


4 各国等のプレゼンテーション (1) オーストラリア



Australian Government
Australian Transport Safety Bureau

Australian Transport Safety Bureau


The Experts Meeting on Marine Casualty Investigations
Tokyo 25 and 26 June 2008
Polar Foley, Director Surface Safety Investigation
Australian Transport Safety Bureau

Safe Transport

ATSB Mission

The ATSB contributes to the wellbeing of all Australians by maintaining and improving transport safety and public confidence through excellence in:


- independent investigation of transport accidents and other safety occurrences
- safety data recording, analysis and research
- raising safety awareness and knowledge



Australian Government
Australian Transport Safety Bureau

ATSB Investigations


- Transport Safety Investigation Act 2003
- Central Office in Canberra, Field Offices in Adelaide, Perth & Brisbane
- No-blame investigation
- Systemic investigation
- Investigation reports cannot be used as evidence in civil or criminal proceedings
- All investigation reports must be publicly released



Australian Government
Australian Transport Safety Bureau

ATSB role and operations


- ATSB approximately 100 staff, 60 investigators, mostly in Canberra and mostly dealing with aviation (Commonwealth sole role)
- Aviation and marine investigation recognised as among best in world (ICAO, ISASI, IMO, MAIIF, ITSA activities)
- Rail safety – building a similar reputation with 9 investigators and professional staff (4 in Adelaide).



Australian Government
Australian Transport Safety Bureau

ATSB Strengths

- Transport Safety Investigation Diploma 12 common units for all investigators complemented by mode-specific on-the-job training. Significant investment in investigator training!
- Safety Investigation Information Management System, document control, shared work space application, work flow application, integrated casualty database, recommendation tracking etc, tailored to suit ATSB analysis model- more on that later...
- Expert technical analysis (failure analysis and data recorder) capability and expert human factors resources



Australian Government
Australian Transport Safety Bureau

The Global Shipping Scene

- 38,500 vessels involved in international trade
- 26,600 companies involved in the ownership
- 155 countries that permit ships to fly their flag

Australian Scene (2006)

- 88 Australian registered trading ships
- 3,517 foreign ships entering Australian waters
- 25,517 calls at Australian ports



Australian Government
Australian Transport Safety Bureau

Commonwealth
 Aviation, international and interstate shipping, GBR
 Pilotage, interstate trains

States
 State trading ships, pilotage, fishing vessels, State railways

Australian Transport Context

Australian Government
 Australian Transport Safety Bureau

Australian Maritime Safety Authority
 - the regulator

Australian Transport Safety Bureau
 - the independent investigator

Australian Government
 Australian Transport Safety Bureau

Marine Investigation Unit

Five investigators drawn from the nautical and engineering disciplines

Jurisdiction includes:

- Australian flag ships
- foreign ships in our Territorial waters
- ships with an Australian crew
- evidence may be found in Australia

Constitutional limitations exclude smaller commercial vessels and recreational craft which are registered and trade intrastate

Australian Government
 Australian Transport Safety Bureau

Groundings

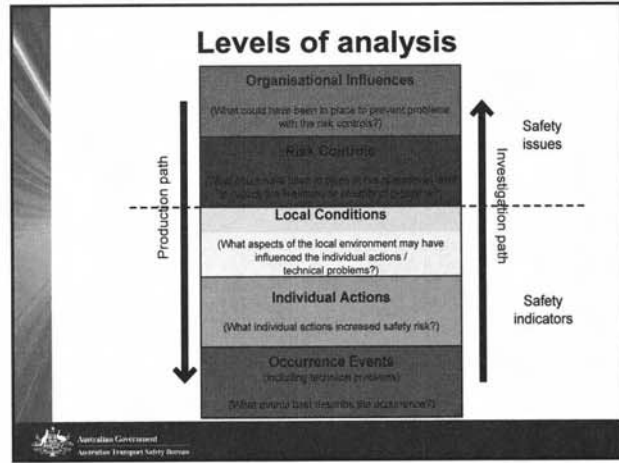
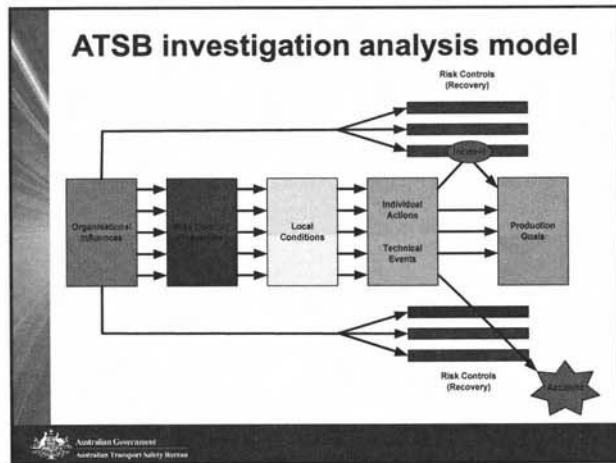
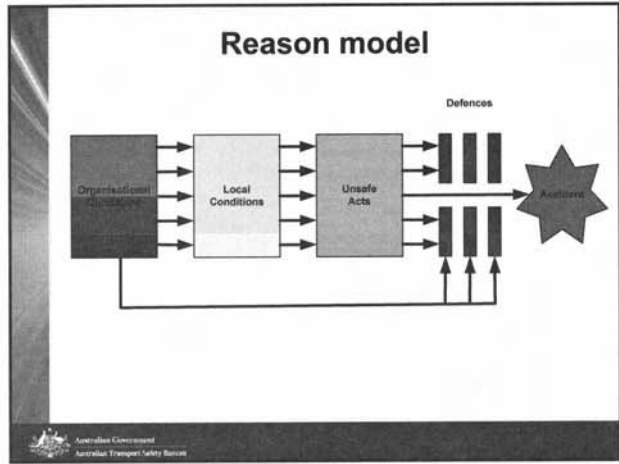
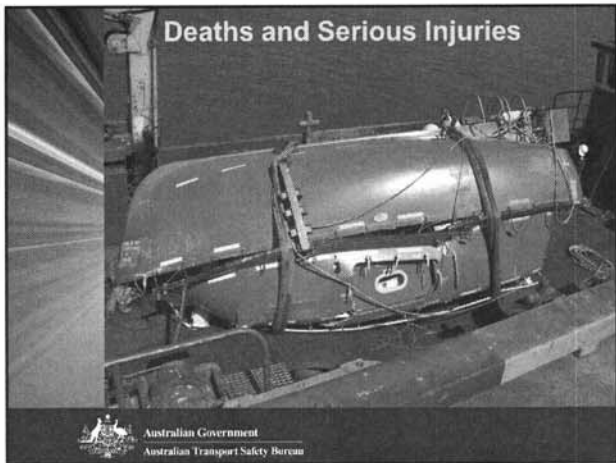
Australian Government
 Australian Transport Safety Bureau

Collisions

Australian Government
 Australian Transport Safety Bureau

Fires and Explosions

Australian Government
 Australian Transport Safety Bureau



International Co-operation

- ATSB has performed joint investigations in the past with other flag authorities notably:-
- Hong Kong on *Nego Kim* and *Lowlands Grace* in 2001 and 2004
- Marshall Islands on *Probo Bear* and *Van Gogh* in 2006 and 2007
- On-going work with Indonesia's National Transportation Safety Committee to deliver training, mentoring of investigators and on-the-ground investigation assistance in Marine and Aviation investigations



Australian Government
Australian Transport Safety Bureau

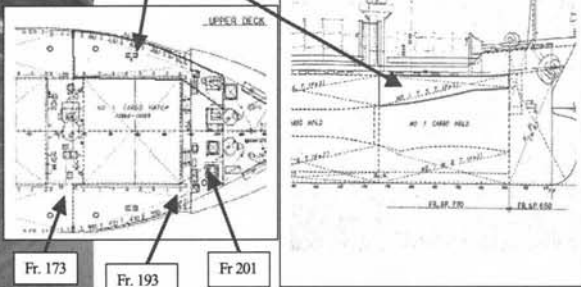
Nego Kim 18 November 2001



Australian Government
Australian Transport Safety Bureau

Number 1 port topside ballast tank plan

No 1. Port, topside ballast tank



Australian Government
Australian Transport Safety Bureau



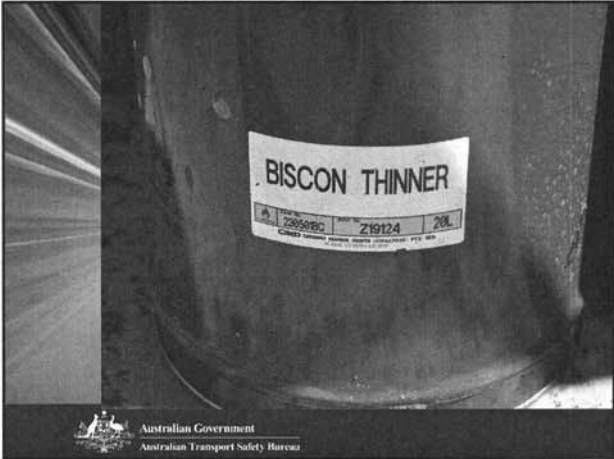
Australian Government
Australian Transport Safety Bureau



