divided into:

- Immediate Cause

This can be further divided into:

- Substandard practices such as rendering safety devices inoperable, incorrect use of equipment, improper lifting, improper securing, failure to use protective equipment, using defective equipment, ignoring signs/warnings.
- Substandard conditions like poor housekeeping, defective tools, inadequate ventilation, poor maintenance, temperature extremes, inadequate barriers, inadequate or poor-quality protective equipment.

- **Casual Factors:** Casual factors are factors that all substandard acts, practices, or conditions to exist or develop. Uncorrected Casual Factors will lead to incidents. An incident often has more than one Casual Factor.

- **Root Causes:** A root cause is a deficiency of a management system that allows the casual factors to occur & exist.

- **Correction:** A correction is an action that eliminates a specific incident. It will not eliminate causes or casual factors that allowed the incident to occur. A correction is often referred to as – 'Quick Fix'.

- **Corrective Action:** A corrective Action is an action to remove casual factors of an incident – 'Permanent Fix'.

- **Preventative Action:** A preventive Action is an action to remove casual factors of potential incidents. Aimed to prevent the occurrence of incidents or situations.

Immediate Cause	Casual Factor	Root Cause
Substandard Act / Practice: • Operating equipment without authority • Under influence of alcohol or substances • Misjudgement • Non fulfilment of specified requirements • Removing/ making safety devices inoperable • Use of defective equipment • Not using PPE • Improper lifting or task position • Servicing equipment in operation • Carelessness • Failure to warn or secure.	**Management Factors:** • Inadequate Supervision • Inadequate Planning • Inadequate Communication • Inadequate Work standard • Inadequate Leadership • Inadequate Engineering • Inadequate Purchasing • Inadequate Maintenance • Inadequate Tools/equipment • Inadequate Work standard • Inadequate Procedures	**Inadequate Management System:** • No system/ issue not addressed. • Not strict enough. • Confusing or incomplete. • Technical Error
Substandard Conditions: • Inadequate guards/barriers • Poor Housekeeping • Inadequate PPE • Defective tools/material • Excessive wear & tear • Workspace restrictions • Hazardous environmental conditions • Noise, High /Low Temperatures • Inadequate Ventilation	**Competence Factors:** • Lack of knowledge • Lack of skill • Lack of experience **Individual Factors:** • Physically Inadequate • Mentally Inadequate • Stress	**Inadequate Compliance:** • Tolerable Risk • Unaware System • Recently changes system • Enforcement Issue **Inadequate Standards:** • Situation not addressed by standard. • Confusing or incomplete. • Inappropriately applied.

5.0 Records

- Written instructions / Procedures.
- Risk assessments /Accident/Incident forms/ Analysis trends

NCPL-IMSP-010
ACCIDENT & INCIDENT INVESTIGATION PROCESS MAP