Attachment 2-1

Causes behind Mar	itime Accidents (4M)
1. Man	2. Machine
 Psychological factors Emotional factors Organizational factors Individual skill factors Management of health and working environment 	 Design flaw in the machinery Defective protection against hazards Lack of fundamental safety (design and ergonomic arrangement) Lack of consideration regarding ergonomic factors Lack of standardization Lack of machinery and facility maintenance, etc.
3. Media (Medium connecting Man and Machine)	4. Management (Control factors) Vessel, Ship Owner/Ship management company
 Lack of information regarding work to be carried out Work preparedness. Inadequate working conditions Inappropriate work method Inadequate working space Poor working environment conditions 	 Inadequate management (organizational) Inadequate/incomplete regulations and procedure manual Inadequate safety management planning Lack of education and training Inadequate layout arrangement Inadequate supervision of his/her subordinates

Attachment 2-2

Maritime Accidents 4M Classification List

	1 Psychological Impulsive action: - Human instinct: where there is a tendency to concentrate on only one thing, unable to see what is occurring peripherally, unaware of hazards (Human beings are sometimes only able to see one thing at a time) Forgetful: - Human beings are limited in that they cannot memorize everything (Human beings	2 Emotional Fatigue Lack of sleep Alcohol, medicine or disease Physical ability (sight, forearm strength, mus- cle strength and good reflexes) Ageing	3 Organizational Desire and will- ingness Leadership and teamwork Communication Commitment (responsible inter- vention)	4 Individual skills 4-1 Inadequate knowledge Inadequate or in- appropriate knowl- edge about the work to be carried out Work content not understood or misunderstood Lack of a sense	5 Management of health andworking environment Health check not implemented prior to working Tool box meeting was not implement- ed	
Man factors that cause errors The vessel, shipowner and ship management company	sometimes forget) Habituation behaviour: Bad habit. Human beings have moments of inattention Personal problems: Relationship between strength to resist stress and stress tolerance Unconscious acts: Human beings are sometimes careless Effects of the human mind that one is unable to control (Carl Gustav Jung) Sense of urgency and sensitivity: High ability to identify differences in sensory stimuli strength, and can identify factors that impair safety or life Mental shortcuts: Human beings are sometimes in a hurry Does not properly complete a part of the work procedure in order to finish it quickly Use of unsafe behaviour to make haste (cutting corners) Cuts corners: Breaks the rules due to extra work all of a sudden or fatigue. Human beings are sometimes lazy and human beings sometimes transgress when no one is lookino)	E	Exa	of urgency and awareness Mistakes regarding work procedure and forgetfulness Lacks basic knowledge of the work 4-2 Inadequate skills Unaccustomed to work, inexperienced, inadequate skills Not enough training The belief that the work done is satisfactory, when objectively it is inadequate 4-3 Poor work ethic Not "ready" to work Intentionally dishonest regarding work, and breaks the rules Covers-up or tolerates dishonest work Protective wear not worn	€ (1/	(3)

