REPUBLIC OF CYPRUS
MARINE ACCIDENT AND INCIDENT INVESTIGATION COMMITTEE

Investigation Report No: 75E/2018

Very Serious Marine Casualty

Manoverboard Fatality from Bulk Carrier "EVNIA" in the Port of Chittagong-Bangladesh on 04 June 2018

MAIC
Marine Accident and Incident Investigation Committee
Cyprus

Foreword

The sole objective of the safety investigation under the Marine Accidents and Incidents Investigation Law N. 94 (I)/2012, in investigating an accident, is to determine its causes and circumstances, with the aim of improving the safety of life at sea and the avoidance of accidents in the future.

It is not the purpose to apportion blame or liability.

Under Section 17-(2) of the Law N. 94 (I)/2012 a person is required to provide witness to investigators truthfully. If the contents of this statement were subsequently submitted as evidence in court proceedings, then this would contradict the principle that a person cannot be required to give evidence against themselves.

Therefore, the Marine Accidents and Incidents Investigation Committee, makes this report available to interested parties, on the strict understanding that, it will not be used in any court proceedings anywhere in the world.

This investigation was carried out as joint investigation with the Hellenic Marine Accident Investigation Authority and the Bangladesh Marine Accident Investigation Authority.

Contents

List of Acronyms and Abbreviations

AB	Able Seaman
BAC	Blood Alcohol Content
C/E	Chief Engineer
C/O	Chief Officer
CoC	Certificate of Competency
GA	General Alarm
DPA	Designated Person Ashore
IFO	Intermediate Fuel Oil
ISM Code	International Management Code for the Safe Operation of Ships
Lat.	Latitude
Long.	Longitude
LT	Local Time
m	Meter
MC	Management Company
MOB	Man-Over-Board
MT	Metric Ton
NM	Nautical Mile
OOW	Officer Of the Watch
OS	Ordinary Seaman
PPE	Personal protective Equipment
PSN	Position
SAR	Search And Rescue
2/O	Second Officer
SMC	ISM Safety Management Certificate
SMM	Safety Management Manual
SMS	Safety Management System
SOLAS	Safety of Life At Sea Convention
STCW95	International Convention on Standards of Training, Certification and Watch keeping for Seafarers 1978, as amended
S-VDR	Simplified -Voyage Data Recorder
UTC	Universal Time Coordinated
VHF	Very High Frequency Radio
ZT	Zone Time

1. Summary

A fatality was investigated in which the Master of a Bulk Carrier fell into the sea from a rope ladder, when attempted to check the ship's aft port side draft.
Investigators of the Bangladesh Marine Accident Investigation Authority boarded the vessel immediately after the accident, shot photographs, collected documentary evidence and carried out interviews of key witnesses. The Marine Accident Investigation Committee (MAIC), and the Hellenic Marine Casualty Investigation Service (HBMCI - ELYDNA) interviewed the Chief Officer of the vessel when he disembarked, as well as the Management Company's Designated Person Ashore, at the offices of the HBMCI at Piraeus. The events surrounding the accident, statements and documentation have been reviewed and performed analyses to determine the causal factors that contributed to the accident including any ship safety management system deficiencies.

Accident Description

On 04 June 2018 the Bulk Carrier "EVNIA" was berthed in Chittagong Port - Karnaphuli River at Jetty No. 7 by starboard side alongside. At about 19:50 LT, the Master with the Chief Officer and the Second Officer, went for checking the aft port side draft of the vessel (sea side). The Master descended the rope ladder. He did not wear PPE (safety harness with safety line, lifejacket, helmet, safety shoes) although he was advised by the Chief Officer. After he checked the draft, while ascending, at about 1m from the poop-deck level, slipped and fell in the river. He was seen to surface after 10 to 15 seconds. The Second Officer threw a life buoy to him. He could not reach the life buoy as it was moving faster than him due to strong river current.
The Master drifted by the current towards the Bunker Barge which was fasted alongside ship at port side in way of cargo holds No.3 and No.4. His body went underneath the Bunker Barge. At about 20:10 LT, rescue boat arrived on site, for search and rescue. Search and rescue operation continued until 05 June 2018. The body of the late Master was found and recovered on 06 June 2018 near Dock No.13 at Chittagong NCT Terminal.

Conclusions

Direct Cause:
Wrong choice of action through false sense of security, was the direct cause of the accident.
Root Cause
Strong negative emotion in conjunction with personality style, were the root cause of the accident.
Contributing Cause(s):
The environmental conditions (tidal current) were a contributing factor to the accident.
A violation, not using the appropriate safety equipment, was a contributing factor to the accident.
Ignored caution/warning was a contributing factor in the accident.

