

Strengthening synergies between Aviation and Maritime in the area of Human Factors towards achieving more efficient and resilient MODES of transportation.



## Retrospective application of SAFEMODE risk models to maritime investigation reports

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28-29 November 2022, Glasgow, UK.





Each risk model is developed for a **specific type of occurrence**, in **a specific operational context**, and considering specific services and systems preventing or contributing to the risk of the accident.

#### Code Risk Model description

- M1 Collision at open sea
- M2 Collision in congested water
- M3 Collision in narrow waters
- M4 Grounding while approach to the berth
- M5 Grounding in shallow waters

# **SAFEMODE** SAFEMODE-RMs Review and Validation



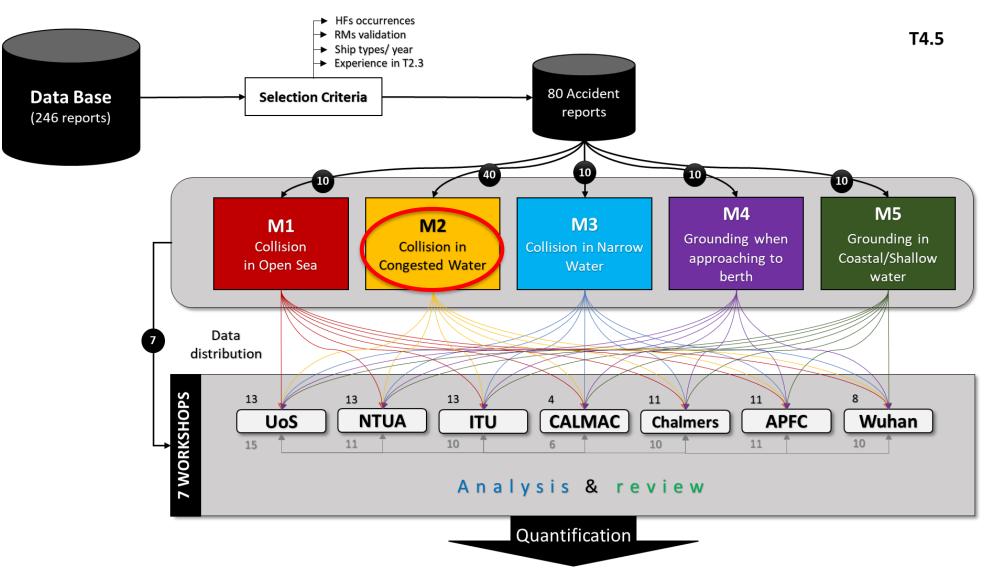
Activity	Date	Participants
1. Introductory meeting	18/06/2021	UoS, NTUA, CHALMERS, ITU, APFC, WUHAN
2. (M5) review-session	23/06/2021	UoS, NTUA
3. (M5) Workshop-I	23/06/2021	UoS, NTUA, CHALMERS, ITU, APFC, CALMAC
4. (M5) review-session	24/06/2021	UoS, NTUA, CHALMERS
5. (M5) Workshop-II	30/06/2021	UoS, NTUA, CHALMERS, ITU, APFC, WUHAN
6. (M4) review-session	05/07/2021	UoS, NTUA, CHALMERS
7. (M4) Workshop	07/07/2021	UoS, NTUA, CHALMERS, ITU, APFC, Kongsberg
8. (M2) review-session	12/07/2021	UoS, NTUA, CHALMERS, CALMAC
9. (M2) Workshop	14/07/2021	UoS, NTUA, CHALMERS, ITU, APFC, CALMAC
10. (M3) review-session	26/07/2021	UoS, NTUA, CHALMERS, CALMAC, ITU
11. (M3) Workshop	28/07/2021	UoS, NTUA, CHALMERS, ITU, APFC, CALMAC, WUHAN
12. (M1) review-session	02/08/2021	UoS, NTUA, CHALMERS, CALMAC
13. (M1) Workshop-I	04/08/2021	UoS, NTUA, CHALMERS, ITU, APFC, CALMAC, WUHAN
14. (M1) review-session	09/08/2021	UoS, NTUA, CHALMERS, CALMAC, ITU
15. (M1) Workshop-II	11/08/2021	UoS, NTUA, CHALMERS, ITU, APFC, CALMAC, WUHAN, Kongsberg
	01/03/2022	
16. Final revision of maritime risk models (deviation reports' remarks were addressed and RMs were updated)	08/03/2022	UoS, NTUA, CHALMERS, ITU
	09/03/2022	



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## **SAFEMODE** Mapping occurrences to the Risk Models





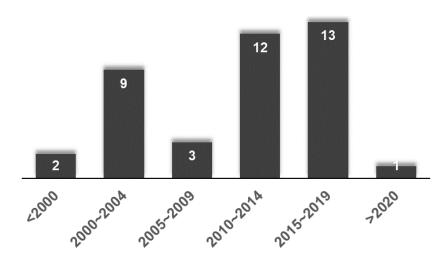
## **SAFE**MODE

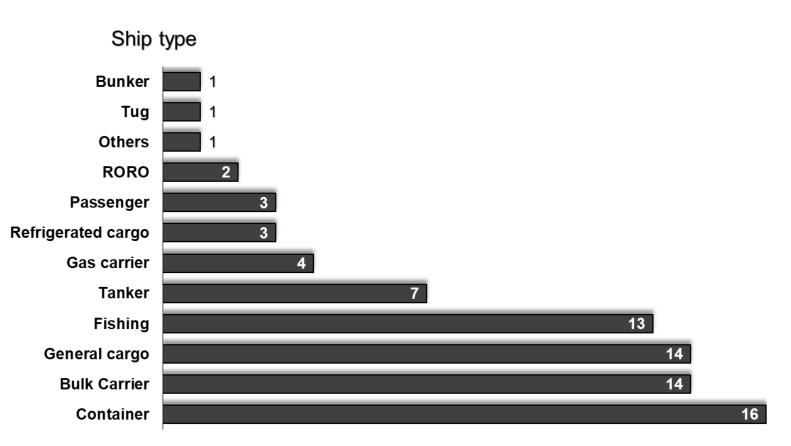
## **Occurrences data (CCW-RM)**



IRs

**IR1** Hampoel and Atlantic Mermaid **IR21** Celtic King and De Bounty IR2 ANL Wyong and King Arthur IR22 Saint Jacques and Gudermes IR3 Saetta and Conger IR23 Philipp and Lynn Marie CMA CGM Florida and Chou Shan IR24 Polar Spirit and Zhe Xiang Yu 41020 IR4 IR25 Baltic Ace and Corvus J IR5 Cepheus J and Ileksa Lykes Voyager and Washington Senator IR26 Condor Vitesse and Les Marquises IR6 IR7 Ash and Dutch Aquamarine IR27 Dream and Ever Decent Spring Bok and Gas Arctic IR28 MV PERSENK and AHMET CAN IR8 IR9 Daroja and Erin Wood IR29 KANALA and LIAODANYU 23626 **IR10** Rickmers Dubai with Walcon Wizard IR30 MV DORIS and ZHE XIANG YU 24005 IR11 MSC Sabrina and Wintertide **IR31** NEPTUNE HELLAS and NUR IR12 Scot Isles and Wadi Halfa IR32 BRITANNICA HAV and Z121 DEBORAH **IR13** Boxford and Admiral Blake **IR33** MV SHARK and Mohammed Badry **IR14** Hyundai Discovery and ACX Hibiscus IR34 MV ADAM ASNYK and MV DK IMAN IR15 Millennium Time and tug Redoubt IR35 Gortynia and DZ Quingdao **IR16** Pasadena Universal and Nordheim IR36 Coulmbus Victoria and Sampet Hope **IR17** Huayang Endeavour and Seafrontier **IR37** Atlantic Hero and Oriental Pioneer IR18 Hyundai Dominion and Sky Hope IR38 Paula C and Darva Gavatri IR19 Kinsale and EastFern **IR39** CLIPPER QUITO and LURONGYU IR20 Scot Explorer and Dorthe Dalsoe IR40 STAR KVARVEN and LULANYU