Machanical (addres such as machinery and working property or belong at of order	ressel mainly	1 Design flaw in the machin- ery Inadequate safety considera- tion regarding facility and machinery design Inadequate protection func- tions on facilities and machines Lacking in strength, durabili- ty and faltique strength Control program defect Inadequate performance and functions Defect in construction mate- rial and work carried out Placement of inappropriate machines	2 Defective protection against hazards No protection (guard, cover, safety fence, insulating mat, etc.) Has protection, but it is easily deactivated Has protection available, but the durability of this is problematic Inadequate fixing (lashing), shielding or nothing at all Inadequate indication of dangerous areas, range and levels	3 Lack of fundamental safety (design and ergo- nomic arrangement) Fool Proof Should function in a way so as not to cause a hazard even when operated incorrectly Fail-safe Maintain safe- ty even if it breaks down Fail Tolerance function Even dur- ing malfunction, the S/B machine has a back-up Redundancy To have many backup systems Safety Interlock	4 Lack of consideration regarding ergonomic factors Affordance Intuitive structure or layout Usability Operability and a layout which is easy to access, yet difficult for errors to be made Universal design Designed so that anyone can use it	5 Lack of stand- ardization Facilities violat- ing laws and regulations, ISO/JIS or standards on board (compa- ny-specific) Inadequate safe- ty measures such as equipment failure (e.g. power cut, residual pressure treatment, etc.) Danger warning on usage not re- layed to the opera- tor	6 Lack of machinery and facility maintenance, etc. Failure or break-down of equipment, machinery sensors etc. Unrepaired breakdown or operation during fixing Inadequate machinery and facility maintenance. Deterioration of machinery, equipment etc. Periodic maintenance has not been carried out Lack of spare parts and supplies Re-using of used spare parts which cannot be re-used
Media connection Man with Machinery	The vessel, shipowner and ship management company	1 Lack of information regarding work to be carried out Inadequate or no work method, work procedure or work standard Inadequate or no Safety Management Code or SMS Manual Lacking or no information or instructions regarding necessary work Information regarding work (safety) is not understood Did not see information about work No or difficult to see displays and signs No signal or warning, or not audible enough Vague and confusing working assignment or personnel allocation Lack of information regarding work to be carried out There is no safety standard on board (company-specific) There is no operating manual or literature on safety precautions Mistakes regarding the work procedure	2 Inadequate work preparedness and working conditions Unsuitable working posture (too narrow, high, low etc.) Working in the same position for an extended length of time Monotonous work "Unreasonableness," "waste" and "inconsistency" during work are to be eliminated Inappropriate use of machinery and equipment Inappropriate use of trools and equipment Technical and physical hardship	3 Inappropriate work method Vital points of work not specified or not clear Floor condition (understands) suppose etc.) Inappropriate placement, stacking or propping up of objects Inadequate layout arrangement of machinery, equipment, containers, fixtures etc.) Used beyond specification (use) limits Inappropriate working environment management	A Inadequate working space Work space is too narrow Keeping the work space neat and tidy while work is being conducted Dedicated or maintenance space not clearly specified Machinery or arrangement of which may easily cause an error or an accident Working in dangerous proximity (between people or between man and machinery) Safety aisles, areas and passages for maintenance not secured Acquisition of Work Permit and confirmation of Media (working environment)	environment conditions Uncomfortable temperature or humidity Inappropriate lighting (too dark, bright, or too changeable) Working in bad weather Noise and sever vibrations Not neat and tidy (4S: sort, set in order, shine and kept spotless Inappropriate arrangement of local ventilating equipment Inappropriate ordinating equipment of working environment (Media) Powdery dust and harmful rays (e.g. during welding operations)	3)