Recommendations

The Management Company to consider the need for providing soft skills (soft skill: ability to interact successfully with people, systems, equipment, procedures and environment) training to its officers. For this purpose, the best practice guide of the OCIMF & INTERTANKO "Behavioral Competency Assessment and Verification for Vessel Operators" – (First Edition 2018), may be used for implementing a system for assessment and improvement of officers technical and soft skills. (Within 3 months)

2. Factual Information

2.1. Bulk Carrier “EVNIA”

2.1.1. Ship Particulars

Name of ship: **EVNIA**
IMO number: **9232163**
Call sign: **5BJG3**
MMSI number: **209279000**
Flag State: **Cyprus**
Type of ship: **Bulk Carrier**
Gross tonnage: **31167**
Length overall: **190.00m**
Breadth overall: **32.26m**
Classification society:**LRS**
Registered shipowner: **Tranquil Navigation Company Limited**
Ship’s company: **Blue Planet Shipping Limited**
Year of build: **2003**
Deadweight: **53806**
Hull material: **Steel**
Hull construction: **Double Hull**
Type of bunkers: **Marine Diesel**
Number of crew on ship’s certificate: **14**

2.1.2. Voyage Particulars

Port of departure: **Singapore**
Port of call: **Chittagong**
Type of voyage: **International**
Cargo information: **Steel Products**
Manning: **21**
Number of passengers: **0**

2.1.3 Marine Casualty or Incident Information

Type of marine casualty/incident:	**Very Serious Marine Casualty**
Date/Time:	**04/06/2018 @ 19:55 Hours LT**
Location:	**Port of Chittagong (Bangladesh)**
Position (Latitude/Longitude) :	**Lat. : 22° 18'40N – Long. : 091°48'20E**
External and Internal Environment:	**Sea State: Smooth/2, Wind: Light air/2, Night, Weather: Clear, Visibility: Good**
Ship operation and Voyage segment:	**Cargo Operations**
Human Factors:	**Yes / Man-Over-Board**
Consequences:	**Death: 1**

2.1.4. Shore authority involvement and emergency response

On 04 June 2018 at approximately 19:55LT the Master while was climbing up, at about 1m from the poop-deck level, slipped and fell in the river. He was seen to surface after 10 to 15 seconds.

The Second Officer threw a life buoy to the Master. The Master could not reach the life buoy as it was moving faster than him due to strong river current.

The Chief Officer run from the poop-deck port side to the main deck in order to keep eye contact with the Master in the river. He was shouting man-over-board to the stevedores who were on the ship's main deck. Their Foreman called by his mobile phone a speed-boat which was nearby.

The Master drifted by the current towards the Bunker Barge which was fasted alongside at port side in way of cargo hold No.3 and 4. His body went underneath the barge.

The Chief Officer and the Second Officer lost sight of the Master.

The Chief Officer went to the berth and run south in the direction of the current, to locate the Master, and alarmed nearby moored vessel.

The Second Officer went on the Nav Bridge and alarmed nearby vessels and informed Port Control on VHF Channel 12 and 16 regarding the incident.

At appr. 20:10 LT, rescue boat arrived on site, for search and rescue.

The Chief Officer returned back to the vessel and informed the Management Company “Blue Planet Shipping Ltd” over the phone.

The Emergency Response Team of “Blue Planet Shipping Ltd” gathered immediately at Head Office at Piraeus-Greece. Notifications were sent to MRCC Chittagong, Cyprus Flag, MRCC Piraeus, Vessel’s Recognised Organization, Greek Ministry of Foreign Affairs. Also, the missing Master’s next of kin was informed.

SAR continued until 05 June 2018. Three (3) dead bodies were recovered but were identified to be of local people.

The body of the late Master was found and recovered on 06 June 2018 near Dock No.13 at Chittagong NCT Terminal.

The late Master was identified by Chief Officer and Chief Engineer and then was transferred to hospital.

3. Narrative

3.1. Sequence of Events

1. Vessel loaded at Pohang, South Korea and Tianjin, China, 28,358 MT steel cargo.

2. Discharged part of cargo in Singapore.

3. On 27 May 2018 at 21:00 LT arrived and anchored in Chittagong Outer Anchorage "Bravo".

4. On 04 June 2018 proceeded to the port of Chittagong. At 15:50LT "All Fast". Vessel berthed in Chittagong Port- Karnaphuli River at Jetty No. 7 by starboard side alongside.

5. Bangladesh Authorities boarded. Formalities and holds' inspection.

6. At 18:00 LT the Second Officer (2/O) took over the watch in port, from the Chief Officer (C/O).

7. At 19:45 LT commenced discharging operations from cargo holds No.1,2,3,5 by ship's cranes.

8. At about 19:50 LT, the Master with the C/O and the 2/O, went for checking the aft port side draft of the vessel (sea side).

9. A rope ladder was already rigged at the aft port side.

10. The C/O stated, that he pointed out to the Master to wear the appropriate personal protective equipment (PPE) and he brought him a safety harness but the Master ignored him.

11. The Master went down the ladder.

12. At appr. 19:55LT the Master while was climbing up, at about 1m from the poop-deck level, slipped and fell in the river.

13. The Master was seen to surface after 10 to 15 seconds.

14. The 2/O threw a life buoy to the Master. The Master could not reach the life buoy as it was moving faster than him due to strong river current.

15. The C/O ran from the poop-deck port side to the main deck in order to keep eye contact with the Master in the river. He was shouting man-over-board to the stevedores who were on the ship's main deck. Their Foreman called by his mobile phone a speed-boat which was nearby.