Australian Government
Australian Transport Safety Bureau



Australian Government
Australian Transport Safety Bureau



Australian Government
Australian Transport Safety Bureau

Paint constituents

Compound	Flammability Limit % by volume in air	Flash Point (°C)	Vapour Density (Air = 1)	Auto-ignition temperature (°C)
Toluene	1.1 – 7.1	4	3.14	480
Xylene	1.1 – 7.0	27	3.7	527
N-butanol	1.7 – 9.8	29	2.6	345
Isobutanol	1.7 – 10.9	28	2.6	415

Australian Government
Australian Transport Safety Bureau



Australian Government
Australian Transport Safety Bureau



Australian Government
Australian Transport Safety Bureau



Australian Government
Australian Transport Safety Bureau



Australian Government
Australian Transport Safety Bureau

Investigation conclusions

- Explosion was caused when paint vapours were ignited inside the tank
- Proximal factors included: poor ventilation, use of excess thinners, high ambient temperature, use of non intrinsically safe equipment, lack of appropriate functioning gas analysis equipment

The ship management company contributed by:

- Failing to recognise the risks associated with the operation and provide appropriate instructions
- appropriate equipment, or even an MSDS for the paint

Co-operation with Hong Kong

- Early notification of the accident
- Decision by Hong Kong Marine Authority to send an investigator
- Liaison and sharing of evidence on the ground to the maximum extent possible
- Later sharing of analysis work
- Draft reports shared
- Release of final reports co-ordinated

Co-operation under the Casualty Investigation Code

- Facilitated by Memorandum of Understanding
- Early notification of intent to investigate
- Sharing of information to the extent practicable throughout investigation
- Points of contact for progress updates
- Flag Authorities to receive copies of draft reports for comment as an "interested party" and to facilitate early safety action
- Flag Authorities to receive final reports
- Coordination of IMO reporting

Questions?

Safe Transport

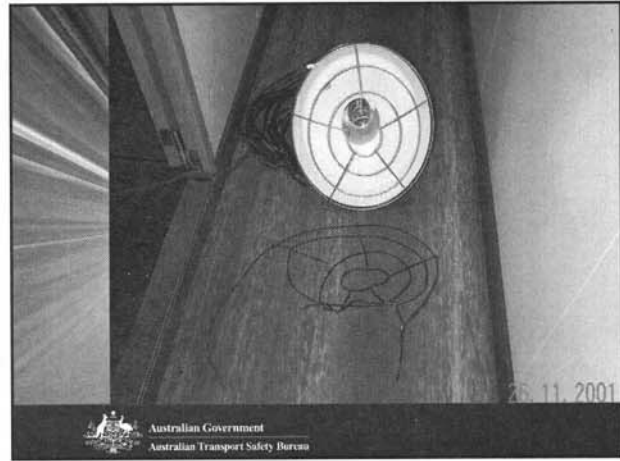
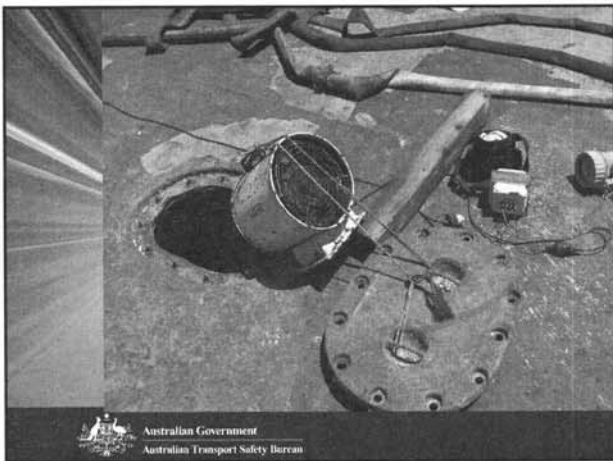
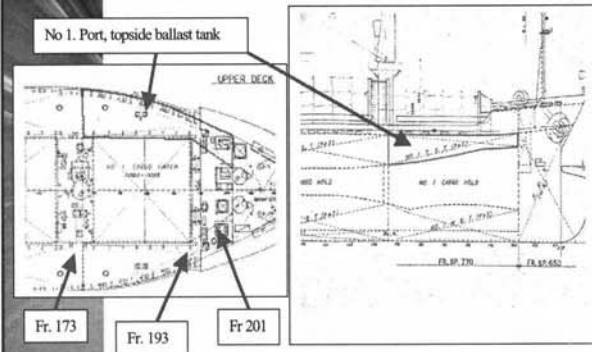
International Co-operation

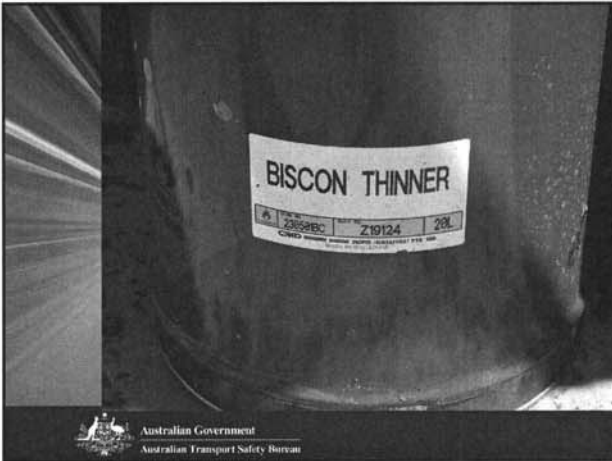
- ATSB has performed joint investigations in the past with other flag authorities notably:-
- Hong Kong on *Nego Kim* and *Lowlands Grace* in 2001 and 2004
- Marshall Islands on *Probo Bear* and *Van Gogh* in 2006 and 2007
- On-going work with Indonesia's National Transportation Safety Committee to deliver training, mentoring of investigators and on-the-ground investigation assistance in Marine and Aviation investigations

Nego Kim 18 November 2001



Number 1 port topside ballast tank plan





Australian Government
Australian Transport Safety Bureau

Paint constituents

Compound	Flammability Limit % by volume in air	Flash Point (°C)	Vapour Density (Air = 1)	Auto-ignition temperature (°C)
Toluene	1.1 – 7.1	4	3.14	480
Xylene	1.1 – 7.0	27	3.7	527
N-butanol	1.7 – 9.8	29	2.6	345
Isobutanol	1.7 – 10.9	28	2.6	415

Australian Government
Australian Transport Safety Bureau



Australian Government
Australian Transport Safety Bureau



Australian Government
Australian Transport Safety Bureau



Australian Government
Australian Transport Safety Bureau



Australian Government
Australian Transport Safety Bureau

Investigation conclusions

- Explosion was caused when paint vapours were ignited inside the tank
- Proximal factors included: poor ventilation, use of excess thinners, high ambient temperature, use of non intrinsically safe equipment, lack of appropriate functioning gas analysis equipment

The ship management company contributed by:

- Failing to recognise the risks associated with the operation and provide appropriate instructions
- appropriate equipment, or even an MSDS for the paint

Co-operation with Hong Kong

- Early notification of the accident
- Decision by Hong Kong Marine Authority to send an investigator
- Liaison and sharing of evidence on the ground to the maximum extent possible
- Later sharing of analysis work
- Draft reports shared
- Release of final reports co-ordinated

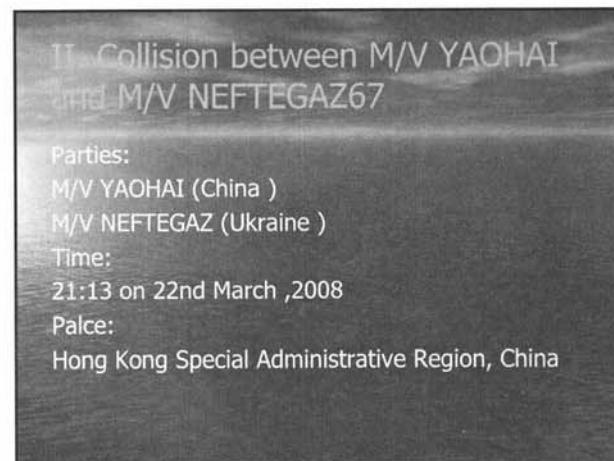
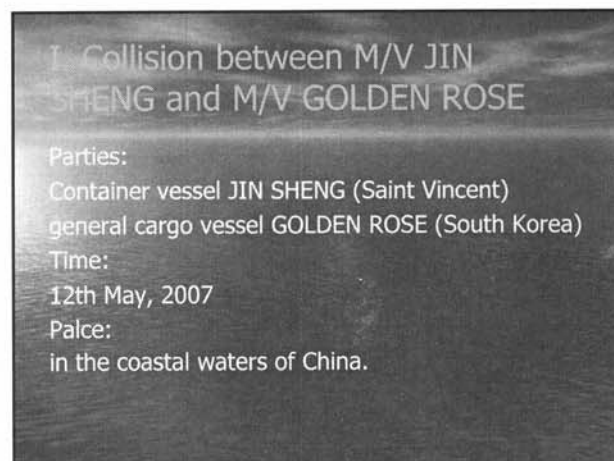
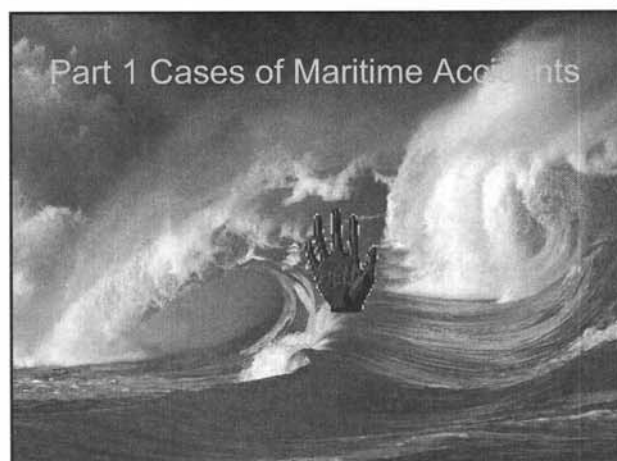
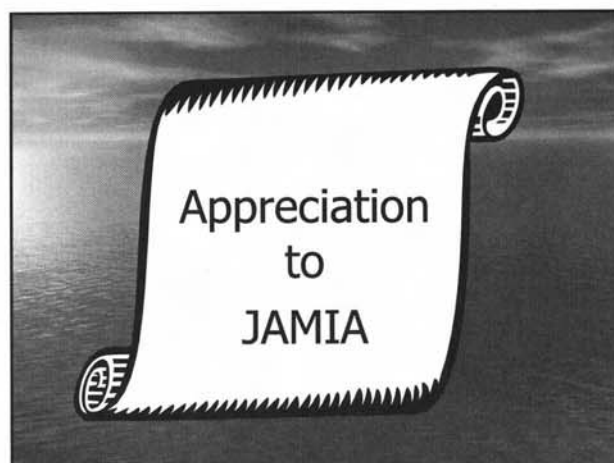
Co-operation under the Casualty Investigation Code