	ion	On the vessel	Inadequate management (organizational) Inadequate itemized legal implementation (person responsible, visibly recognizable, inspection, etc.) Repeating the same or similar accidents Risk assessment is not carried out "Hiyari-Hatto" (near miss) scenanios not carried out Violations and oversight of the rules on a daily basis Inadequate communication and sharing of information between supervisors and work colleagues, among the vessel, shipowner and ship management company or between ship-owner and ship management company	2 Inadequate/ incomplete reg- ulations and pro- cedure manual Inadequate or inappropriate con- tents in Safety Management Code or SMS Manual. Or, is there a point of contact to report inadequate adher- ence to the Safety Management Code or SMS manu- al or non-compli- ance which may not be widely known Inadequate edu- cation and creation of work method and procedure manual Inadequate ed- ucation and review of work method and procedure manual Inadequate reducation and review of work method and procedure manual Inadequate ro- irregular work pro- cedure manual	3 Inadequate safety management planning Work schedule is vague Deviation between PMS (Planned Maintenance System) and implementation Inadequate safety measures and risk assessment while working Unexpected work or work which was not planned in the schedule Unsuitable work that relies on excessive concentration and an individual's memory Inappropriate or inadequate work Inadequate work Inadequate work Inadequate communication or meeting prior to work (including between/among de-	4 Lack of education and training Inadequate planning of education and training oboard (pre-board-ing, annually, every few years, etc.) Inadequate guidance and education (including OJT) for workers Inadequate safety training for supervisors and managers Daily safety guidance (e.g. pro-vision for on site inquiries, etc.) is not carried out	5 Inadequate lay- out arrangement Absence of on- site managers such as leaders and su- pervisors Inadequate con- sideration of qualifi- cations (knowledge), experience (skills) and physical capac- ity (good health) Inadequate con- sideration of work specifications and characteristics, and attitudes and be- haviours of individ- uals Lack of consid- eration and meas- ures for aged or young crew	6 Inadequate su- pervision of his/ her subordinates Inappropriate work instructions (5W1H) Lack or shortage of Ho-Ren-So (re- porting, contacting, and consultation) on board and between vessel and company Inadequate com- munication between leaders and subor- dinates Information about hazards is not shared Inadequate take over regarding per- sonnel assignment
Management	Management factors and organization	Shipowner and ship management company	Inadequate management (organizational) Inadequate safety management due to budget cutting and cost-cuts(Inadequate safety management due to personnel assignment and deterioration of machinery) Excessive quota for crew and unreasonable operations Inadequate itemized legal implementation (person responsible, wisibly recognizable, inspection, etc.) Repeating the same or similar accidents Risk assessment is not carried out "Hiyari-Hatto" (near miss) scenarios not carried out Violations and oversight of the rules on a daily basis Inadequate periodical vessel inspections Vague roles, responsibilities and competence regarding health and safety duty Inadequate communication and sharing of information between supervisors and work colleagues, among the vessel, shipower and ship management company.	2 Inadequate/in-complete regulations and procedure manual Inadequate or inappropriate contents in Safety Manage- ment Code or SMS Manual Inadequate un- derstanding of work method without method without Inadequate edu- cation and review of work method manual Inadequate or no irregular work procedure manual	as Inadequate safety management planning Work plan or schedule is vague Deviation between PMS (Plannor PMS (P	4 Lack of education and training Inadequate planning of education and training from company departments (pre-boarding, annually, every few years, etc.) Inadequate guidance and education for workers Inadequate safety training for supervisors and managers Daily safety guidance (e.g. provision for on-site inquiries during vessel visits, etc.) is not carried out	5 Inadequate lay- out arrangement Inadequate of on-site managers such as leaders and supervisors Inadequate con- sideration of qualifications (knowledge), experi- ence (skills) and physical capacity (good health) Inadequate con- sideration of work specifications and characteristics, and attitudes and behaviours of individuals Lack of consideration and measures for aged or young crew	Inadequate supervision of crew Inappropriate work instructions (SW1H) Lack or shortage of Ho-Ren-So (re- porting, contacting, and consultation) on board and between vessel and Information about hazards is not shared Inadequate ex- planation for crew prior to boarding

Attachment 3

Maritime Accident Summary of Related Facts

						ect	Acc	Re-
Reference No.		Identi	fied problems from	survey findings	Unsafe behaviou	Unsafe conditions	Accident cause evaluation	Re-examination necessity
	Date	Time	Caused by	Check facts and problem areas		0,	ă	Ÿ
1	Unspecified date	Approx. 3 p.m.	Vessel superinten- dent	Did not report a forecast of low visibility to the Master	0		4	
2	Unspecified date	Approx. 4 p.m.	Vessel radar	No. 1 radar was out of order		0	3	0
3	Unspecified date	Approx. 5 p.m.	Vessel superinten- dent	Requested the Master to navigate using only No. 2 radar until next port, because arrangement to fix No. 1 radar at the port had been made	0		5	0
4	Unspecified date	Approx. 5 p.m.	Master	Approved navigation to the next port using only one radar.	0		6	
5	Unspecified date	Unspecified time	2/0	Did not report to the Master, although there was the low visibility (less than 2 nautical miles) (According to the Safe- ty Management Code, low visibility is de- fined as less than 3 nautical miles.)	0		2	
6	Unspecified date	Unspecified time	2/0	Searched for the other vessel at 6.6 nau- tical miles via radar, but did not notice the image captured on ARPA, because he believed he could pass starboard to star- board	0		1	
				Exa	n			e

Accident cause assessment: Prioritized according to the scale of the cause

Attachment 4 Maritime Accident Accident Causes (Unsafe Behaviour)