16. The Master drifted by the current towards the Bunker Barge fasted alongside at port side in way of cargo hold No.3 and 4. His body went underneath the Bunker Barge.
17. The C/O and the 2/O lost sight of the Master.

18. The C/O went to the berth and ran south in the direction of the current, to locate the Master, and alarmed nearby moored vessel.

19. The 2/O went on the Nav Bridge and alarmed nearby vessels and informed Port Control on VHF Ch. 12 and 16 regarding the incident.

20. At appr. 20:10 LT, rescue boat arrived on site, for search and rescue (SAR).

21. The C/O returned back to the vessel and informed the Management Company (MC) "Blue Planet Shipping Ltd" over the phone.

22. The Emergency Response Team of "Blue Planet Shipping Ltd" gathered immediately at Head Office at Piraeus-Greece. Notifications were sent to MRCC Chittagong, Cyprus Flag, MRCC Piraeus, Vessel's Recognised Organization, Greek Ministry of Foreign Affairs. Also, the missing Master's next of kin was informed.

23. SAR continued through the 05 June 2018. Three (3) dead bodies were recovered but were identified to be of local people.

24. On 06 June 2018, new Master who was scheduled to take over command from the late Master, arrived onboard.

25. On 06 June 2018 at 08:45 LT, the body of the late Master was found and recovered near Dock No.13 at Chittagong NCT Terminal.

26. The late Master was identified by C/O and C/E and then was transferred to hospital.

27. On 09 June 2018 "Blue Planet Shipping Ltd" Operations Manager & Deputy DPA arrived on board for investigation.

28. On 14 June 2018 the body of the late Master arrived in Greece.

29. On 15 June 2018, post mortem examination was conducted as required by Greek Law, in the presence of Forensic Expert appointed by the "Blue Planet Shipping Ltd".

30. The same day, the body of the late Master was released to his family.

4. Analysis

(The purpose of the analysis is to determine the contributory causes and circumstances of the accident as a basis for making recommendations to prevent similar accidents occurring in the future).

4.1. The Crew

Certification

The Master, and the Deck Officers of the Bulk Carrier "EVNIA", were licensed and qualified in accordance with the requirements of the International Convention on Standards of Training Certification and Watch keeping (STCW) Convention as amended.

The Master, Greek national, was holder of a Certificate of Competency as Master / STCW-95 II/2 issued by the Hellenic Republic. He had 12 years sea service as Master.

The Chief Officer, Greek national, was holder of a Certificate of Competency as Master / STCW-95 II/2 issued by the Hellenic Republic. He had 3.8 years sea service as Chief Officer.

The Second Officer, Greek national, was holder of a Certificate of Competency as Officer in Charge of a Navigational Watch / STCW-95 II/2 issued by the Hellenic Republic. He had 10 months sea service as Second Officer.

The other Second Officer, Ukrainian national, was holder of a Certificate of Competency as Officer in Charge of a Navigational Watch / STCW-95 II/2 issued by Ukraine. He had 4 years sea service as Second Officer.

A lack of certification was not a contributory factor to the accident.

Physiological, Psychological, Psychosocial Condition

The Master of "EVNIA" was holder of a valid medical certificate for service at sea (issued by certified practitioner in Greece on 16/01/2018 – expiration on 16/01/2020), in compliance with the STCW and MLC, 2006 Conventions as amended. He was certificated as fit for sea duty without restrictions and not suffering from any medical condition likely to be aggravated by service at sea or to render him unfit for such service or to endanger the health of other persons on board.

There was no evidence to suggest that the physical, physiological, psychological, or psychosocial condition of the Master of "EVNIA" was such that could have contributed to the accident. He was physically and mentally fit.

Fatigue

Prior and on the day of the accident, the recorded hours of Work/Rest of the Master of the "EVNIA", were in accordance with the requirements of MLC, 2006 and STCW 78 as amended.

Fatigue was not considered a contributory factor to the accident.

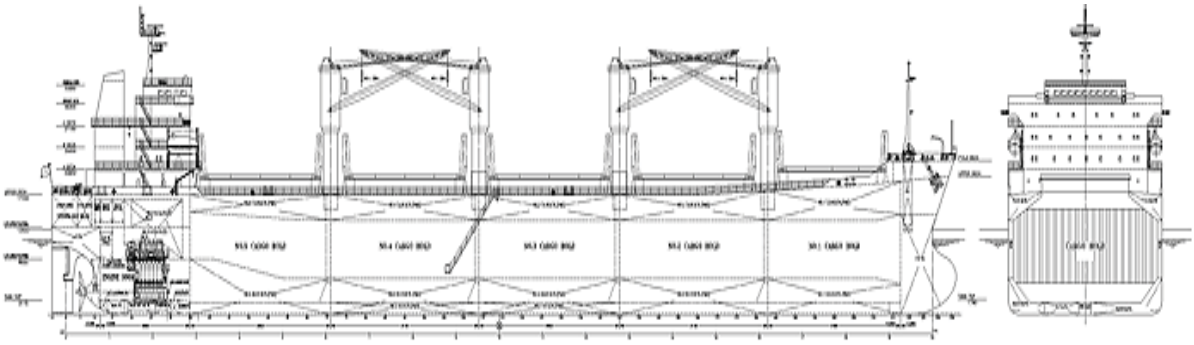
Manning level

At the time of the incident, the "EVNIA" was manned in excess of the Minimum Safe Manning Document (MSMD). The "EVNIA" had a crew of 21, whilst the MSMD requires 14.