- Facilitated by Memorandum of Understanding
- Early notification of intent to investigate
- Sharing of information to the extent practicable throughout investigation
- Points of contact for progress updates
- Flag Authorities to receive copies of draft reports for comment as an "interested party" and to facilitate early safety action
- Flag Authorities to receive final reports
- Coordination of IMO reporting

Questions?

Safe
Transport

(2) 中 国



A successful joint investigation



III. Collision between M/V PANBLESS and fishing boat LUJIAOYU 0597

Parties:

M/V PANBLESS (South Korean)
fishing boat LUJIAOYU 0597 (China)

Time:

08:30 on 7th April, 2008

Place:

outside the mouth of the Yangtze river, China



The weather was very bad and the communication between the two ships was very poor. The investigation became impossible before the ship left.

Part 2 Problems

The rights of ship owners

no obligations to accept investigations from non-flag states.



II. The rights of crew

The right of crew to remain silent only can fail the investigation be conducted effectively.



III. The power of the authorities

States should entitle their authorities of necessary investigation powers

IV. The independence of the investigation

As an independent and non-blame investigation whose basic principle is cause-finding philosophy, it should be separated from diplomatic intervention and other types of investigation.



Part 3 Future prospect

- New development of the code;
- pay more attentions on the cooperation among us ;
- developing bilateral or multilateral agreements with the aim at facilitating the parties participation in investigations;
- make MAIFA be better by common effort.

We believe, on the existing basis the cooperation among us in the future will be deeper, more efficient and effective, and will make the Asian oceans safer and clearer!

THANKS!

(3) インド

"The Experts Meeting on Promoting Co-operation of Marine Casualty Investigations in Asia"
Convened By
Japan Marine Accident Inquiry Agency
Tokyo Japan


Presented by:
 Capt. Derrick Frank Vaz
 Nautical Surveyor Cum Deputy Director General (Tech.),
 Mercantile Marine Department, Mumbai India

Maritime Accidents – Myth or Reality?



ITAL FLORIDA TRIESTE
 22 06 107


Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMMD Mumbai, India



Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMMD Mumbai, India

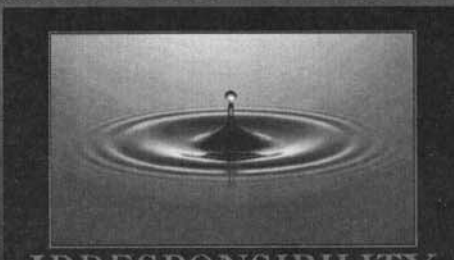
Maritime Accidents – Myth Or Reality?

Maritime Accidents – Myth Or Reality?



Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMMD Mumbai, India

Why are we here today? To take Responsibility!



IRRESPONSIBILITY
 NO SINGLE RAINDROP BELIEVES IT IS TO BLAME FOR THE FLOOD.

www.dfrsaii.com
Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMMD Mumbai, India

THERE IS MORE TO SHIPPING THAN MEETS THE EYE



Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMMD Mumbai, India

Safety at Sea, Pollution Prevention, Environment Control, Security ...

Some Regulations

- First SOLAS Convention adopted 1929
- COLREG 72
- MARPOL 73/78
- Amend. SOLAS for protection
- Amend. to ...
- OPA 90
- ISM; enforced 1998
- Revised single hull phase ... schedules;
- TITANIC lives lost
- Traffic made mandatory; English Channel
- ... major oil tanker
- Incl. Lakonia, ...
- ... lives
- ... Cadiz ... Exxon Valdez
- 1994 Estonia, ... lives lost
- 2001 Erika & 2002 Prestige

Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMMD Mumbai, India

Who is this?

AN OWNER ?? A MANAGER ??
A SEAFARER

Burnt-out!

Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMMD Mumbai, India

Regret may come too late!

REGRET
IT HURTS TO ADMIT WHEN YOU MAKE MISTAKES, BUT WHEN THEY'RE BIG ENOUGH, THE PAIN ONLY LASTS A SECOND.

www.d6spair.com

Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMMD Mumbai, India

ARROGANCE
THE BEST LEADERS INSPIRE BY EXAMPLE. WHEN THAT'S NOT AN OPTION, BRUTE INTIMIDATION WORKS PRETTY WELL, TOO.

Flag States Should Lead by Example. When that's not an option, Brute Intimidation Works Pretty Well too!

Capt. Derrick Frank Vaz NS Cum DDG (Tech), MMMD Mumbai, India

Problem Areas – Who is the weakest link?

DYSFUNCTION
A chain is only as strong as its weakest link.

www.d6spair.com

Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMMD Mumbai, India

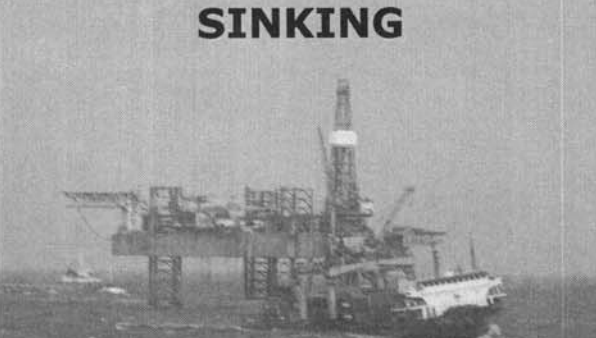
GROUNDING

Flag: Tuvalu, age 33 yrs, Passenger cum car carrier, Off Andaman & Nicobar

Primary causes: Failure of tug propulsion & inclement weather

Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMMD Mumbai, India

SINKING

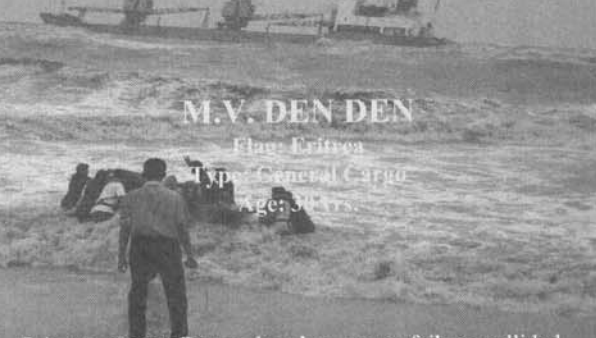


Flag India, Container vessel, age 27 yrs
Primary cause: Technical failure, poor maintenance, inclement weather

*Capt. Derrick Frank Vaz
 NS Cum DDG (Tech), MMMD Mumbai, India*

M.V. DEN DEN

Flag: Eritrea
 Type: General Cargo
 Age: 30 yrs.

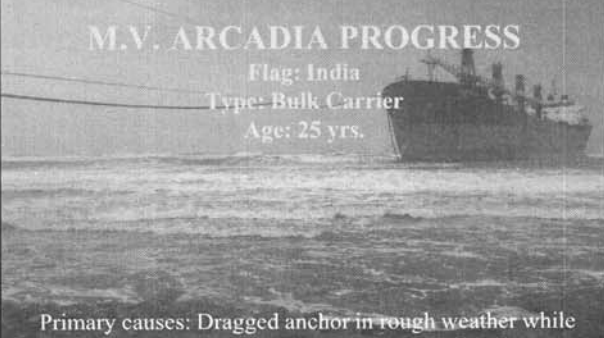


Primary causes: Dragged anchor, power failure, collided with buoy and ran aground off New Mangalore

*Capt. Derrick Frank Vaz
 NS Cum DDG (Tech), MMMD Mumbai, India*

M.V. ARCADIA PROGRESS

Flag: India
 Type: Bulk Carrier
 Age: 25 yrs.




Primary causes: Dragged anchor in rough weather while awaiting berth. Ran aground off Porbandar

*Capt. Derrick Frank Vaz
 NS Cum DDG (Tech), MMMD Mumbai, India*

M.V. MARIA-S

Flag: Panama
 Type: General Cargo
 Age: 20 yrs.




Primary causes: Sub standard ship on account of poor maintenance, lack of competency & poor working conditions supplemented by inclement weather. Vessel eventually sank while entering navigational channel of Cochin harbour

*Capt. Derrick Frank Vaz
 NS Cum DDG (Tech), MMMD Mumbai, India*

GIANT STEP OCT'2006




*Capt. Derrick Frank Vaz
 NS Cum DDG (Tech), MMMD Mumbai, India*



CONFORMITY


When Unscrupulous Shipowners Are Free To Do What They Please,
 They Usually Imitate Each Other!