																				Ma	an	
		Hu	man	facto	r (Th	e ves	ssel, s	hipo	wner	and:	ship ı	mana	geme	ent co	ompa	ny)						
	Cause (Unsafe behaviour)					1	Psych	ologi	cal						2 E	motic	onal		3 (Orgar	nizatio	onal
fac cau The Reg (Hu	, write down a direct cause ich was investigated based on the tsk After , write down the root use using the Why Why Analysis. en, circle each applicable cause. garding items other than Man uman factors), enter the sub-item mber of each item in the 4 M assification List.	Impulsive action	Forgetful	Habituation behaviour	Personal problems	Unconscious acts	Sense of urgency and sensi- tively	Mental shortcuts	Cuts corners	Judgement based on specu- lation	Mistakes and perceptual illusion	Habituation phenomenon	Personality	Fatigue	Lack of sleep	Alcohol, medicine or disease	Physical ability	Ageing	Desire and willingness	Leadership and teamwork	Communication	intervention)
1	Why did the 2/O not notice the image captured on ARPA?			0					0			0										
	Why did he think he could pass starboard to starboard?	į.								0							_					
	Why did he think that the bearing of the other vessel was changing? Why did he not continue checking?	†							0		0	0		i	luct tem	ed a	acco t wa	naly: ordin	ig to	ea cted	ch fro	m
	4	=												Ľ	ne s	um	mai	ry of	Kei	ateo	ı Fa	cts
2	Why was low visibility not report- ed to the Master												0	0							0	
	Why did he not comply with the Safety Management Code?		0				0					0	0									
5	Why did the superintendent request that the vessel navigate with only one radar?	0					0	0				0										
	Why was the radar not repaired before port departure?						0	0		0		0										
6	Why did the Master approve navigation with only one radar?	0				0	0					0										
	Why did he not request that the radar be repaired prior to port departure?								0	0		0										
XX																						
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																Med	chani	cal facto	ors suc	n as	ma-
	Cause (Unsafe behaviour)					4	Individu	al sk	ills					5 Mar men healtl	it of		b	eing out	t of ord	er	
		4-1 Ina	adequ	ate k	nowle	edge	4-2 Ina ski		uate	4-3	Poor w ethic	vork		workir viron	ng en-	Mai	nly o	n the ve	essel		
fac cau The Re (Hi		Inadequate or inappropriate knowledge about the work to be carried out	Work content not under- stood or misunderstood	Lack of a sense of urgency and awareness	Mistakes regarding work procedure/ forgetfulness	Lacks basic knowledge of the work	Unaccustomed to work, inexperienced, inadequate skills	Not enough training	The belief that the work done is satisfactory, when objectively it is inadequate	Not "ready" to work	Intentionally dishonest regarding work, and breaks the rules	Covers up or tolerates dis- honest work	Protective wear not worn	Health check not imple- mented prior to working	Tool box meeting was not implemented	Design flaw in the machinery	Defective protection against hazards	Lack of fundamental safety (design and ergonomic ar- rangement)	Lack of consideration re- garding ergonomic factors	Lack of standardization	Lack of machinery and fa- cility maintenance, etc.
1	Why did the 2/O not notice the image captured on ARPA?			0																	
	Why did he think he could pass starboard to starboard?																				
	Why did he think that the bearing of the other vessel was changing?																				
	Why did he not continue checking?																				
2	Why was low visibility not report-																				
	ed to the Master Why did he not comply with the Safety Management Code?																				
5	Why did the superintendent request that the vessel navigate with only one radar?	0	0	0	0		0				0										
	Why was the radar not repaired before port departure?			0								0									
6	Why did the Master approve navigation with only one radar?										0										
	Why did he not request that the radar be repaired prior to port departure?			0							0										
XX																					
XX																					
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	Cause (Unsafe behaviour)	Ma	ledia an wit	conr th Ma	nectir	ng ery			Man	agen	nent i	facto	rs an	d org	janiza	ition			Z
		and	vess ship pany	man	nipov agen	vner	On	the v	essel						er an			ın-	ecessity o
fac cau The Reg (Hu nur	write down a direct cause ich was investigated based on the tots After , write down the root isse using the Why Why Analysis. an, circle each applicable cause. parding items other than Man imman factors), enter the sub-item mober of each item in the 4 M ssification List.	Lack of information regard- ing work to be carried out	Work preparedness/inade- quate working conditions	Inappropriate work method	Inadequate work space	Poor working environment conditions	Inadequate management/ organization	Inadequate/incomplete regulations and procedure manual	Inadequate safety manage- ment planning	Lack of education and train- ing	Inadequate layout arrange- ment	Inadequate supervision of his/her subordinates	Inadequate management/ organization	Inadequate/incomplete regu- lations and procedure manual	Inadequate safety manage- ment planning	Lack of education and train- ing	Inadequate layout arrange- ment	Inadequate supervision of his/her subordinates	Necessity of re-investigation
	Why did the 2/O not notice the image captured on ARPA?																		
	Why did he think he could pass starboard to starboard?																		
	Why did he think that the bearing																		
	of the other vessel was changing? Why did he not continue check-																		
	ing?																		
2	Why was low visibility not report- ed to the Master																		
	Why did he not comply with the Safety Management Code?																		
	, ,																		
5	Why did the superintendent request that the vessel navigate with only one radar?																		
	Why was the radar not repaired before port departure?																		
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6	Why did the Master approve navigation with only one radar?																		
	Why did he not request that the radar be repaired prior to port departure?																		
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Attachment 5 Maritime Accident Accident Causes (Unsafe Conditions)