A lack of manpower was not a contributory factor to the accident.

4.2 The Ship

M/V "EVNIA" is a Bulk Carrier, Single Deck, Double Skin, built in 2003 by New Century Shipbuilding - Jingjiang, China. Operates under the flag of Cyprus. Its gross tonnage is 31167MT. Its overall length is 189.99 m, the moulded beam is 32.26 m. The deadweight of the vessel is 53,806 MT on 12.49m summer draft and the gross tonnage is 31,167 GT. The "EVNIA" has five cargo holds with maximized hatch openings (5 HO/HA -MacGregor Folding Type - Electro-Hydraulic) to load various cargoes such as grain, ore, coal, coils, steel pipes. The total cargo capacity of the vessel (grain) is 65,748 cbm. The cargoes can be handled with four 40MT deck cranes and four 18.5MT grabs. The main engine is low-speed and long-stroke electronically controlled MAN B+W 6S50MC-C 12,870 BHP. The service speed is about 14 knots on about 29MT IFO. The "EVNIA" at the time of the accident, was classed with LRS and had valid certificates including ISM and ISPS certificates. The maintenance records indicated that she was maintained in accordance with existing regulations and approved procedures. Class notation: Lloyd's Register / 100A1, Bulk Carrier, Strengthened for Heavy Cargoes, Nos. 2 & 4 may be empty, Shipright (SDA, FDA, CM), ESP, LI, IWS, LMC, UMS.



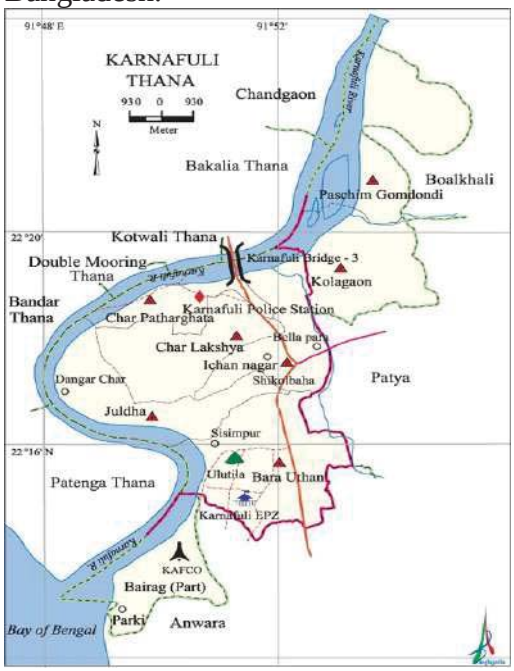
4.3 The Environment

External environment:

The weather conditions at the time of the accident were good. Sea State: Slight, Wind: Light air, It was night / dark at 19:55 LT. There was no evidence, of a sudden and unexpected extreme vibration, or any sudden movement of the vessel which could have caused the Master slipping and falling when he was ascending the rope ladder. There was strong river current.

Port of Chittagong

The Port of Chittagong is the busiest port on the coastline of the Bay of Bengal. Located in the Bangladeshi city of Chittagong and on the banks of the Karnaphuli River, 12 NM from its mouth. Karnaphuli, meaning "western river", is a 667m wide river in the south-eastern part of Bangladesh.



The Port of Chittagong Lat. 22 18N-Long.:091 50E,12 NM from Karnaphuli River's mouth.

Tides at Chittagong, during vessel's stay in the port on Monday 04/06/2018 were as follows:

FALLING TIDE	-	High Water: Time 04:04 Tide Height 4.09m Tidal Range: 4.09m – 0.86m = 3.23m
RISING TIDE	-	Low Water: Time 10:20 Tide Height 0.86 Tidal Range: 4.46m – 0.86m = 3.60m
FALLING TIDE	-	High Water: Time 16:18 Tide Height 4.46m Tidal Range: 4.46m – 0.80m = 3.66m Low Water: Time 22:59 Tide Height 0.80

On Monday 04/06/2018 at 20:55 hours LT, it was falling tide, downstream, with the tidal current at its highest velocity, estimated approximately 3.8 knots. Therefore, the environmental conditions, i.e. the tidal current were a contributory factor to the accident because it had moved quickly the Master away from the position of fall where a life buoy was thrown.

The environmental conditions (tidal current) were a contributing factor to the accident.