Accident Investigation



CHALLENGES

I Expected Times Like This – But I Never Thought They'd Be So Bad, So Long, and So Frequent!



M.V. "Miss Fortune"

MISFORTUNE

While Good Fortune Often Eludes Shipowners & Seafarers, This Kind Never Misses!

PREFACE

The Ministry set up a committee on 4th July 2007 under the Director General of Shipping to recommend urgent measures within 15 days. DGS associated

- *Coast Guards, Navy, Maritime boards, Major port trusts, technical Advisers of DG Shipping*

The Committee submitted its report to the Ministry on 3rd August 2007. Consequently, only obvious measures are included.

Source: Experts committee report

Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMD Mumbai, India

METHODOLOGY

Analysis:

- 3 years casualty data
- Existing felt shortcomings

Recommendations:

- Preventive-14
- Emergency response-5
- Relief & rehabilitation-2
- Short term-8

Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMD Mumbai, India

ANALYSIS OF DATA

Ship casualties are increasing...

Incidents involving Indian ships, coastal waters, seafarers:

2005	2006	2007(till July)
99	111	126

Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMD Mumbai, India

ANALYSIS OF DATA... Contd.

Serious shipping casualties:

Marine Accidents	2005	2006	2007
Collisions	12	5	11
Groundings	8	7	8
Sinkings	5	1	2
TOTAL	25	13	21

Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMD Mumbai, India

ANALYSIS OF DATA... Contd.

During the monsoon, of 29 vessels lost:

- 65% (18/29) were 25 years
- In 50% (15/29), the initiating cause was machinery breakdown
- Of these, 93% (14/15) were more than 25 years old.

Old vessels are being flagged because of high freight rates

Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMD Mumbai, India

ANALYSIS OF SHORTCOMINGS

- Indian Coast Guards is the first agency to be informed of ships in distress.
- DGS obtains the information from Coast Guards on MRCC or others.
- The information received is generally incomplete.
- The responsibility of coordination falls on DGS though no authority is vested.
- Time is often lost because DGS authority is questioned and responses are delayed.
- Coast Guard's role in salvage is minimal.
- Resources for SAR and salvage are inadequate.
- Legislation is not supportive for wreck removal

Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMD Mumbai, India

LOSSES ARE SIGNIFICANT

Financial:

- In the event of a major oil pollution disaster, losses go up to billions
- In one incident, BHN platform (2005), the country wrote off USD 40 million
- Erika, off the shore of France (1999) was estimated over USD 286 million.

Source: IOPC Fund, P & I group & ONGC reports
Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMD Mumbai, India

ANALYSIS...

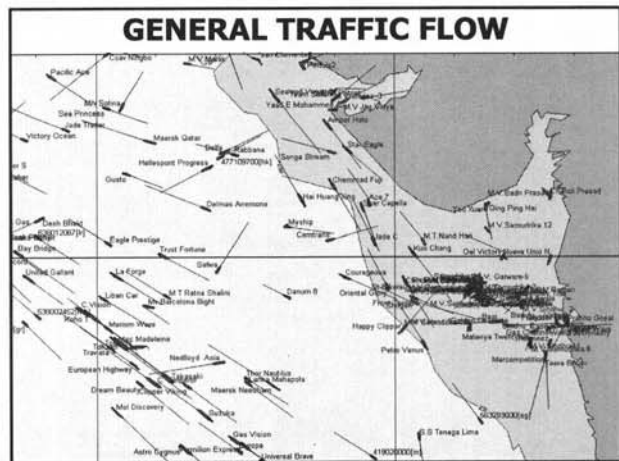
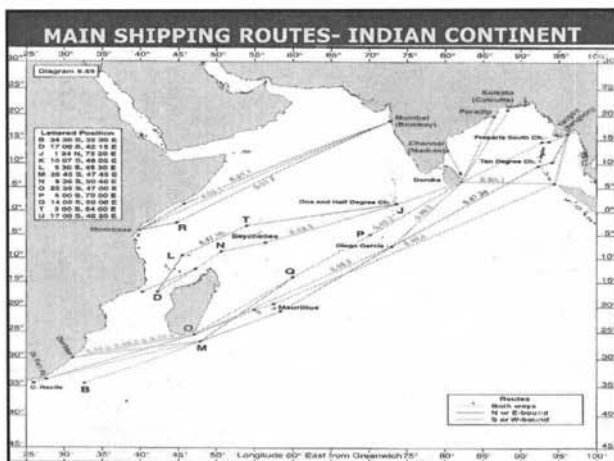
TRAFFIC IS GROWING

- Over 48,000 ships over 1000 GRT engaged in international trade.
- An estimated 12000 vessels call at Indian ports daily.
- An estimated 1000 foreign flag ships present in Indian waters on any given day.
- In addition, 882 MS registered vessels under the Indian flag and an estimated 300,000 fishing and sailing vessels navigate in Indian waters.

Economic growth will see Indian coastal waters getting further crowded.

India's own growth in offshore activity & development in ports, ship building & energy needs will make the coastline more accident prone.

Source: National & International journals
Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMD Mumbai, India



RECOMMENDATIONS

IMMEDIATE PREVENTIVE MEASURES

- Restriction on old vessels in TW and EEZ.
- Sensitive offshore area protection.
- Vessel traffic management.
- Safeguarding port navigational waters.
- Stringent inspection of older vessels.
- Places of refuge.

*Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMD Mumbai, India*

IMMEDIATE PREVENTIVE MEASURES...

Restriction of old vessels in TW & EEZ:

- Advisory to ship owners of vessels 25 yrs. & above in age to discourage operation in south west monsoon through IMO.
- No chartering permission should be given to vessels more than 25 yrs. of age.
- Only double hull or CAS certified tankers to be permitted during the monsoons.
- An advisory to ship agents to discourage operation of vessels of above 25 yrs. age during the monsoons.

*Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMD Mumbai, India*

PREVENTIVE MEASURES....

Sensitive offshore area protection:

- OSVs & other vessels in offshore areas more than 20 yrs. of age to undergo mandatory technical inspection by IRS.

Stringent inspection of older vessels:

- Targeting based on age, size, flag, class & ownership for foreign ships (PSC).
- FSI inspection of Indian ships increased targeting based on cargo, safety profile of owner, age etc.

*Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMD Mumbai, India*

Sea lanes and traffic management:

- VTIMS to be introduced along the coast
- Sea lanes to be set up in the vicinity of oilfield development area
- Coast Guard to augment surveillance and patrolling of sea lanes during fair and foul seasons

Places of refuge:

- Being a sensitive issue politically, the Ministry of Shipping should choose on POR each on the East & west coast for timely assistance (port to follow IMO guidelines)

*Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMD Mumbai, India*

Safeguarding port navigational waters:

- All ports to provide services of vessel monitoring traffic with effective communication and AIS system for safety of navigation.
- All ports to issue weather warnings in time through VHF radio for the safety of small fishing craft, tugs, barges etc.
- All ports to display storm signals to warn fishing and shipping traffic.
- All ports & Customs to review entry & exit clearances based on technical fitness certificates. IPA to draw up checklist of clearances of Customs clearance in consultation with DG Shipping.
- MS Act and Indian Ports Act to give more power to the Administration and ports for the removal of wrecks posing a hazard to navigation.

*Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMD Mumbai, India*

EMERGENCY RESPONSE MEASURES

Authorities Responsible for Emergency response:

- At national level, DGS to assume responsibility.
- At local level, within ports and for at least 2 nautical miles around, Port chairman responsible, however DGS to be empowered to take over if situation demands.
- For national disasters, DGS to coordinate with MHA..

*Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMD Mumbai, India*

Essential Equipment:

- Salvage companies of international repute to be encouraged to sign MOU with Govt. for salvage vessels.
- To set up 2 ETVs of 120 BP with salvage insurance equipment, hot tab etc. on east/ west coast of India.
- All ports to augment their resources with respect to oil pollution response/ containment equipments/ manpower.

SAR response:

- Coast Guard/ Navy to have twin engine helicopters- heavy duty with longer endurance at standby during rough weather).

*Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMMD Mumbai, India*

REHABILITATION AND RELIEF MEASURES

Emergency Funds:

- A separate fund and PL account to be established under the control of shipping to meet expenses for bankrupt owners, underprivileged fishermen, removal of wrecks, mortal remains of seafarers, hospitalizations etc.

Facilitation of Settlement of claims:

- To provide expertise in line with national & international laws for expeditious settlement of claims during salvage operations.

*Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMMD Mumbai, India*

SHORT TERM MEASURES

- The Important ones are:
- Information sharing on casualties with coastal agencies.
- Augmentation of coastal surveillance by coast guard/ Navy, ONGC, marine police, ports etc. including AIS.
- Long Range identification tracking within 1000 miles from the coast.
- Establishment of Casualty Investigation Bureau for timely investigation..
- Facilities of salvage and oil response experts for timely assistance to distressed and disabled vessels.
- Legislative Changes with respect to wreck removal & port entry rules..

*Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMMD Mumbai, India*

ASSESSMENT OF REPORT

- **Controversial: Vessels more than 25 years of age.**
- **Costs- ETV, Emergency funds.**
- **Role of Coast Guard.**
- **Manpower of DGS.**

*Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMMD Mumbai, India*

DATA SUPPORT FOR DECISION TO RESTRICT OLD VESSELS

All year ship casualties	2005	2006	2007	TOTAL
All ships	37	30	57	124
During MW	16	18	32	66
Serious/loss	25	13	21	59
More than 25 yrs	10	7	16	33
Loss/ serious during MW	8	5	16	29
More than 25 yrs	6	4	8	18

CONCLUSION: the combination of age, poor maintenance and rough weather is FATAL

*Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMMD Mumbai, India*

VESSELS MORE THAN 25 YEARS

Begin cautiously by tightening up -

- Chartered vessels in offshore areas- all weather.
- All chartered vessels (except gas carriers) during monsoons.
- Bulk- We should, but look at the freight rates!

Port entry rules are urgently required.

*Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMMD Mumbai, India*

FINANCIAL IMPLICATIONS

ETVs (EMERGENCY TOWING VESSELS):

- Need to involve petroleum sector to minimize costs.
- Either they take anchor handling supply vessels with salvage capabilities under MOU with INSA and DGS

OR

We mandate salvage capability on their standby OSVs (OFFSHORE SUPPLY VESSELS) with anchor handling & towing capabilities (AHTS)

- Govt. to bear only charter hire recurring costs for days tugs are taken for salvage work. Recurring NP expenditure estimated Rs. 3 crores

Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMD Mumbai, India

Contd....

FINANCIAL IMPLICATIONS...Contd

Emergency fund for immediate relief:

Rs. 2 crores per annum with powers to DGS as to relief coordinators for national emergencies.

A budget line and Rs. 5 crores per annum non planned (NP) expenditure is required.

Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMD Mumbai, India

AGE PROFILE- WORLD FLEET- 01.01.2005

Types of vessel	% of GT					Avg. age
	0-4 yrs	5-9 yrs	10-14 yrs	15-19 yrs	> 20yrs	
All ships	23.0%	21.9%	16.5%	11.3%	27.3%	12.3
Tankers	29.0%	22.8%	20.9%	11.7%	15.7%	10.3
Bulk carriers	20.0%	22.0%	14.6%	12.4%	30.8%	13.0
General cargo	7.3%	15.0%	10.7%	10.9%	56.1%	17.5
Container ships	31.9%	29.3%	16.3%	16.3%	13.7%	9.4
All Others	16.0%	15.7%	11.9%	11.9%	48.4%	15.6

Classification societies have explicit survey requirements for vessels of over 20 yrs. Of age. No data is available for vessels over 20 yrs. Of age.

Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMD Mumbai, India

AGE PROFILE- INDIAN FLEET AS ON 31/12/2007

Types of vessel	% of GT					Avg. age
	0-4 yrs	5-9 yrs	10-14 yrs	15-19 yrs	> 20yrs	
All ships	18.27%	7.71%	15.06%	14.54%	44.42%	15.62
Crude tankers	31.86%	5.39%	24.33%	15.15%	23.28%	11.98
Product tankers	19.47%	11.45%	8.31%	8.92%	51.86%	15.89
Dry bulk carriers	7.97%	7.31%	9.30%	14.77%	60.65%	18.55
Container ships	0.00%	0.00%	56.20%	0.00%	43.80%	17.04
All Others	4.34%	10.35%	8.54%	22.75%	54.01%	18.31

Classification societies have explicit survey requirements for vessels of over 20 yrs. Of age. No data is available for vessels over 20 yrs. Of age.

Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMD Mumbai, India

ADVANCE ACTION TAKEN

- Draft circular on restrictions on chartering of old vessels.
- Emphasis on PSC and FSI.
- Safety fairway for offshore areas- Last stages.
- Separate casualty investigation bureau- Draft not issued.
- Port entry rules.
- Wreck removal legislation amendment.

Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMD Mumbai, India

BACK UP SLIDES

• YEAR	2005	2006	2007	TOTAL
• TYPE				
• Collision	12	5	26	43
• Grounding	8	7	15	30
• Fire	0	0	7	7
• Sinking	0	0	27	27
• Explosion	5	1	1	7
• TOTAL	25	13	76	114

Findings : Contributing factors are poor maintenance, advancing age, hostile weather etc.

Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMD Mumbai, India

OCCUPATIONAL ACCIDENTS

YEAR	2005	2006	2007	TOTAL
Accidental death	45	26	1	72
Suicide	1	0	3	4
Natural death	4	19	45	68
Injured	5	12	11	28
Missing	25	12	13	50
TOTAL	80	69	73	222

Findings : Contributing factors – substandard crew, fatigue, poor living conditions and poor working conditions etc.

*Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MEMD Mumbai, India*

CASUALTY STATISTICS WORLD- WIDE 2005 TO 2007

YEAR	2005	2006	2007	TOTAL
TYPE				
Collision	12(4)*	5(9)*	11	28(24)*
Grounding	8(5)*	7(15)*	8	23(28)*
Fire/Expl				
Sinking	5(2)*	1(3)*	2(7)*	8(12)*
TOTAL	25(11)	13(27)	21(26)	59(64)

Findings : Contributing factors are poor maintenance, advancing age, hostile weather etc.

*Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MEMD Mumbai, India*

CASUALTY STATISTICS WORLD - WIDE FROM 1st July, 07 TILL 31st DEC. 07

Collision / contact	15
Grounding	7
Fire / explosion / Sinking	0
Total	22

PS – Out of these cases 2 occurred in Indian waters and remaining in foreign waters.

*Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MEMD Mumbai, India*

SHIP CASUALTIES ANALYSIS WORLD - WIDE FROM 2005 TO 2007 (ALL YEAR ROUND)

	2005	2006	2007	TOTAL
Total Ships affected	64	146	260	470
Age over 25 yrs	9	31	61	101
Age less than 25 yrs	40	89	138	267
Total	49	120	199	368

PS – Cases of ships age not known, small crafts, port facilities and misc. not taken into account.

*Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MEMD Mumbai, India*

SHIP CASUALTIES ANALYSIS FOR 2005 TO 2007 DURING MONSOON IN INDIAN WATERS (1st JUNE to 31st AUG., 2007)

	2005	2006	2007	TOTAL
Total Ships affected	9	26	26	61
Age over 25 yrs	4	11	13	28
Age less than 25 yrs	2	12	9	23
Total	6	23	22	51

PS- Cases of ships age not known not taken into account.

*Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MEMD Mumbai, India*

SHIP CASUALTIES ANALYSIS FOR 2007 DURING MONSOON IN INDIAN WATERS (FROM 25th JULY to 31st AUG., 2007)

- Data between 25th July to 31st Aug., 2007
- Total Ships affected 12
- Age over 25 yrs 5
- Age less than 25 yrs 7

PS- Cases of ships age not known not taken into account.

*Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MEMD Mumbai, India*

**OCCUPATIONAL ACCIDENTS
WORLD – WIDE (2005 TO
31/12/2007)**

• YEAR	2005	2006	2007	TOTAL
• Deaths*	75	57	121	253
• Injured	5	12	15	32
• TOTAL	80	69	136	285

• * Include accidental, natural, missing & suicide.
• Findings : Contributing factors – substandard crew, fatigue, poor living conditions and poor working conditions etc.

*Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMD Mumbai, India*



FEAR

Until One Has The Courage To Lose Sight Of The Shore,
He Will Not Know The Terrors Of Being Lost Forever At Sea!

*Mandatory Code For Investigation Of
Marine Casualties And Incidents Agreed For
Adoption In 2008.*

*Sub committee of Flag States at its 15th Session agreed on
the subject Code*

*The New Code is to replace the existing Code A 849(20) as
amended by A 884(21).*

*This code will be submitted for adoption by MSC at its 84th
Session in mid 2008.*

*The Code would require a Flag State to conduct a Marine
Safety Investigation into every "Very Serious Marine
Casualty" ... involving the Total Constructive Loss of a
Ship, death or severe damage to the Environment.*

Capt. Derrick Frank Vaz, NS Cum DDG (Tech), MMD Mumbai, India

*Mandatory Code For Investigation Of
Marine Casualties And Incidents
Agreed For Adoption In 2008.*

*The Code would also recommend a Flag State to
conduct a Marine Safety Investigation into
Marine Casualties (other than Very Serious) and
incidents, if it is considered that the investigation
will provide information that can avert recurrence*

*The New Code would include a new Regulation
6 in Solas Chpt. XI-I. Part I and II will be
mandatory. Part III will be recommendatory.*

*Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMD Mumbai, India*



CHANGE

When The Winds Of Change
Blow Hard Enough,
The Most Trivial Things
Can Turn Into
Deadly Projectiles!

*Capt. Derrick Frank Vaz
NS Cum DDG (Tech), MMD Mumbai, India*

*Thanks
for your
Attention !*

Capt. Derrick Frank Vaz

*Nautical Surveyor cum Deputy Director General (Tech),
MMD Mumbai, INDIA*

(4) インドネシア

WHO WE ARE

- The Komisi Penelitian Penyebab Kecelakaan Pesawat Udara (KPPKPU) – The Investigation Committee On Civil Aviation Accidents – was established in 1994 to conduct independent investigations of all civil aviation accidents in Indonesia;
- In 1999 it became Komite Nasional Keselamatan Transportasi (KNKT) or NTSC. Its objectives is to conduct investigation on all major accidents in all modes of transportation;
- NTSC is a division under Ministry of Transportation and is reporting directly to the Minister.