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		Hur	man fa	actor	(The v	/essel	, ship	owne	r and	ship r	nanag	emen	t com	pany)				1			
Cau	ise (Unsafe behaviour)					1	Psych	nologi	cal						2 E	motic	nal		3 (Organ	izatio	nal
caus Ana appl item man	write down a direct se which was investigat- based on the facts After write down the root se using the Why Why lysis. Then, circle each licable cause. Regarding is other than Man (Hu- in factors), enter the sub- number of each item in 4M Classification List.	Impulsive action	Forgetful	Habituation behaviour	Personal problems	Unconscious acts	Sense of urgency and sensitively	Mental shortcuts	Cuts corners	Judgement based on speculation	Mistakes and perceptual illusion	Habituation phenomenon	Personality	Fatigue	Lack of sleep	Alcohol, medicine or disease	Physical ability	Ageing	Desire and willingness	Leadership and teamwork	Communication	intervention)
2	Why was No. 1 radar out of order?																					
	Why was there no time to place a repair order while in port?																					
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									201							Med	chanic	al fact	ors su	ch as r	ma- / or
Cau	se (Unsafe behaviour)					4 1	ndivid	uar sl	UIIS					5 Mana	gement Ith and		Dei	ing out	or or	uer	
		4-1 I	nadeo	uate	knowl	edge	4-2 I skills	nade	quate	4-3 F	Poor v	vork e	thic	workin	g envi- nent		Maii	nly on	the ve	ssel	
ed b caus Anal appl item man item	, write down a direct se which was investigat- sased on the facts After write down the root se using the Why Why yiss. Then, circle each licable cause. Regarding is other than Man (Hufactors), enter the sub-number of each item in 4M Classification List.	Inadequate or inappropriate knowledge about the work to be carried out	Work content not understood or misunderstood	Lack of a sense of urgency and awareness	Mistakes regarding work procedure/ forgetfulness	Lacks basic knowledge of the work	Unaccustomed to work, inexperienced, inadequate skills	Not enough training	The belief that the work done is satisfactory, when objectively it is inadequate	Not "ready" to work	Intentionally dishonest regarding work, and breaks the rules	Covers up or tolerates dishonest work	Protective wear not worn	Health check not implemented prior to working	Tool box meeting was not implemented	Design flaw in the machinery	Defective protection against hazards	Lack of fundamental safety (design and ergonomic arrangement)	Lack of consideration regarding ergonomic factors	Lack of standardization	Lack of machinery and facility maintenance, etc.
2	Why was No. 1 radar out of order?																				
	Why was there no time to place a repair order while in port?			0							0									ı	L.
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		Med	ia con		g Man	with				Manag					nizatior	1			
Cau	se (Unsafe behaviour)	The ship	vesse manag	l, ship gemen	owner t comp	and any			On the	vesse	el		Ship	owner	and S	Ship m	anage	ment	Necessity
ed b caus Anal appl item man item	, write down a direct se which was investigat- assed on the facts After write down the root se using the Why Why ysis. Then, circle each icable cause. Regarding s other than Man (Hu- ifactors), enter the sub- number of each item in 4M Classification List.	Lack of information regarding work to be carried out	Work preparedness/inadequate working conditions	Inappropriate work method	Inadequate work space	Poor working environment conditions	Inadequate management/ organization	Inadequate/incomplete regulations and procedure manual	Inadequate safety management planning	Lack of education and training	Inadequate layout arrangement	Inadequate supervision of his/her subordinates	Inadequate management/ organization	Inadequate/incomplete regulations and procedure manual	Inadequate safety management planning	Lack of education and training	Inadequate layout arrangement	Inadequate supervision of his/her subordinates	Necessity of re-investigation
2	Why was No. 1 radar out of order?																		
	Why was there no time to place a repair order while in port?																		
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Attachment 6