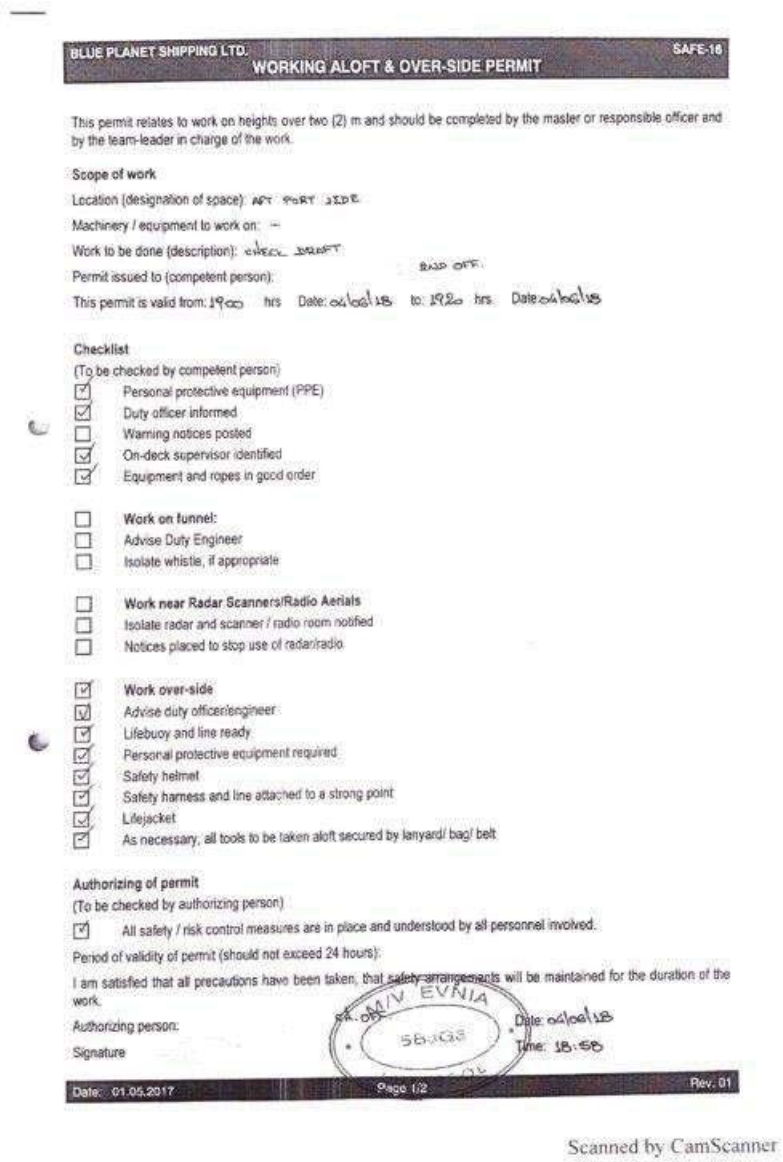
Karnaphuli "western river" at night.

View of the Karnaphuli "western river".

4.4 Safety Management

The requirements for working aloft / over the side of the "Cyprus Code Of Safe Working Practices For Seafarers" and the ILO code of practice "Accident prevention on board ship at sea and in port", are contained in the ship's Safety Management Manual (SMM).
According to the ship's SMM [Shipboard Manual Part I Paragraph 4.3 Working Aloft / Over the side]: proper precautions should always be taken to ensure personal safety when work is to be done over the side. A safety harness with life line attached on a fixed point of the ship, helmet, lifejacket, safety shoes and a lifebuoy with sufficient line. Also, the SMM provides for a work permit: Form Safe-16 "Working Aloft and Over Side Permit".

The below Work Permit, was issued by the C/O to the 2/O before checking the aft draft. The same was issued by the 2/O to the C/O.



BLUE PLANET SHIPPING LTD. SAFE-16

WORKING ALOFT & OVER-SIDE PERMIT

This permit relates to work on heights over two (2) m and should be completed by the master or responsible officer and by the team-leader in charge of the work.

Scope of work

Location (designation of space): APT PORT SIDE

Machinery / equipment to work on: –

Work to be done (description): CHECK DRAFT

Permit issued to (competent person): 2ND OFF.

This permit is valid from: 1900 hrs Date: 04/06/18 to: 1920 hrs Date 04/06/18

Checklist

(To be checked by competent person)

- ☑ Personal protective equipment (PPE)
- ☑ Duty officer informed
- ☐ Warning notices posted
- ☑ On-deck supervisor identified
- ☑ Equipment and ropes in good order

- ☐ **Work on funnel:**
- ☐ Advise Duty Engineer
- ☐ Isolate whistle, if appropriate

- ☐ **Work near Radar Scanners/Radio Aerials**
- ☐ Isolate radar and scanner / radio room notified
- ☐ Notices placed to stop use of radar/radio

- ☑ **Work over-side**
- ☑ Advise duty officer/engineer
- ☑ Lifebuoy and line ready
- ☑ Personal protective equipment required
- ☑ Safety helmet
- ☑ Safety harness and line attached to a strong point
- ☑ Lifejacket
- ☑ As necessary, all tools to be taken aloft secured by lanyard/ bag/ belt

Authorizing of permit

(To be checked by authorizing person)

- ☑ All safety / risk control measures are in place and understood by all personnel involved.

Period of validity of permit (should not exceed 24 hours):

I am satisfied that all precautions have been taken, that safety arrangements will be maintained for the duration of the work.