NTSC / Transportation Safety Committee (NTSC)

2

NTSC LEGAL SOURCE

- UNCLOS Article 94. Duties of the Flag State;
- IMO Resolution A.849(20). Code for the Investigation of Marine Casualties;
- SOLAS Chapter 1, Regulation 21;
- PRESIDENTIAL DECREE No. 105 / 1999 (NTSC responsible to The MINISTER OF TRANSPORTATION).
- REGULATION NO.17/2008, ARTICLE 256

NTSC / Transportation Safety Committee (NTSC)

4



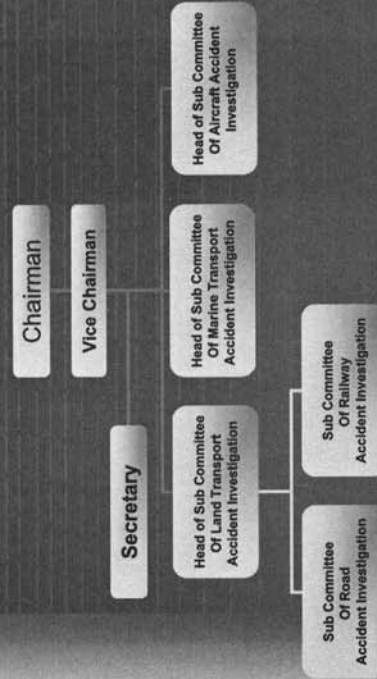
NATIONAL TRANSPORTATION SAFETY COMMITTEE (NTSC)

MINISTRY OF TRANSPORTATION
REPUBLIC OF INDONESIA

PRESENTED BY:

Expert Meeting on Promoting Co-operation of the Marine Casualty Investigation in Asia,
JUNE 25-26, 2008
TOKYO, JAPAN

NTSC STRUCTURE



NTSC / Transportation Safety Committee (NTSC)

3

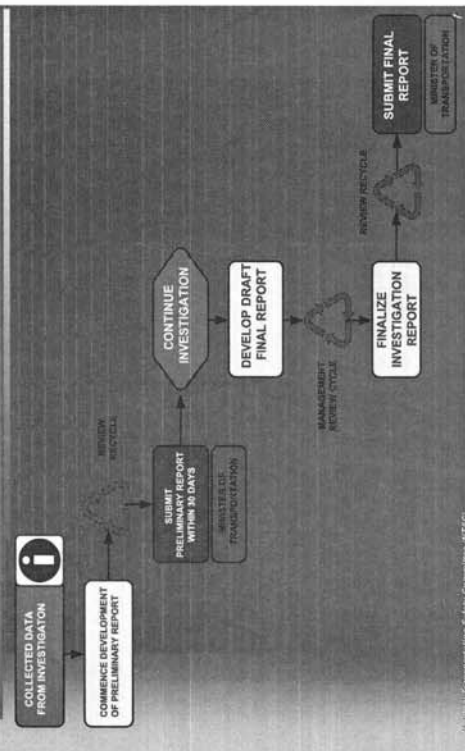
OUR VISION

To Become A Single Self Regulating Organization That Is Capable In Conducting Investigations And Surveys And Improving Safety Of Life At Sea In Indonesia.

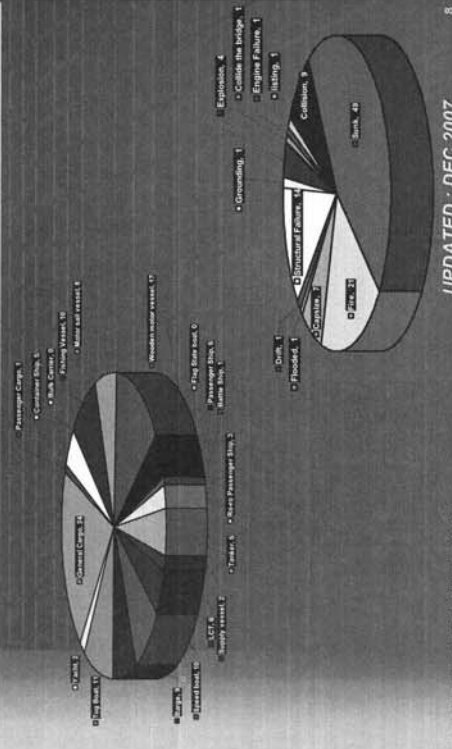
OUR MISSION

- To Determine Probable Factors Or Causes of Transportation Accidents Based On Identification Of The Standard of The Safety System In Order To Prevent Similar Accidents Happened In The Future;
- To Recommend Safety Regulations To Be Administered Consistently By The Respective Party.

REPORTING PROCEDURE



INDONESIA MARINE ACCIDENT DATA 2007



INTERNATIONAL JOINT CO-CORPORATION

- TRAINING & EDUCATION WITH AUSTRALIAN TRANSPORT SAFETY BUREAU (ATSB)
 - INVESTIGATION TECHNICAL ASSISTANCE
 - HUMAN FACTOR TRAINING FOR INVESTIGATOR
 - HUMAN FACTOR TRAINING FOR ENGINEER
 - SENT NTSC'S INVESTIGATOR TO FOLLOW IN ATSB INVESTIGATOR DIPLOME PROGRAM
- ACCIDENT DATA EXCHANGE WITH JAPANESE COASTGUARD

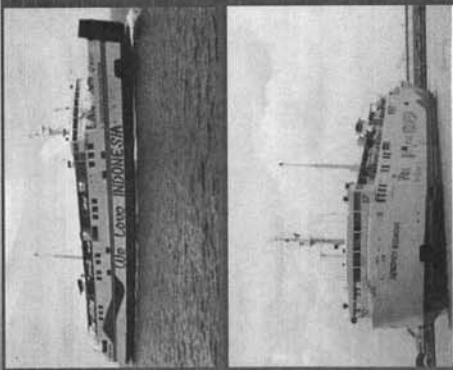
NTSC's Transportation Safety Committee (NTSC)

9

INVESTIGATED CASES

SENOPATI NUSANTARA (DECEMBER 2006)

- **Year Built :**
 - 1985
- **Dockyard :**
 - Japan
- **Type of Accident :**
 - Capsize
- **Location :**
 - Mandalika water, Java Sea
- **Findings :**
 - Construction Modification
 - Bad Weather
 - Last Docking On October 2006
 - Close Space Carddeck
- **Most probable cause :**
 - Bad Weather & Manning Regulation
- **Contributing Factors :**
 - Regulation for ferry ropax
 - Inaccuracy cargo data
 - Free Surface Effect
 - Leakage On Water Tight Ramp
 - Cargo Securing Material
 - Ship's Handling in Bad Weather
 - Implementation of ISM Code

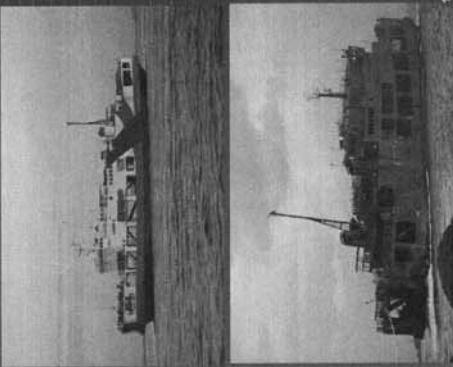


11

NTSC's Transportation Safety Committee (NTSC)

LEVINA I (FEBRUARY 2007)

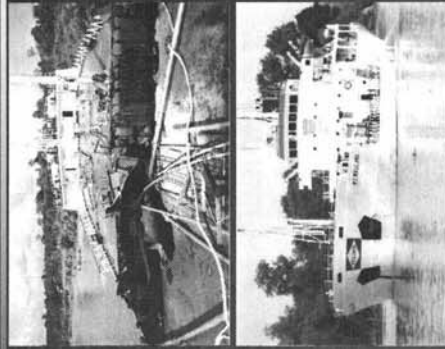
- **Years Built :**
 - 1980
- **Dockyard :**
 - Fokuoka Shipbuilding Co.Ltd, Japan
- **Type of Accident :**
 - Fire
- **Location :**
 - + 40 nmil Northern Tanjung Priok Port, Jakarta
- **Findings :**
 - Inaccuracy of Cargo Data
 - Passenger list is not same with Actual numbers of passenger onboard
- **Most probable cause :**
 - Fire on non-declared Dangerous goods on vehicle on deck
- **Contributing Factors :**
 - Cargo booking supervision
 - Fire detector and fire fighting system vehicles onboard
 - Inadequate distance between vehicles onboard
 - Lack of skill in crowd & crisis management



12

NTSC's Transportation Safety Committee (NTSC)

MT. MAULANA (APRIL 2007)

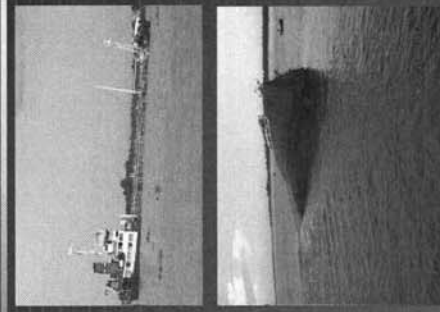


- **Years Built:**
 - 1992
- **Dockyard:**
 - Inggom Dockyard, Jakarta, Indonesia
- **Type of Accident:**
 - Explosion
- **Location:**
 - Telepung Blight, Siak River, Riau
- **Findings:**
 - Overload on electrical system
 - Tank Cleaning While steaming
 - Leakage caused by corrosion on gas discharge piping system
- **Contributing Factors:**
 - Weather/Temperature
- **Recommendation:**
 - Improvement on piping maintenance system