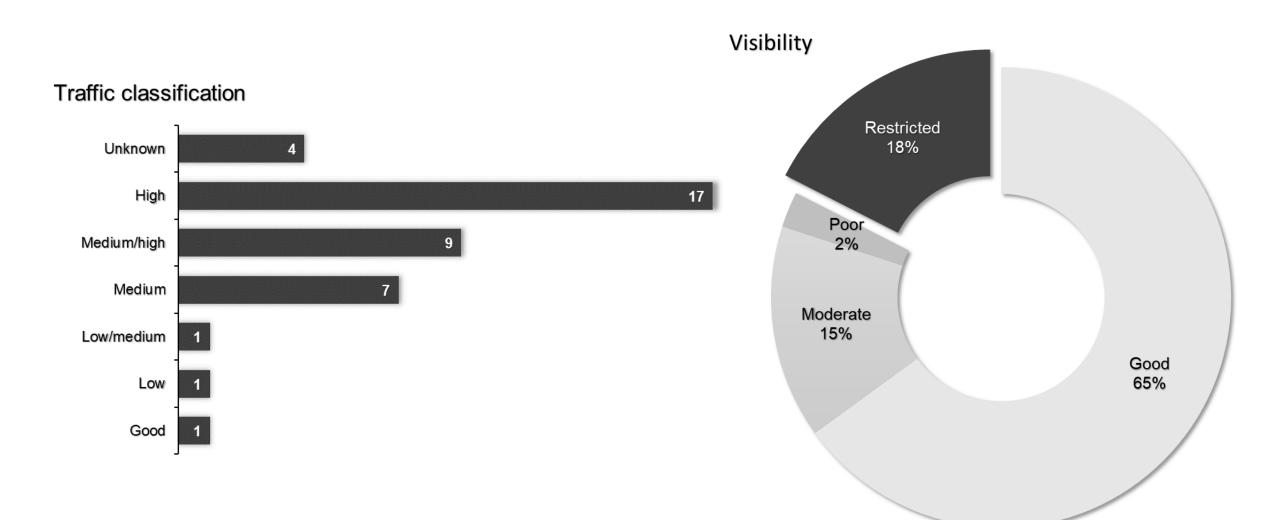






## **Occurrences data (CCW-RM)**





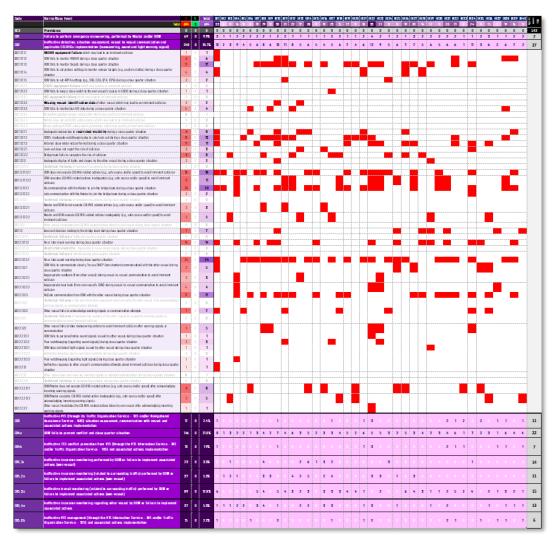


## **CCW-RM occurrences DNA**



Code	Barrier/Base Event		S	Total
	Total	694	0	694
RC3	Providence	0	0	0
CB1	Failure to perform emergency manoeuvring, performed by Master and/or OOW	69	0	9.9%
CB1.1.1	00W fails to assess the action required to conduct evasive manoeuvring (incorrect decision making)	18	0	18
CB1.1.2.1	Steering systems failure during emergency manoeuvring	1	0	1
CB1.1.2.2	Propulsion system failure during emergency manoeuvring	1	0	1
CB1.1.3.1	No execution by the Master and/or OOW for emergency manoeuvring	11	0	11
CB1.1.3.2	Wrong execution by the Master and/or OOW for emergency manoeuvring	10	0	10
CB1.1.3.3	Late execution by the Master and/or OOW for emergency manoeuvring	24	0	24
CB1.2	Other vessel invalidates the emergency manoeuvring actions taken by own vessel	4	0	4
CB2	Ineffective detection, situation assessment, vessel to vessel communication and applicable COLREGs implementation (manoeuvring, sound and light warning signal)	248	0	35.7%