Authorizing person: M.V. EVNIA Date: 04/06/18

Signature 5B-GS Time: 18:50

Date: 01.05.2017 Page 1/2 Rev. 01

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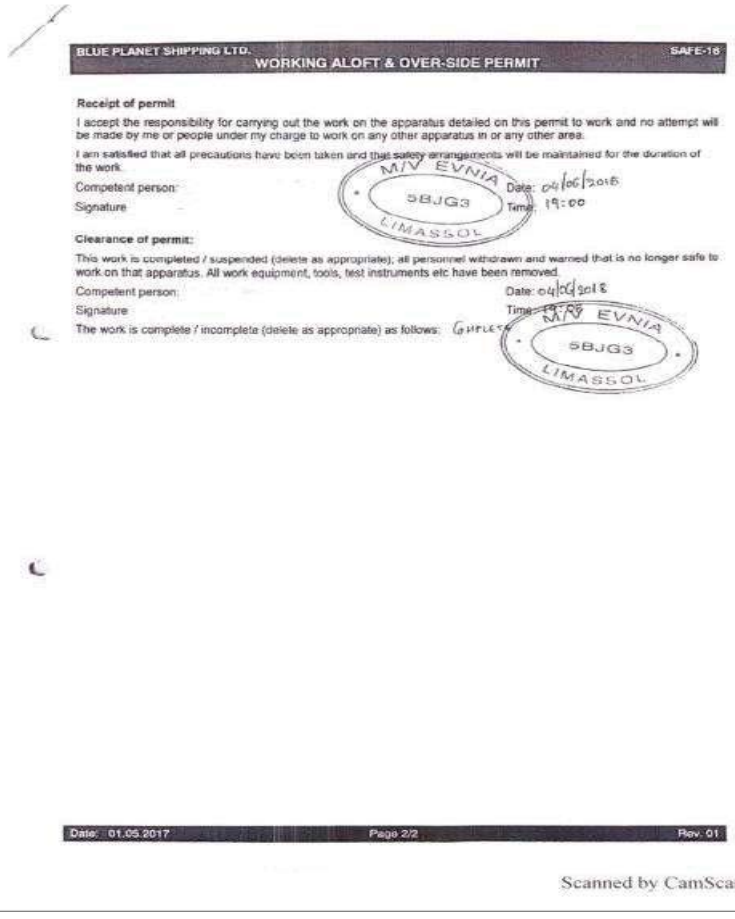

BLUE PLANET SHIPPING LTD. SAFE-16

WORKING ALOFT & OVER-SIDE PERMIT

Receipt of permit

I accept the responsibility for carrying out the work on the apparatus detailed on this permit to work and no attempt will be made by me or people under my charge to work on any other apparatus in or any other area.

I am satisfied that all precautions have been taken and that safety arrangements will be maintained for the duration of the work.

Competent person:

Signature

M/V EVNIA 5BJG3 LIMASSOL

Date: 04/06/2018

Time: 19:00

Clearance of permit:

This work is completed / suspended (delete as appropriate); all personnel withdrawn and warned that is no longer safe to work on that apparatus. All work equipment, tools, test instruments etc have been removed.

Competent person:

Signature

Date: 04/06/2018

Time: 19:00

The work is complete / incomplete (delete as appropriate) as follows: COMPLETED

M/V EVNIA 5BJG3 LIMASSOL

Date: 01.05.2017 Page 2/2 Rev. 01

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Form Safe-16 “Working Aloft and Over Side Permit” was issued when the C/O and the 2/O checked the draft but not when the Master attempted to do the same. According to the evidence gathered during the investigation process, the Master refused to wear the safety harness which the C/O brought him and follow the SMS procedure i.e., to issue a work permit and implement its requirements. Obviously, he had considered that it was safe to descend and ascend the rope ladder without taking any safety measures. He made this action, due to a sense of security. He did not expect that he may slip or his stamina was not adequate to ascend the rope ladder (as it was when he was young). Also, when he was young officer, 2/O in his 20’s and C/O around his 30’s, the ISM Code was not yet introduced and no requirement existed for a work permit to be issued and a safety harness to be worn with safety line attached on a fixed point of the ship. Nevertheless, safety shoes and a person above were a must.

Wrong choice of action due to false sense of security, resulting from erroneous expectation and/or complacency and/or overconfidence and/or a sense of invulnerableness, made him to not adequately evaluate the risk associated with descending-ascending the rope ladder. This faulty evaluation leaded to subsequent fall in the river, which resulted in his drowning.

Wrong choice of action due to false sense of security, was the immediate cause of the accident.