Maritime Accident Analysis using 4M5E and Countermeasure List (Unsafe behaviour)

	Man	Machine	Media	Manag	jement
	The vessel, shipowner and ship management company	Mainly on the vessel	The vessel, shipowner and ship management company	On the vessel	Shipowner and ship management company
Risk factors (Direct cause and in- direct/root cause)	The vessel, shipowner and ship management company 1. Why the did 2/O not notice the image captured on ARPA? (1-, , , and 4-1-) 2. Why was low visibility not reported to the Master? (1-, , , 2- and 3-) 6. Why was navigation approved using only one radar? (1-, , , , 4-1-, , 4-2- and 4-3-) Shipowner and ship management company 5. Why was it requested that the vessel navigate with only one radar?	Why was No. 1 radar left out of order? (Re-ex-amination necessary)		1. Why was low visibility not reported to the Master? (2- and 6-) 4. Why was navigation approved using only one radar? (1- , 2-, 3- and -3)	Why was low visibility not reported to the Master? (2- and 6-) Why was it requested that the vessel navigate with only one radar?
Education Education and training Knowledge, skills, consciousness, being given information, etc.	Training in behaviour psychology Learn to notice things Education to reinforce habitually that optical illusions/errors and assump- tions can cause a risky behaviour			Thorough com- pliance with work procedure	Thorough com- pliance with work procedure
Engineering Technology and engineering Engineering countermeasure		Pursue the cause behind the failure and formulate measures (Re-ex- amination neces- sary)			
Enforcement Thorough guidance and enforcement Standardization, pro- ceduralization, alerting, reward and punish- ment KYT, campagnes etc.				Thoroughly clarify procedures for low visibility in the procedure manual Create a procedure manual that states that a vessel is not to leave port while an important nautical auxiliary instrument is out of order	Thoroughly clarify procedures for low visibility in the procedure manual An important nautical auxiliary instrument was also out of order
Examples Case studies, counter- measures and rules Lead by example, ex- perience of success, introduce model cases, "Hiyari-Hatto" (near misses), etc.	Gain a sense of experience using navigation simulations, for example				Implementation of navigational simu- lation training
Environment Working environment, office internal man- agement, on-board organization, etc.				Formulate a pro- cedure for internal company reporting	Formulate a pro- cedure for internal company reporting

Maritime Accident Analysis using 4M5E and Countermeasure List (Unsafe behaviour)

Attachment 7

Maritime Accident Analysis using 4M5E and Countermeasure List (Unsafe condition)