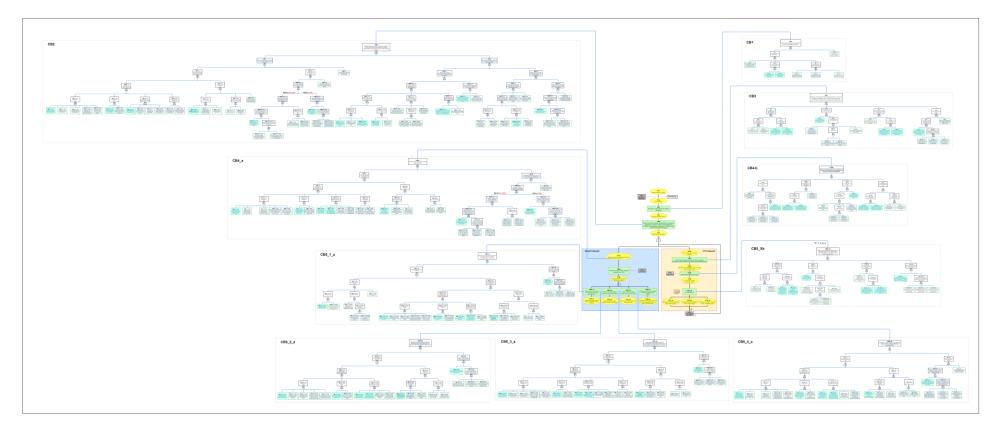
#### Yaser.Farag@strath.ac.uk

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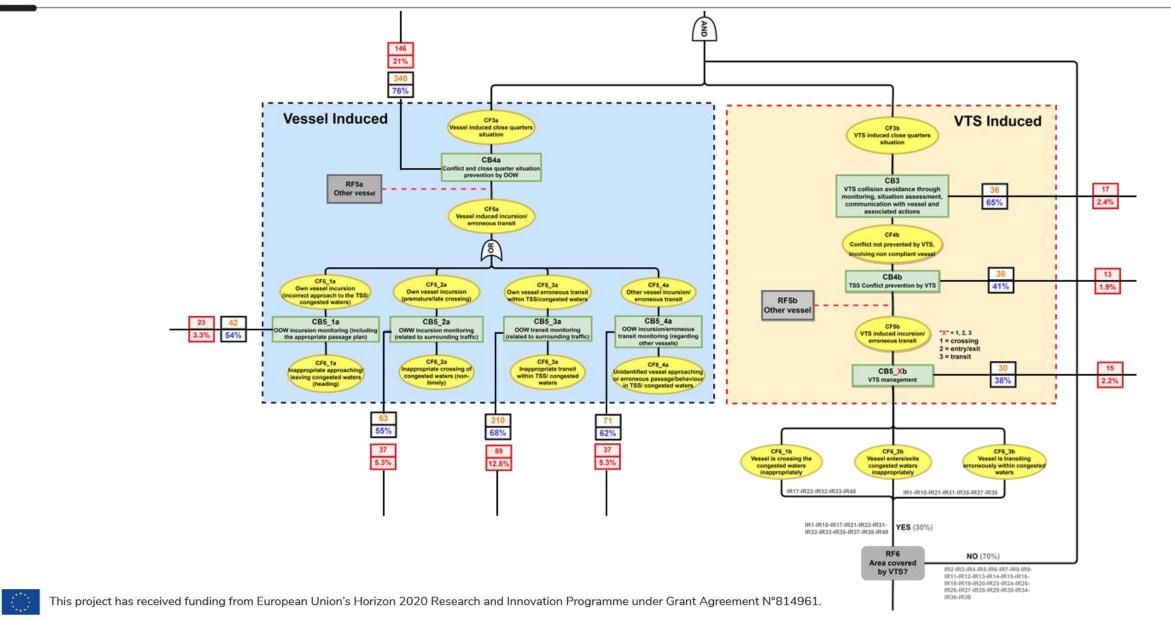


	Human	Technical	Total
BEs in the Risk Model	168 (76%)	53 (24%)	221
BEs seen in the Incidents	135 (80%)	8 (15%)	<b>143</b> (65%)