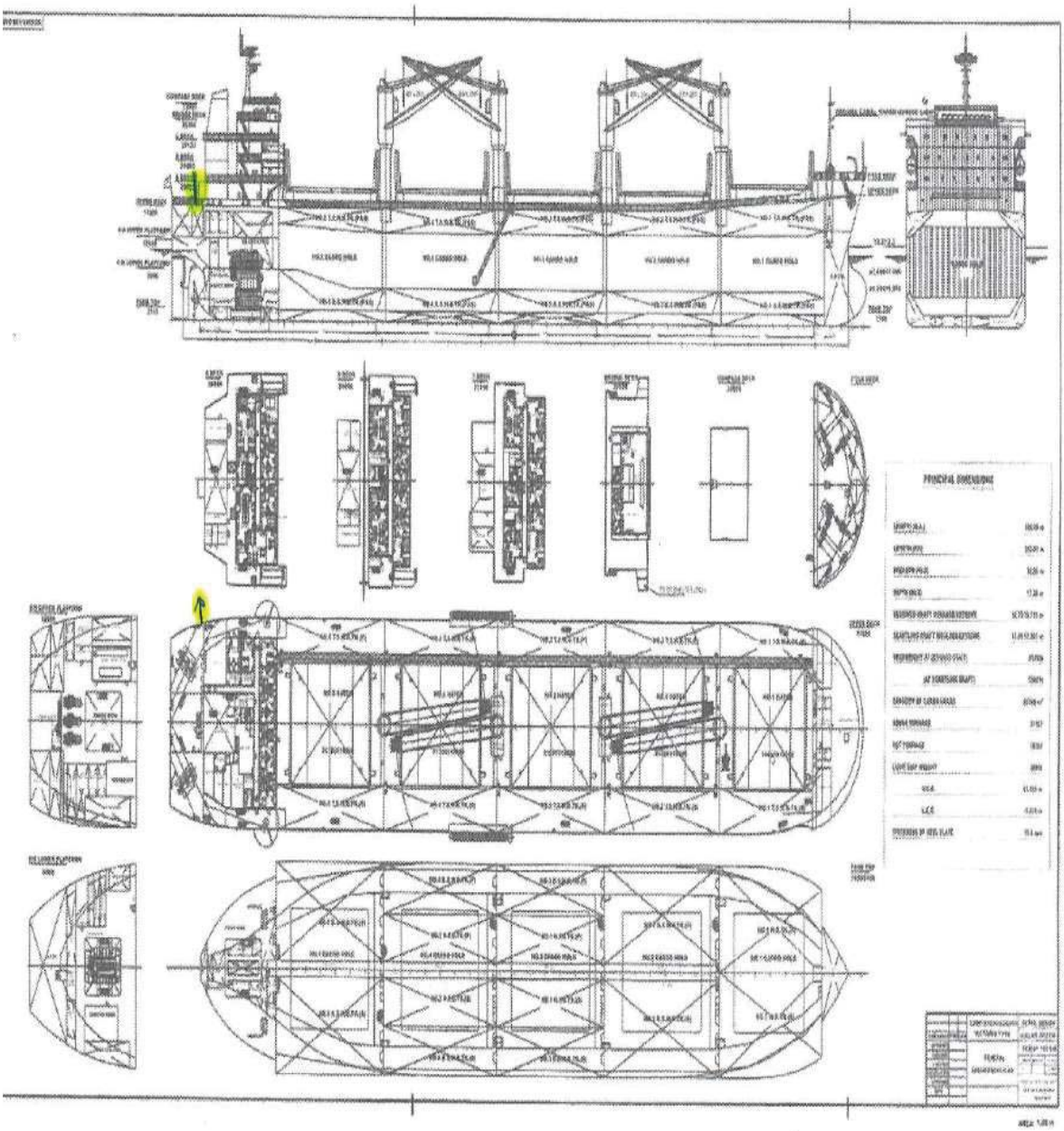
A violation, not using the appropriate safety equipment, was a contributing factor to the accident.

The Master ignored the C/O by refusing to wear the safety harness which he brought him. Had he not ignored the C/O and worn the safety harness had great possibility to not fall in the river. Therefore, ignored caution/warning was a factor in the accident.

Ignored caution/warning was a factor in the accident.

It is not commonplace for a Master to check the draft. Draft check is not included in the Master's duties, not only in the SMS of the particular vessel but of any vessel.
According to the evidence gathered during the investigation process, there was a dispute between the Master and the Charterers' Agent, for the aft portside draft. The reason of the dispute was that according to the Agent, if the draft was more than the declared 8.55m, then an additional payment was to be made. The declared draft at pre-arrival documentation was 8.55m, therefore there was no basis of the Agent's allegations. Also, any such payment would be for "Charterers Account" since the vessel was under Time Charter, therefore there would not be any financial burden to the Master's employer. Nevertheless, the Master, seems that he took it personally. He did not keep calm and reacted emotionally. He did not consult with his Management Company or his senior officers or local P&I corresponded and allowed a perceived commercial pressure to influence his decision making, although he should have been aware as experienced Master, about dirty tricks of shipping industry people in third world countries. When the Charterers' Agent disembarked, from the vessel, after a few minutes the Master went to deck and asked the 2/O, to check the portside aft draft. The 2/O checked the draft and reported to the Master that it was 8.48 m, then the Master returned to his office. After some time, the Master called the C/O on the walkie-talkie and asked him to check the aft portside draft. The C/O checked the draft and reported to the Master that it was the same 8.48m. After a few minutes, the Master informed the C/O and 2/O, that he will check the aft portside draft himself.
The late Master according to the evidence gathered during the investigation, was considered as a capable captain. He was commanding his vessel with authority mixed with dearness, safely and efficiently. He was safety conscious, insisting to implement safety procedures, motivating his crew to be always on alert.
The Master of the "EVNIA" attempted to perform a task which was not his duty, due to his emotional state: He was under the influence of a strong negative emotion. That emotion, along with his personality style, interfered with his duties and created an unsafe situation.