Original Transportation Safety Committee (NTSC)

13

MT. JOSPHINE (MAY 2007)

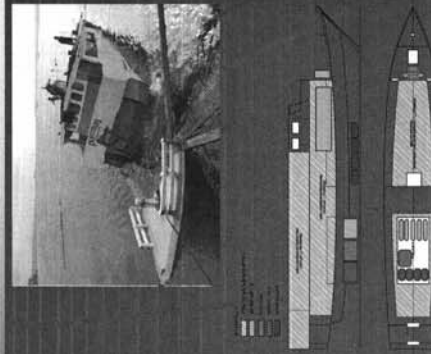


- **Years Built:**
 - 1985
- **Dockyard:**
 - Mikalshima Dockyard Co.Ltd Japan
- **Type of Accident:**
 - Capsize
- **Location:**
 - Misi River, South Sumatera
- **Findings:**
 - Crack on the bottom hull cause flood in ballast tank
 - Improper handling of flood
- **Contributing Factors:**
 - Management decision;
 - Pilot recommendations not obligated;
 - Ship sailing route (form salt water to fresh water);
 - Crew's experience on local water
- **Recommendation:**
 - Enhancing on ISM Code Implementation

Original Transportation Safety Committee (NTSC)

14

MV. ACITA 03 (OCT 2007)



- **Years Built:**
 - 2003
- **Dockyard:**
 - Magale, Taliabu,
- **Type of Accident:**
 - Capsize
- **Location:**
 - Lakelab Beach, Bau-bau, South East Celebes
- **Findings:**
 - Passengers distributed on one side which cause
 - No Controls of Passenger on board by local authority;
- **Contributing Factors:**
 - Lack of crew control on passengers;
 - Lack of Passenger's Safety Knowledge;
 - Transportation availability during peak season;
 - Shallow
 - Shallow, General and Accommodation's design
- **Recommendation:**
 - Improvement on local built wooden passenger cargo vessels
 - Enhancement on safety control in local authority
 - Crews training for emergency conditions,

Original Transportation Safety Committee (NTSC)

15

MT. KHARISMA SELATAN (DEC 2007)



- **Years Built:**
 - 1986
- **Dockyard:**
 - Murakami Hide Shipyard, Japan
- **Type of Accident:**
 - Capsize
- **Location:**
 - Mirah Pier, Surabaya
- **Findings:**
 - Ship loaded with no load line certificate
- **Contributing Factors:**
 - Lack of Crew's Understanding on ship operation procedure
 - No Load line Installed
- **Recommendation:**
 - Enhancing supervision on ISM-Code Implementation;
 - Enhancing on ship's boarding control;
 - Enhancing ship maintenance Plan;
 - Enhancing Crew's Training on ship's familiarity;

Original Transportation Safety Committee (NTSC)

16

ISSUED SAFETY RECOMMENDATIONS

- Revise or amend on Ferry Ro-Ro Safety Regulations;
- Improvement on the Application Ship Safety System;
- Enforced or Urge the Company to Develop Planned Maintenance System;
- Supervision and Enforcement on the Implementation of All Laws for Carriage and Handling of Dangerous Goods;
- Close Audit for Crew's Understanding on Ship Management System;
- Improvement on Manning Regulation and Crew's Training on safety aspect (e.g. *Fire Drill, Abandon Ship, Crowd Management*) and In Competency.

(National Transportation Safety Committee (NTSC))

17

PRESENT COMMITTEE CONDITIONS

- Vast Coverage Area compare with the number of investigators and while Committee concentrated in Jakarta;
- Lack of Independence in the Aspect of Hierarchy As Well As Budget;
- Cheap Fare For Passenger (Government Controlled) Due To Low People's Income, Make It Difficult To Fulfill All Safety Requirement;
- Global problem of fuel supply

(National Transportation Safety Committee (NTSC))

18

FUTURE CONDITION

- Independent Agency, Under and be responsible directly to the PRESIDENT of Republic Indonesia;
- Enactment of Transportation Safety Investigation ACT;
- Enactment of Procedure for the Acceptance of NTSC Recommendations and To monitoring Them;
- To Have Adequate Number Of Investigators;

(National Transportation Safety Committee (NTSC))

19

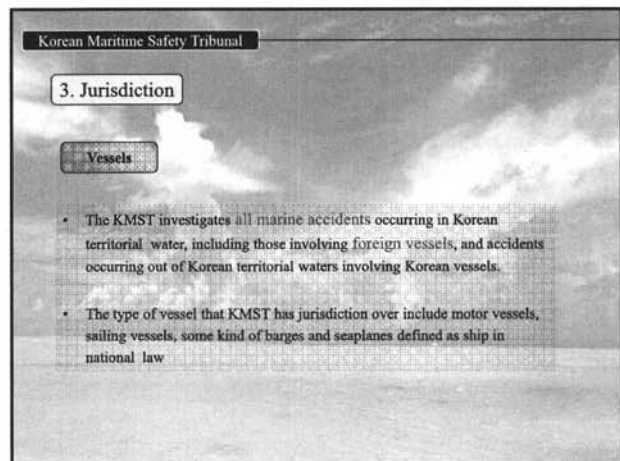
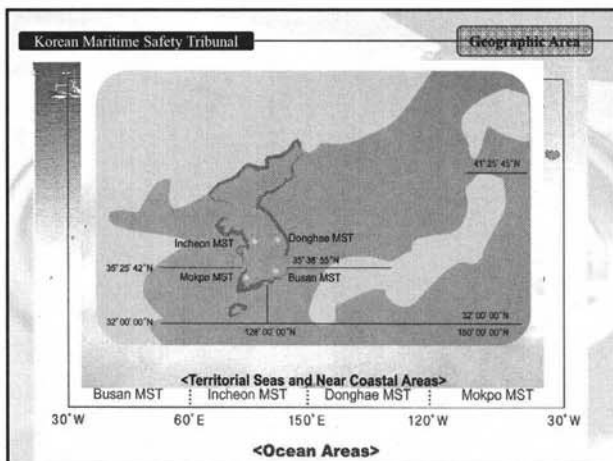
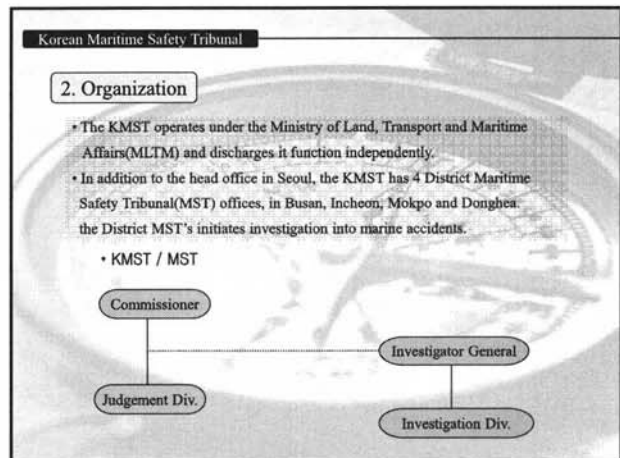
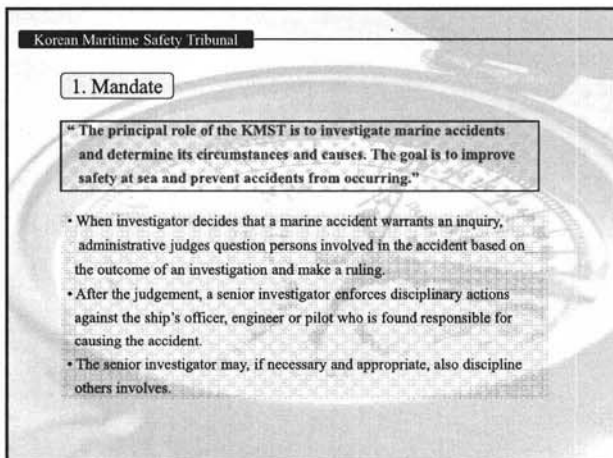
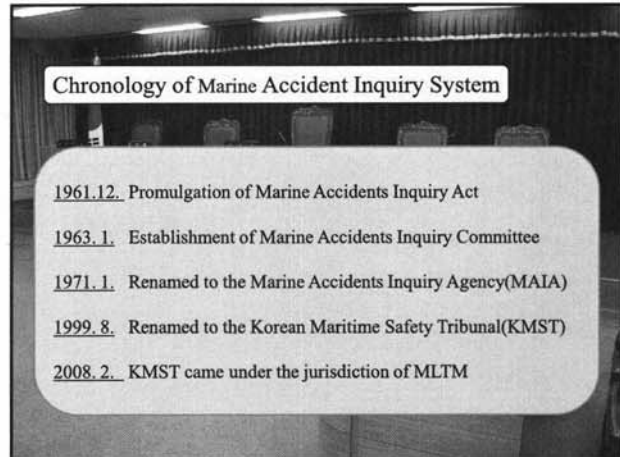
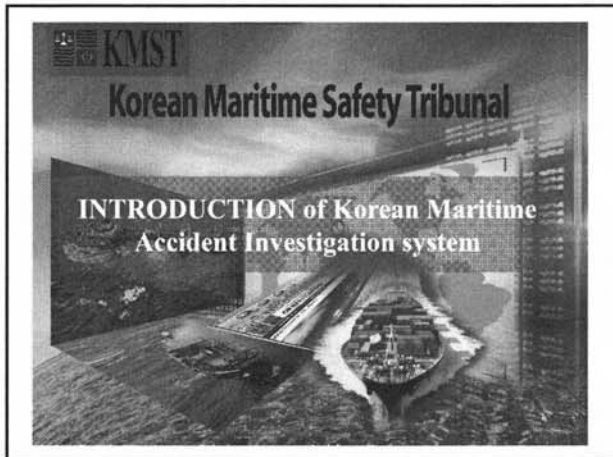
TERIMA KASIH THANK YOU