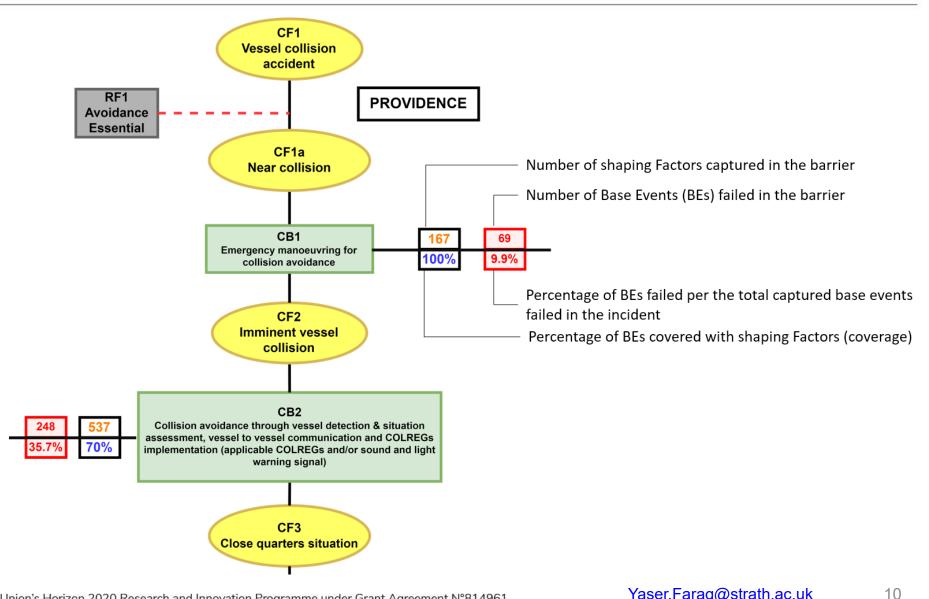








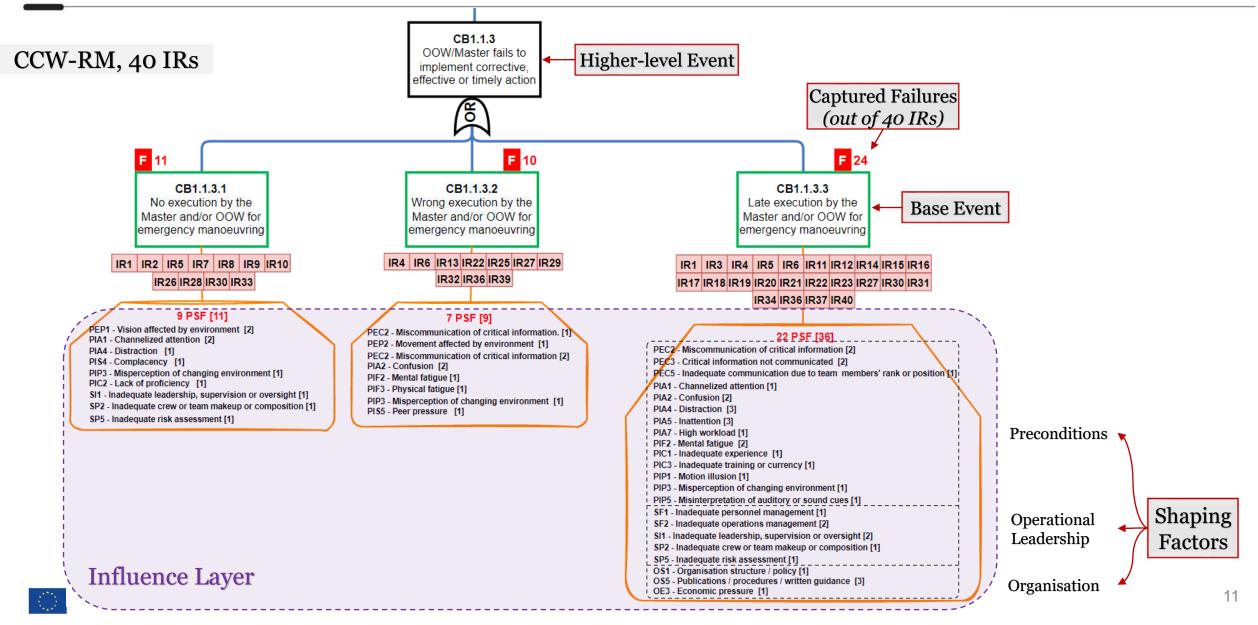




**SAFE**MODE

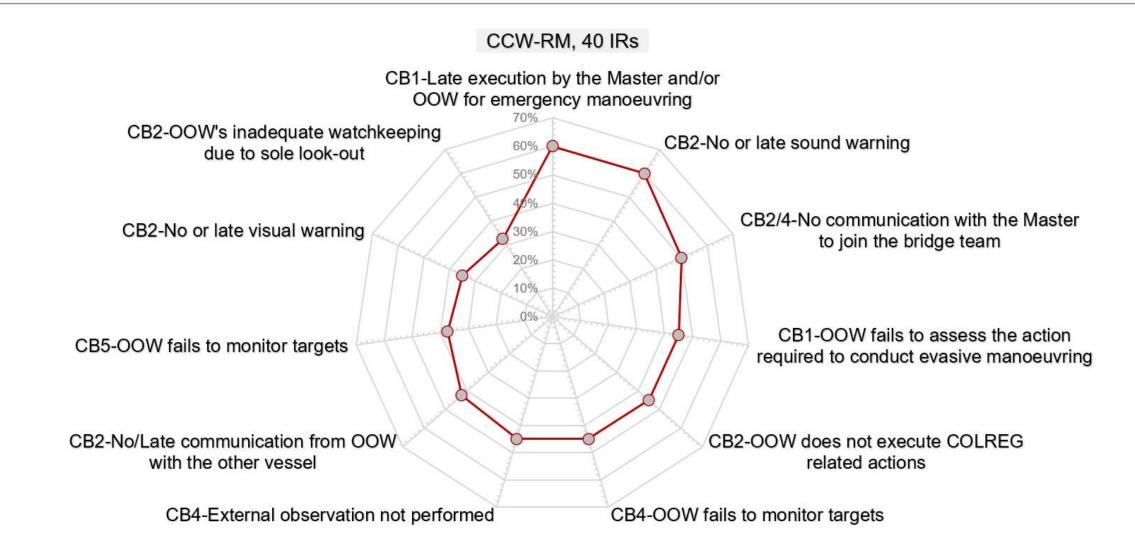






## **SAFEMODE** Occurrences analysis results

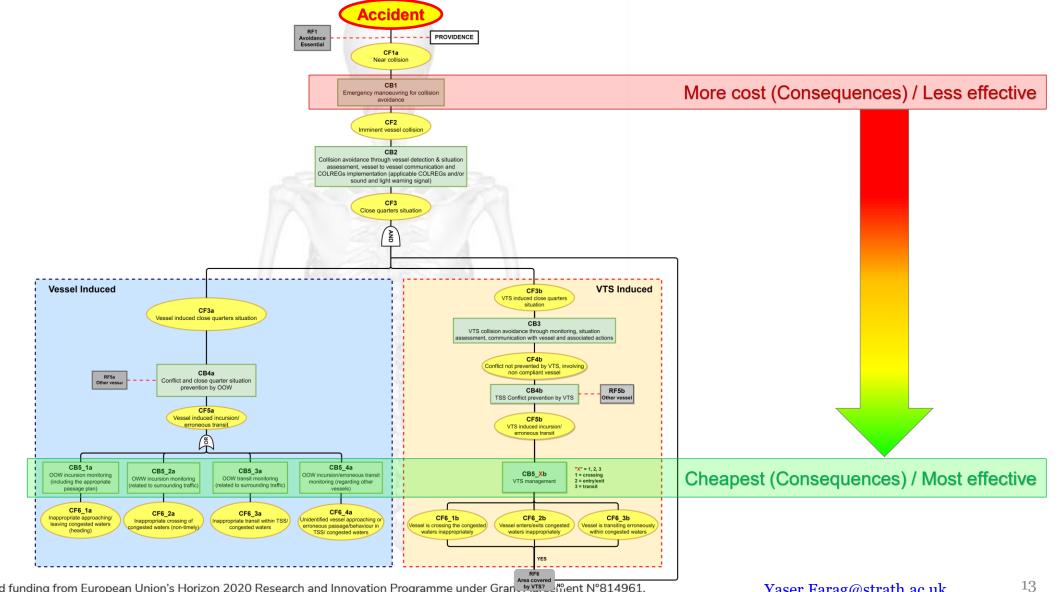






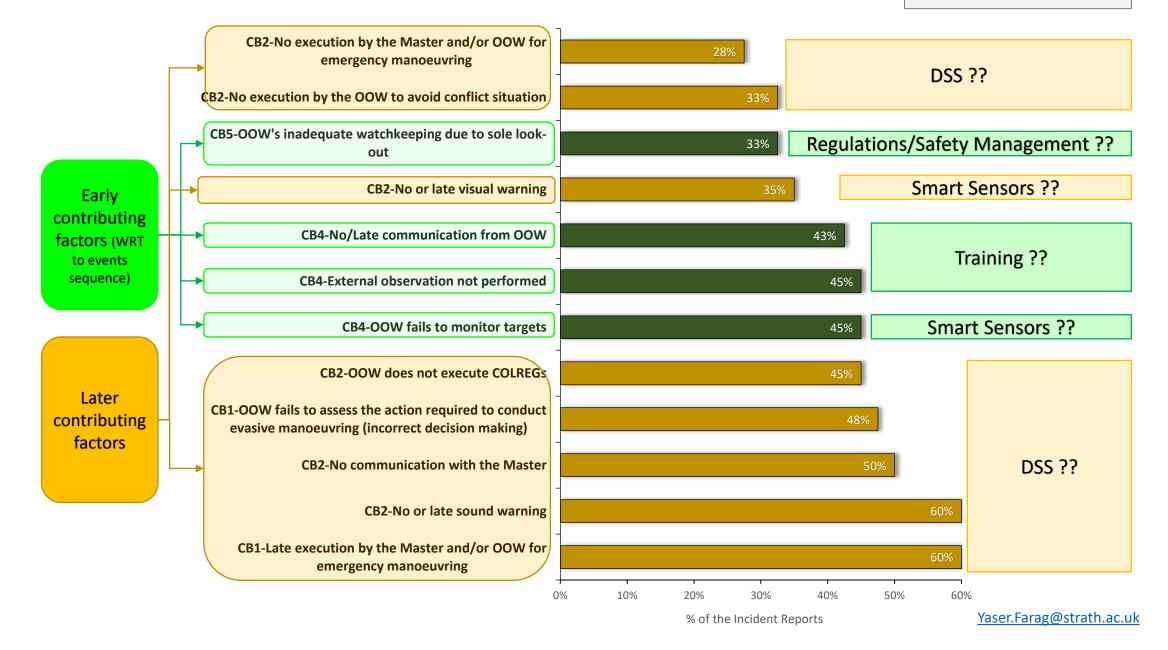
Initial assessment of new safety barriers/measures