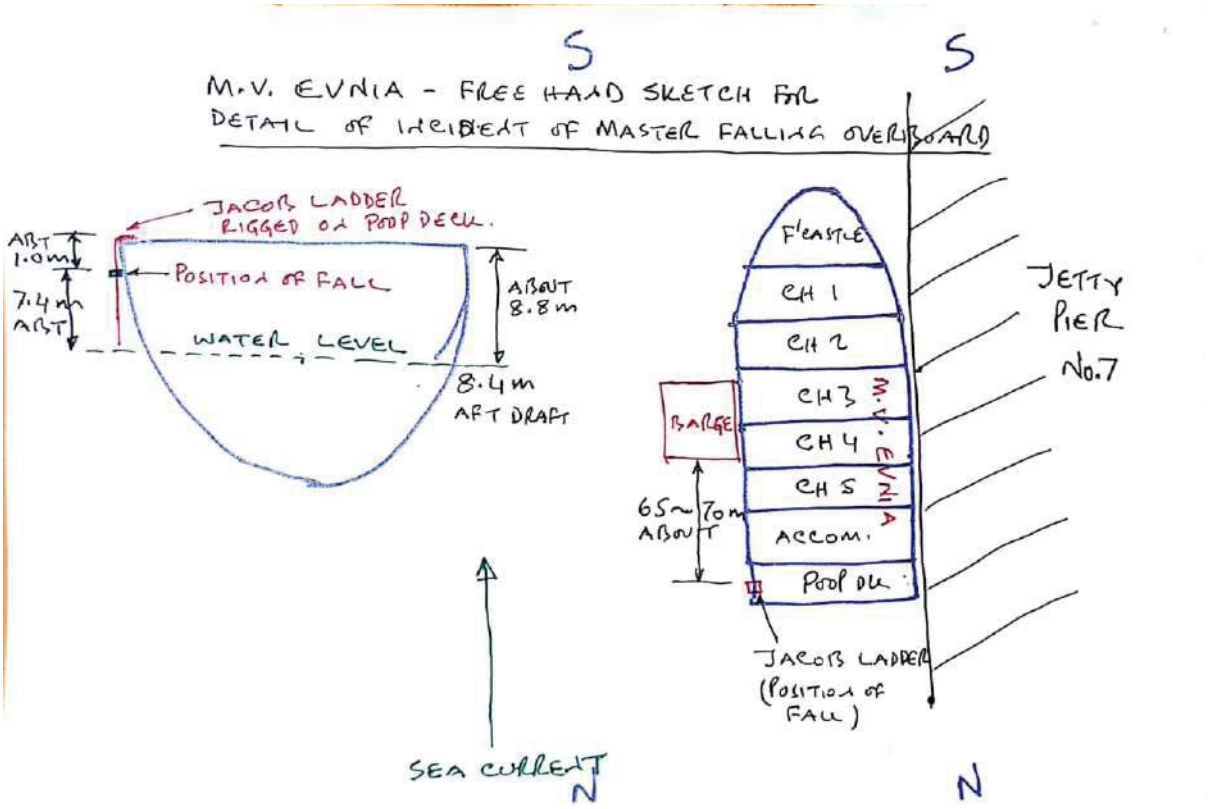
Therefore, strong negative emotion in conjunction with personality style, were the root cause of the accident.



With yellow colour: The rope ladder place of rigging for aft port side draft checking.

Port side view. Bunker barge fasted between No.2 and No.3 cargo holds.

View from poop deck of the rope ladder rigged for aft port side draft checking.



The sketch on the left, indicating the rope ladder rigged on the rails of the poop deck and the appr. ship's draft. (At Frame No.5(P).
The sketch on the right, indicating the Bunker Barge where the Master went underneath after his fall from the rope ladder. Also, the direction of the current is noted.

5. Conclusions

Direct Cause:

(The immediate events or conditions that caused the accident)

Wrong choice of action through false sense of security, was the direct cause of the accident.

Root Cause:

(The causal factor(s) that, if corrected, would prevent recurrence of the accident)

Strong negative emotion in conjunction with personality style, were the root cause of the accident.

Contributing Cause(s):

(An event or condition that collectively with other causes increases the likelihood of an accident but that individually did not cause the accident)

The environmental conditions (tidal current) were a contributing factor to the accident.

A violation, not using the appropriate safety equipment, was a contributing factor to the accident.

Ignored caution/warning was a contributing factor in the accident.

6. Recommendations

The Management Company to consider the need for providing soft skills (soft skill: ability to interact successfully with people, systems, equipment, procedures and environment) training to its officers. For this purpose, the best practice guide of the OCIMF & INTERTANKO "Behavioral Competency Assessment and Verification for Vessel Operators" – (First Edition 2018), may be used for implementing a system for assessment and improvement of officers technical and soft skills. (Within 3 months)