INCIDENT ANALYSIS

Identifying the roots
OF AN INCIDENT

Hsinchu City MIAOLI COUNTY 苗栗縣 **Taichung City** Hualien County 花蓮縣 Taiwan **Tainan City** COUNTY Kaohsiung City

Incident details

- Vessels during STS operation
- Emerging STS location
- Bad weather conditions
- 4 Mooring lines parted
- Steel to steel contact



Records taken into consideration



VDR records

An hour prior the incident took place.



Screening report

3rd Party report for assessing the vessels.



Master's assessment form

Statement about the incident from the crew and ship board investigation report.



Email correspondence

3rd Party report for assessing the vessels.



Equasis Web data



OSIS Database

Online Sts Information System records.



Photos & vessels' drawings



OCIMF guidelines

Latest guidelines.



What really happened

Sequence of

events



Root causes

Due diligence was not exercised

at best possible extent. The official 3rd party process was not followed.

JPO was incomplete

Weather conditions were not examined, absence of mooring plan configuration.

Inadequate assessment from POAC

POAC did not assess the situation timely.

No evidence from STS provider

For the qualifications and experience of the POAC.







Crew fatigue

One of the vessels involved in consecutive STS operations.

Inadequate assessment of the COG

Speed and course not evaluated correctly in combination with the interaction effect.

Lack of training

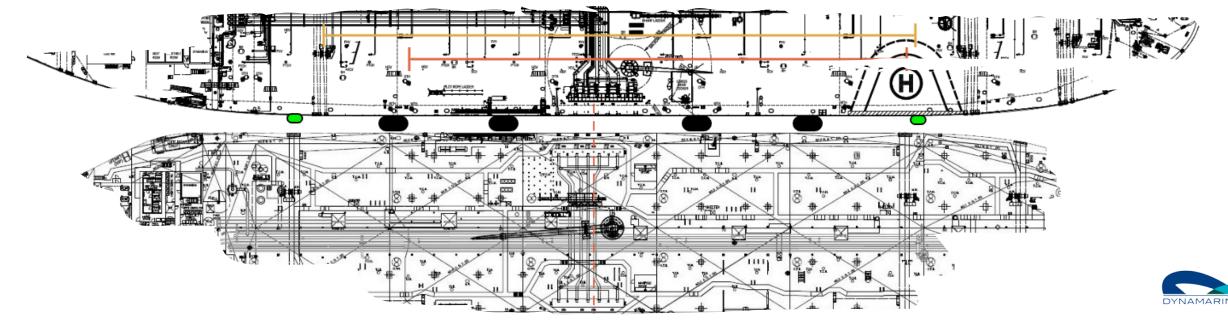
Crew preparedness was not adequate.





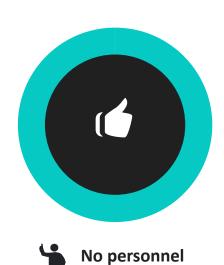
04.05.2018

Correct fender positioning



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What went right



injuries









Lessons learned

The hard way.

HOW WE GO ON TO LEARN FROM THE INCIDENT

from the charterer for the experience of the POAC





Final Lesson

Lesson 4

Training is required

for senior officers

about the best

practices.

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Master shall bear in mind that he is responsible and that he can aboard the operation anytime he feels unsafe