### **Initial assessment of new safety barriers/measures**

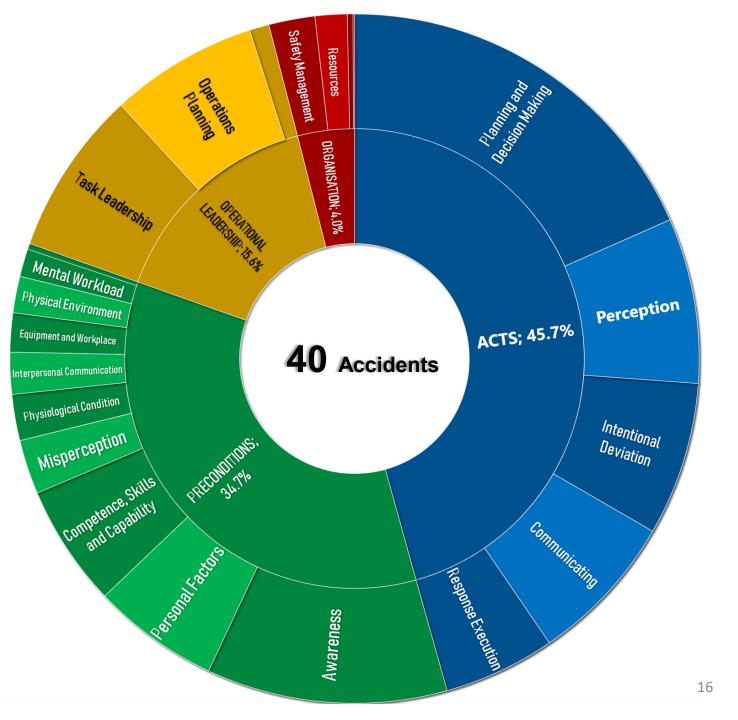
Possible solutions?



Layer	Category	Count
ACTS 697	Planning and Decision Making	281
	Perception Intentional Deviation	118 110
Ă Ŵ	Communicating	108
	Response Execution	80
	Awareness	172
	Personal Factors	91
	Competence, Skills and Capability	87
S	Misperception	39
NO	Physiological Condition	33
PRECONDITIONS 530	Interpersonal Communication	30
530 530	Physical Environment	26
SEC.	Equipment and Workplace	28
đ	Mental Workload	20
	Memory	4
	Team/Group	0
	Drugs and Nutrition	0
SHIP	Task Leadership	118
ORGANISATION 61 238 238	Operations Planning	106
	Personnel Leadership	14
NOIT	Safety Management	33
VISA 61	Resources	23
GAN	Culture	4
OR	Economy and Business	1

Layer	With RM	SHIELD only
ACTS	697	264
PRECONDITIONS	530	164
OPERATIONAL LEADERSHIP	238	87
ORGANISATION	61	35
TOTAL	1526	550

Layer	Category	Count
ACTS 697	Planning and Decision Making	281
	Perception	118
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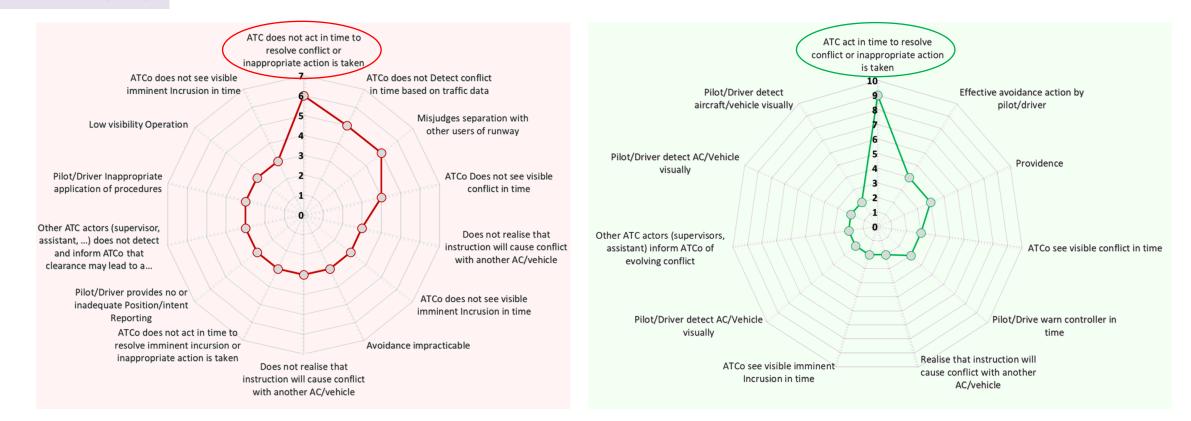




## **Positive Learning**



#### RWY-RM (A1)



#### Runway collision RM (SAFEMODE-Aviation)

38 near miss-reports

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### Collision between the City of Rotterdam and the Primula Seaways



Source: https://assets.publishing.service.gov.uk/media/58984f60ed915d06e1000025/MAIBInvReport3-2017.pdf

This project has received funding from European Union's Horizon 2020 Research and Innovation Programme under Grant Agreement N°814961.



## **Factual information**

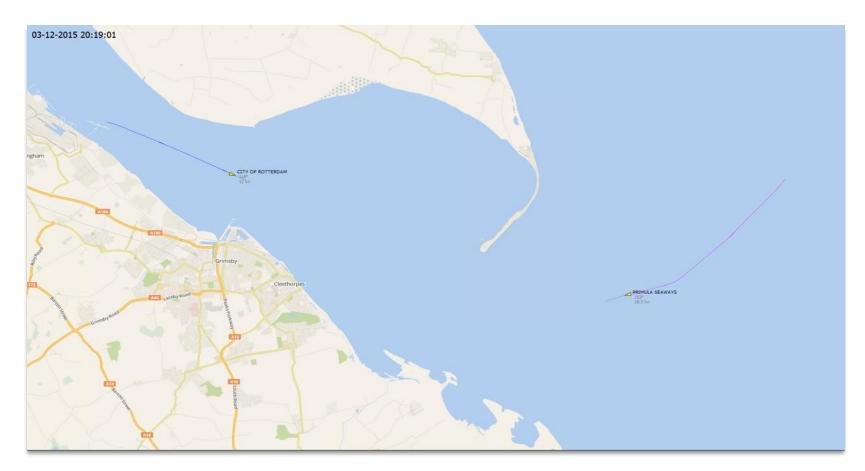


	City of Rotterdam ( <u>link</u> )	Primula Seaways ( <u>link</u> )	Comments	
Year of Built	2011 (4 yrs. age)	2004 (11 yrs. age)	Both ships are relatively newly built.	
Flag	(FOC: Flag of Convenience)	Denmark (Int. register)	<b>Int. register:</b> Some countries maintain an international register to compete with FOC.	
Class	Bureau Veritas	Lloyd's Register	Both are <u>IACS</u> members	
Operator	Owned by <u>Picer Marine S.A.</u> (Panama) and was on long-term time charter to Nissan Motor Car Carrier (NMCC), Japan. Last internal audit identified only minor non-conformities.	DFDS Seaways, The vessel's last external and internal audits under the ISM Code didn't identify any non-conformities or made any observations concerning navigation or bridge procedures.	No findings related to both companies safety management.	
Master	62 yrs., Bulgarian, 2 yrs. as a master for this ship	53 yrs. old, Swedish, 7 yrs. as a master, joined 3 days before the accident	Both ships' masters can be considered as experienced Captains.	
OOW	34 yrs., Filipino, He had been on board the vessel for 4 months.	64 yrs., British, 3.5 yrs. experience onboard	Not significantly contributed to the accident	
Pilot	61 yrs., British, Humber (the river) pilot for 14 years.	Master held a Pilotage Exemption Certificate (PEC)	Pilotage was compulsory in the Humber for all vessels 60m or over in length	
<b>Crew Certification</b>	•	Primula Seaways' bridge teams held the STCV		
Work load	for their positions on board and met the Convention's requirements concerning hours of work and rest.			
VTS	The duty VTS operators were all British nationals. The watch manager was 33 years of age and had been a VTS operator for 7 years.		Three levels of VTS are available: an information service (INS), a traffic organisation service (TOS), and a navigation assistance service (NAS).	
Environment	Wind: south-south-west gusting to <b>40kts</b> flooding at about 1.5kts	. It was dark with clear skies. The <b>visibility</b> was	good and the <b>tidal</b> stream was	





### Collision between the City of Rotterdam and the Primula Seaways



VesselFinder: https://www.youtube.com/watch?v=g2q8-J-dQH4

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CITY OF ROTTERDAM The pilot primarily monitored the vessel's position by eye.