	Man	Machine	Media	Management		
	The vessel, shipowner and ship management company	Mainly on the vessel	The vessel, shipowner and ship manage- ment company	On the vessel	Shipowner and ship management company	
Risk factors (Direct cause and indirect/root cause)		2. Why was No. 1 radar left out of order?		2. Why was there no time to place a repair order while in port?	2. Why was there no time to place a repair order while in port?	
Education Education and training Knowledge, skills, con- sciousness, being given information, etc				Lack of risk aware- ness regarding the danger of navigating with a radar left out of order Education about important nautical instruments	Lack of risk awareness re- garding the dan- ger of navigating with a radar left out of order Education about important nautical instruments	
Engineering Technology and engineering Engineering countermeasure		Pursue the cause behind the failure and formulate measures (Re-examina- tion neces- sary)				
Enforcement Thorough guidance and enforcement Standardization, proceduralization, alerting, reward and punishment KYT, Campagnes etc				Review Safety Management Code (handling important equipment)		
Examples Case studies, counter- measures and rules Lead by example, experience of success, introduce model cases, "Hiyari-Hatto" (near misses), etc.						
Environment Working environment, office internal man- agement, on-board organization, etc.						

Each item number (bold and red coloured) corresponds to the Summary of Related Facts No. in the Attachment 3
The number in the circle applies to the number in Attachment 2-2 (Maritime Accidents 4 M Classification List)

Attachment 8 Movements of Vessel A and Vessel B

Time	AIS Position of Vessel A		AIS Position of Vessel B		Vessel B s bearing, distance, CPA and TCPA as observed from Vessel A				
	North latitude	East longitude	North latitude	East longitude	Bearing	Dis	stance	CPA	TCPA
06:45:00	34° 34 min. 03.5 sec.	135° 15 min. 34.3 sec.	34° 37 min. 56.5 sec.	135° 22 min. 44.50 sec.			Nautical		
	Ship s course <040> reducing speed at 15.1 kts Pilot A Visually confirmed Vessel B		Ship s course <235> at a speed of 14.1 kts		<056.6>	7.08	miles	-	-
06:50:00	34°35min. 02.2 sec.135°16min. 33.4 sec.		34°37min. 14.9 sec.	135°21min. 33.80 sec.	<061.7>	4.69	Nautical		
	Ship s course <040> reducing speed at 14.9 kts		Ship's course <235> at a speed of 14.2 kts Visually confirmed Vessel A		<001.7>	4.09	miles	-	-
06:53:00	34°35min. 35.6 sec.	135°17min. 06.8 sec.	34°36min. 55.4 sec.	135°20min. 8.90 sec.					
	Ship's course <041> reducing speed at 14.8 kts		Ship's course <253> at a speed of 14.0 kts		<068.0>	3.35	Nautical miles	1.07 Nautical miles	6.64 mins.
	Master A Visually confirmed Vessel B		Started steering to starboard side while heading for Kobe Central Fairway						
06:55:00	34°35min. 58.4 sec.	135°17min. 29.8 sec.	34°36min. 53.5 sec.	135°20min. 21.00 sec.					
	Ship's course <041> reducing speed at 14.6 kts		Ship s course <293> at a speed of 13.8 kts		<069.1>	2.53	Nautical miles	0.22 Nautical miles	6.51 mins.
	Pilot A Instructed vessel to steer to port side in order to head for Kobe Rokko Island East Waterway								
	34°36min. 20.6 sec.	135°17min. 51.5 sec.	34°37min. 02.5 sec.	135°19min. 49.60 sec.					
06:57:00	Ship s course <032> reducing speed at 13.8 kts		Ship's course <294> at a speed of 13.8 kts		<068.1>	2.13	Nautical miles	0.22 Nautical miles	5.69 mins.
	Pilot A Started steering to port side while heading for Kobe Rokko Island East Waterway								
07:00:45			Instructed vessel to starboard at an angle of 10°as he felt there was a danger of collision		-	-		-	-
	34°37min. 08.5 sec.	135°18min. 17.5 sec.	34°37min. 24.6 sec.	135°18min. 47.80 sec.					
07:01:00	Ship s course <006> reducing speed at 12.3 kts		Ship's course <297> at a speed of 13.8 kts		<056.8>	0.49	Nautical miles	0.08 Nautical miles	1.81 mins.
	Pilot A Half Ah'd Instructed Hard Port							IIIIICS	
07:02:10			Called Vessel A twice via VHF Instructed Nav. Full		- -		-	-	
07:02:49	34°37min. 29.9 sec.	Collisions			0.00 Nautical miles	0.00 mins.			