There was a potential for relative motion illusion when looking through an off-axis window.

There were no visual clues, e.g., a forward structure, and the illusion would have been compelling.

The master and the third officer left the responsibility for the vessel's safe passage predominantly to the pilot onboard City of Rotterdam.

City of Rotterdam's bridge team over-relied on the pilot, and thus, there was a lack of effective monitoring of the vessel's progress.

PRIMULA SEAWAYS There was confidence in the bridge team onboard Primula Seaways that City of Rotterdam's Pilot would turn the ship to the south.

A more substantial reduction of speed should have warranted for Primula Seaways.

VTS The VTS intervention could have been more effective in alerting the bridge teams.



## **Design failure**



Image courtesy of Tomas Østberg-Jacobsen



#### **Relative motion illusion**

- errors in judgement from 'relative motion illusion' may occur if objects are viewed through side windows on the curved section of this wheelhouse.
- 'relative motion illusion' is a phenomenon in which objects appear to move as though the ship was heading in the direction of view through the window. it is more likely to occur during periods of darkness

City of Rotterdam's **hemispherical** bow was designed to reduce wind resistance and carbon emissions and to provide better fuel economy (*without considering HFs in design*). A consequence of the bow's shape was that **the vessel's bridge was of unconventional design**.

Source: https://assets.publishing.service.gov.uk/media/58984f60ed915d06e1000025/MAIBInvReport3-2017.pdf

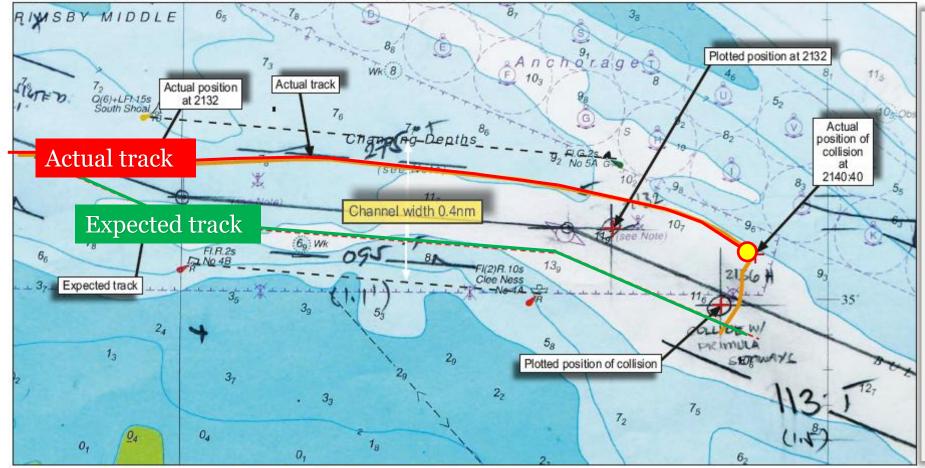
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## **Accident summary**



Reproduced from Admiralty Chart BA 109 by permission of the Controller of HMSO and the UK Hydrographic Office

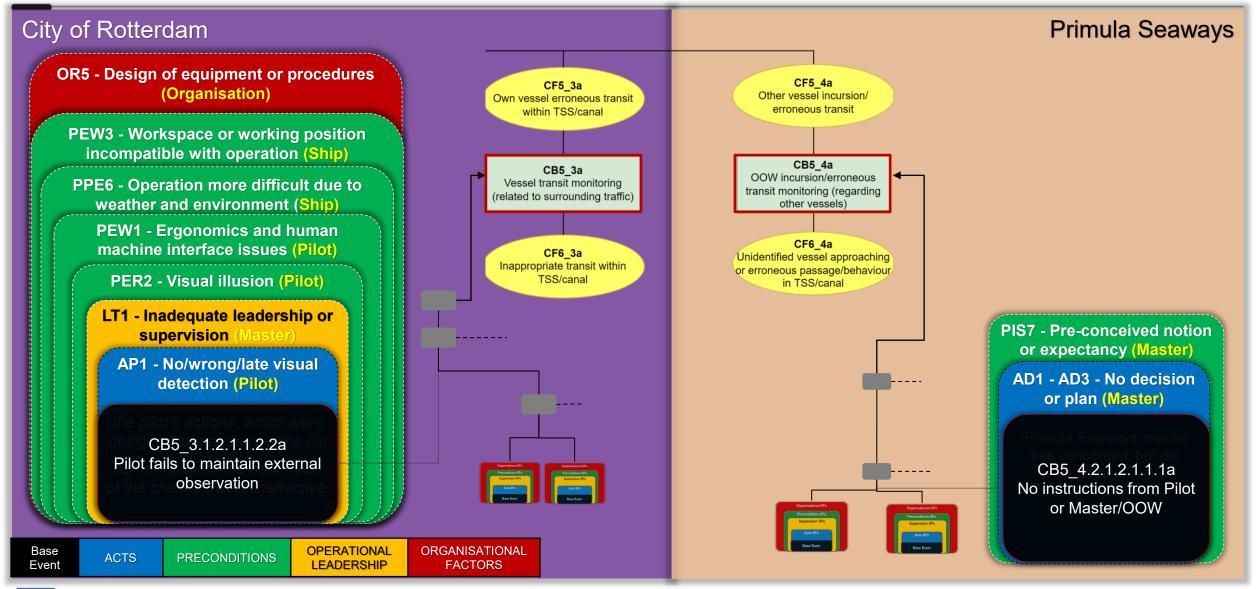


- City of Rotterdam's pilot's relative motion illusion **deceived** him into thinking that his view from the window above the starboard VHF radio, which was 33° off the vessel's centreline axis, was the vessel's direction of travel.
- As **it was dark**, the inward slope of the window **removed all objects** in the pilot's periphery, and there were **no visual clues** such as a forward structure or bow tip, the illusion would have been compelling.

#### Source: https://assets.publishing.service.gov.uk/media/58984f60ed915d06e1000025/MAIBInvReport3-2017.pdf

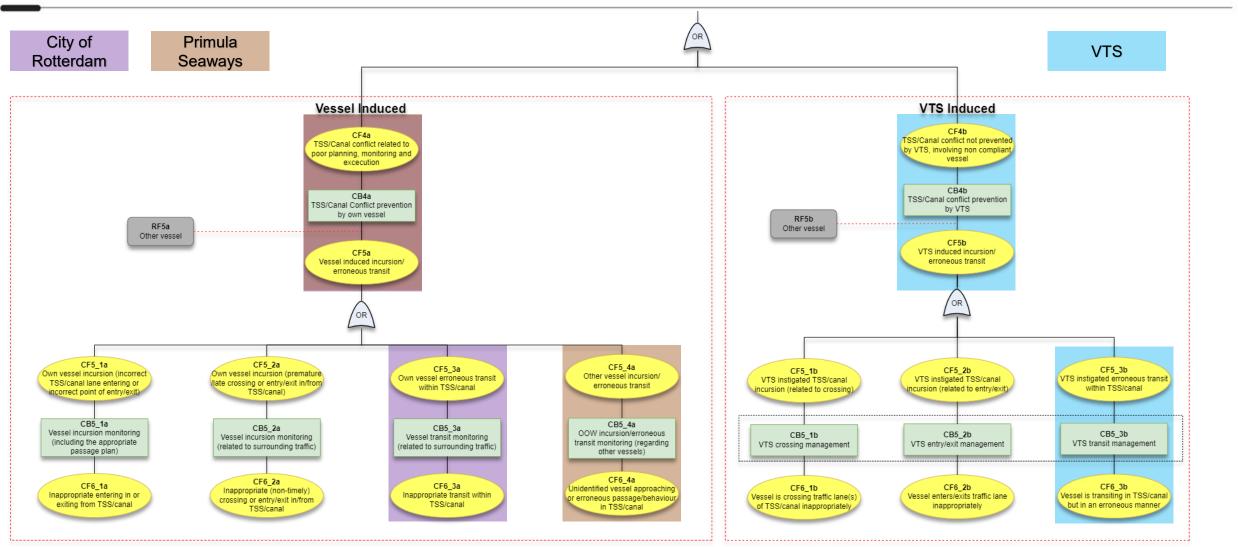


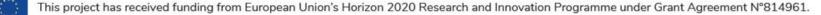
### **Base Event and its Shaping Factors**





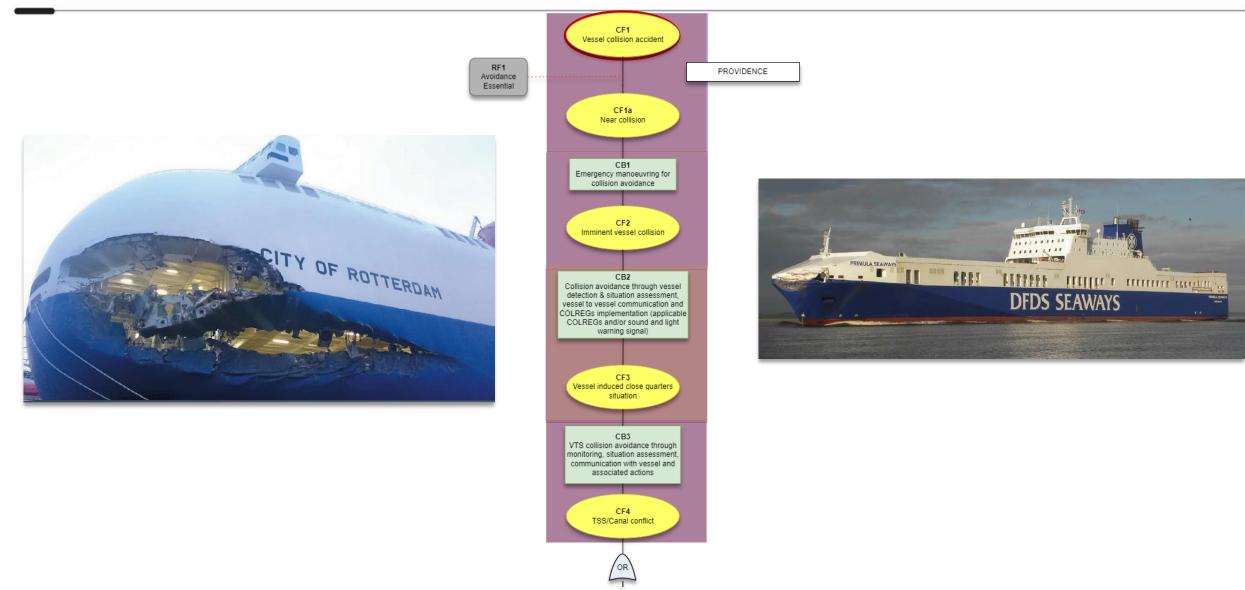
## **Safety Barriers failure**







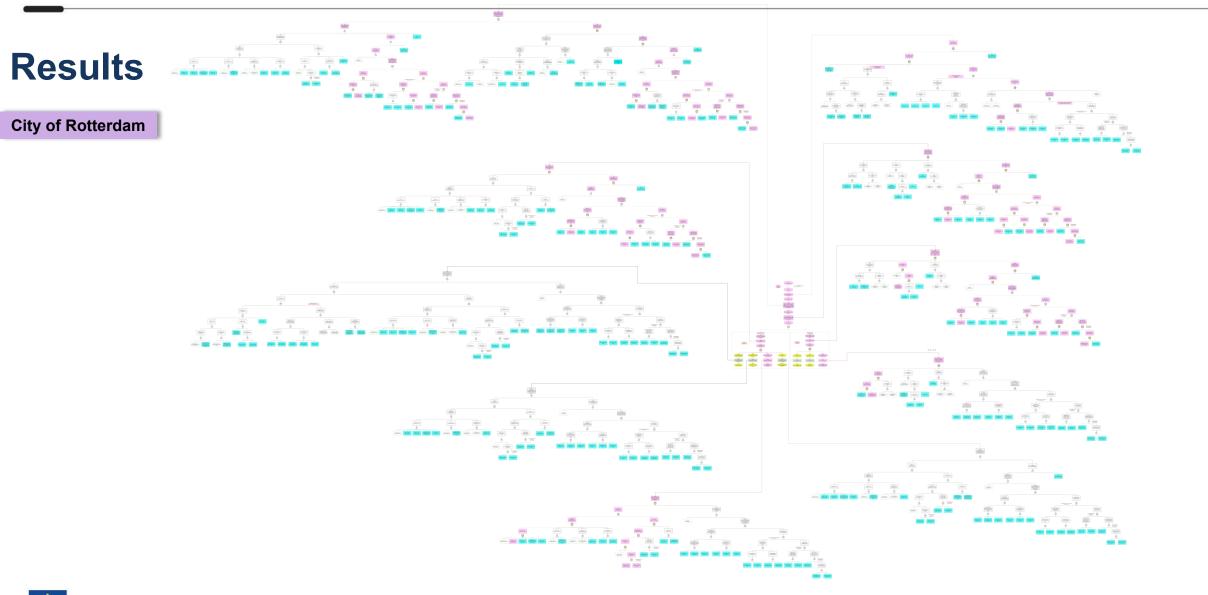
## **Safety Barriers failure**





**Contributors' Mapping** 

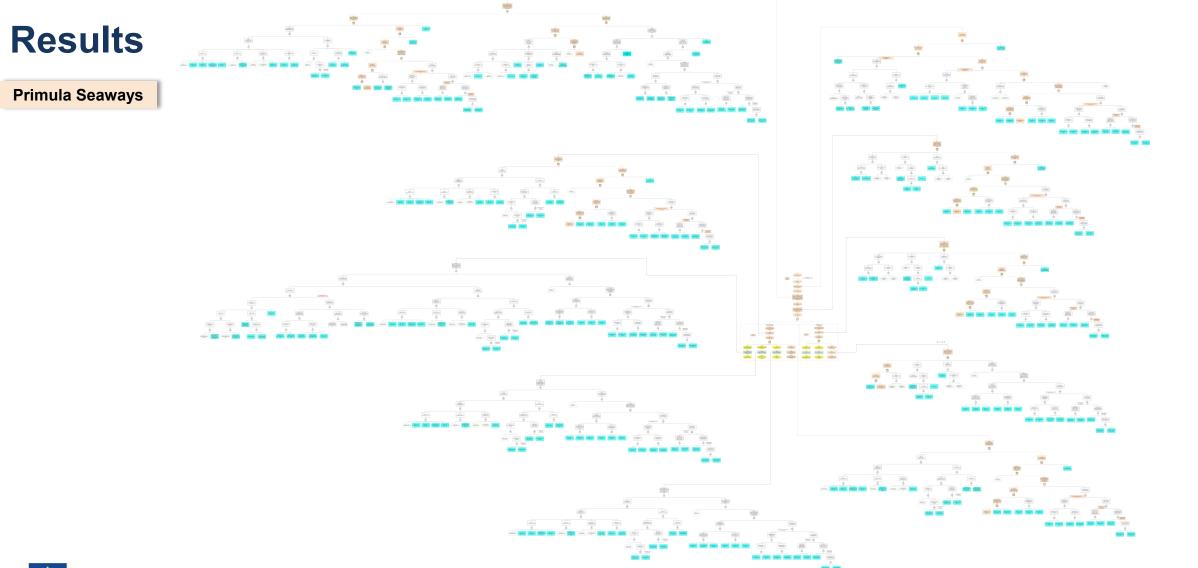






**Contributors' Mapping** 

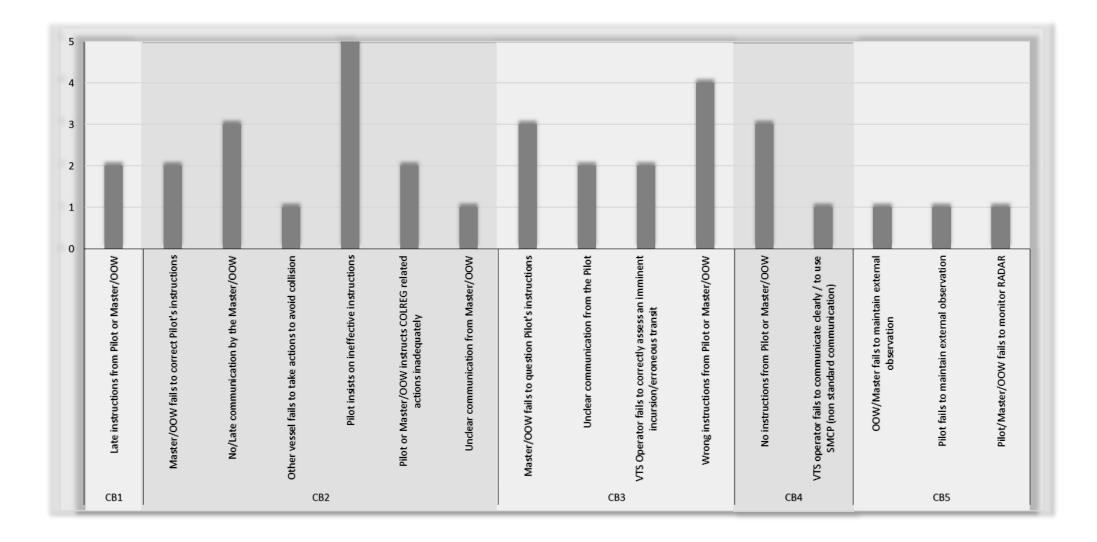






**Contributors' by barrier** 







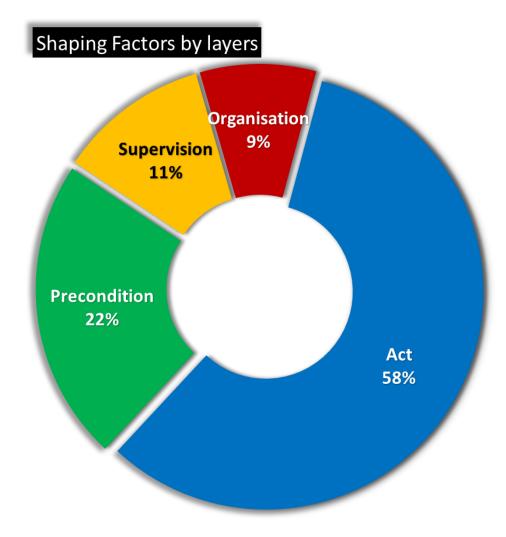


## **Performance Shaping Factors**

City of Rotterdam

Primula Seaways

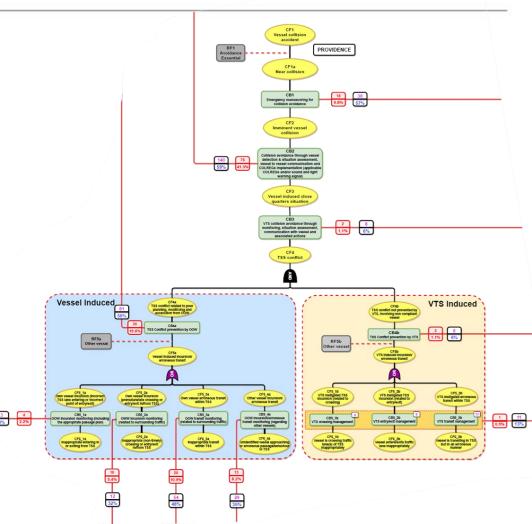
Party	Actor	BEs	SFs
Shin 1	Pilot (Actor1)	14	36
Ship-1	Master (Actor2)	11	31
Ship-2	Master (Actor3)	6	9
VTS	VTS Controller (Actor4)		7
	Total	34	83



## SAFEMODE

## Conclusion

- It helps to **understand** the context of a certain accident type.
- It can be used to identify HFs contribution and evaluate their influence on failure as well as success.
- It is generic and can be **implemented** in other accident types (e.g., Fire, cargo handling, pollution, etc.).
- It can support risk management by informing safety managers with valuable information about their existing safety measures.
- It can by used for prioritising different safety alternatives and estimate their impact on the system reliability.
- It can be used to identify the key HFs impacted by the implementation of new solution/concept (e.g., new bridge design).
- It is a powerful tool to **quantifiably assess** the Human error probabilities and the overall System's Reliability.



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## Finally, can you spot the difference between the two?



## Thank you for your attention

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