NATIONAL TRANSPORTATION SAFETY COMMITTEE
MINISTRY OF TRANSPORTATION

KARYA BLD. 7TH FL. JL. MERDEKA BARAT NO. 8,
JAKARTA PUSAT, INDONESIA, 10110
TELP. : 62 21 3517606, 3511398 EXT: 1497, FAX. : 62 21 3517606
WEB : WWW.DEPHUB.GO.ID/NTSK
EMAIL : NNTK@DEPHUB.GO.ID

(5) 韓 国



Korean Maritime Safety Tribunal

3. Jurisdiction

Marine accident

- An injury or disappearance of person relating to operation of ship or ship's structure or outfits
- A damage of Ship or shore facility relating to ship's operation
- A ship's collapse, losing or missing
- Ship's collision, grounding, capsizing or immobility of ship
- Oil pollution relating to ship's operation

Korean Maritime Safety Tribunal

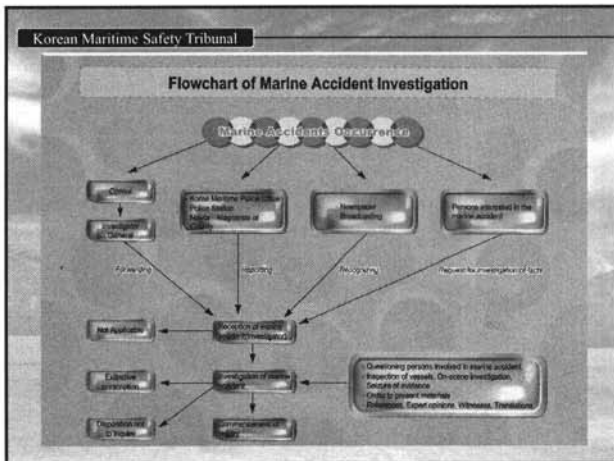
4. Investigation and Inquiry Procedure

Investigation

When other authorities such as the marine police inform the KMST of a marine accident, an investigator at a district MST begins to investigate. Based on the initial findings, if investigator believe that the accident should be inquired further, he refers that case to the Court of the district MST.

Inquiry and judgement

When a marine accident is referred to a district MST Court, the judges examine the case by questioning the persons involved and make a judgement in the Court. Three judges discuss the circumstances of the case and come to verdict.



Korean Maritime Safety Tribunal

4. Investigation and Inquiry Procedure

Instance

If the investigator or the person involved in the marine accident does not accept the judgement of the local MST Court, they can appeal and request the KMST in Seoul to reexamine the case, If they reject the KMST's ruling, they can take the case to the Supreme Court.

(First) District MST → (Second) KMST → (Third) Supreme Court

Appeal process Appeal process

Korean Maritime Safety Tribunal

4. Investigation and Inquiry Procedure

Execution of judgement

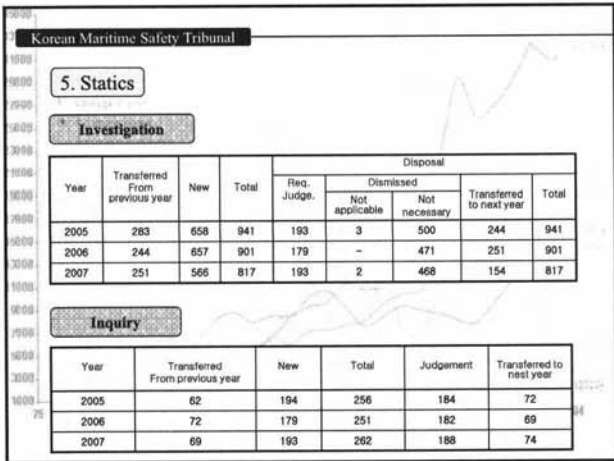
- If a marine accident is determined to be caused by an international act or negligence of a ship's officer or pilot on duty, the district MST and the KMST sentence will decide the appropriate disciplinary action.
- The district MST and the KMST may, if necessary and appropriate, impose disciplinary action against other person(s), in addition to those mentioned, who are involved in the accident

Korean Maritime Safety Tribunal

5. Statics

Marine accidents (vessel type)

Year	Passenger	Cargo	Fishing	Oil tanker	Tug boat	Others	Total
2003	10	120	483	28	92	34	767
2004	20	130	734	24	122	40	1,070
2005	8	99	657	24	72	24	884
2006	17	110	584	43	93	18	865
2007	13	96	495	31	109	15	759
Total	68	555	2,953	150	488	131	4,345
%	1.6	12.8	68.0	3.5	10.2	3.9	100



Korean Maritime Safety Tribunal

5. Investigation Policy for IMO Investigation Code

- Under consideration of accepting IMO investigation code to domestic law
 - Collection of internal opinions
 - Comparison with other investigation agencies

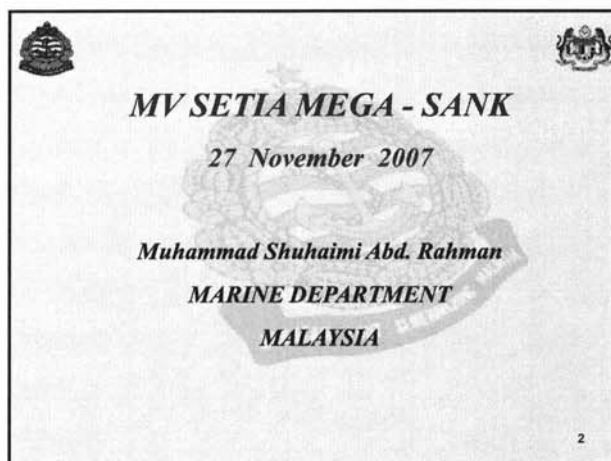
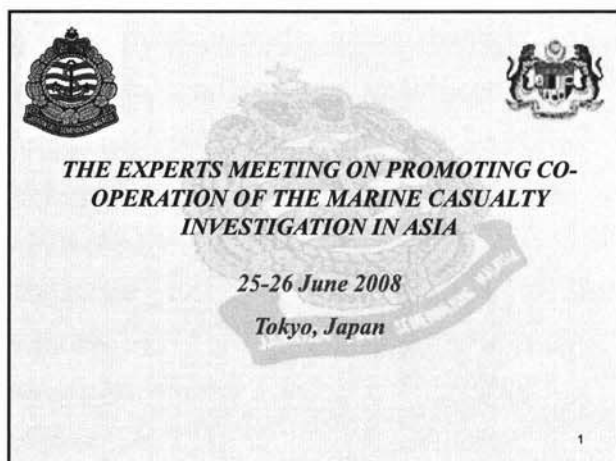
Korean Maritime Safety Tribunal

KOREAN MARITIME SAFETY TRIBUNAL (KMST)

中央海洋安全審判院

The Korean Maritime Safety Tribunal (KMST) was established in 1963 to investigate marine accidents and seek out ways to prevent them.

(6) マレーシア



Ship Particulars	
Name of Vessel	: MV Setia Mega
Port of Registry	: Labuan, Malaysia
Type of Vessel	: Anchor Handling Tug
Year of Built	: 2005
GRT/NRT	: 496/149
IMO	: 9338450
Class	: BV
Crew on Board	: 14
Cargo on Board	: 3 units of N2 tanks (each 13 tns)

Item	Particulars
Date of Incident	November 29, 2007
Time Of Incident	1225 hrs
Location	Off Resak Oilfield , 05° 28.8N / 104° 03.4E
Weather	Strong breeze , swell 3-4 meters ,wind speed 27 knots
Master In Command	Capt Imran Tanjung , >5 years as Master on board offshore vessel
Cargo on Board	3 units of Nitrogen tanks (size 8'x6'x8') each weighing 13 tons
ROB (during incident)	MGO – 173,643 liters, FW-163,900 liters, LO-914 liters, Hydraulic Oil – 600 liters (in drums)

Description Of Incident

- Vessel underway from KSB to DLB experiencing strong breeze and high swell;
- On voyage, vessel lost stability due to excessive listing to port ;
- Crews abandoned ship, boarded life raft and rescued by another boat;
- Ship sank- 70meters depth

Date	Time	Description
26/11/07	1200hrs	MV Setia Mega departed from Dulang B (Location PFSO) to Kemaman Supply Base (Port) for scheduled maintenance and taking provision. On board, deck space 95% occupied with backload. Weather-Swell 1.5-2 meters, Wind N-E , Wind speed – 15-20 knots. 3 rd Engineer inspected steering gear room and found no abnormalities.

Events Leading to Incident (Con't)		
Date	Time	Description
27/11/07	0330hrs	Vessel arrived at KSB anchorage and dropped anchor.
	0900hrs	Anchor aweigh and proceed to KSB Berth#3.
	1040 hrs	Internal Audit by Company.
	1045 hrs	Commenced maintenance in E/R by ships' staff & Company's maintenance team.
		Maintenance done : 1. Service M/E stbd side injectors, 2. Repair M/E stbd exhaust silencer, 3. Repair A/E 1 starter motor.

Events Leading to Incident (Con't)		
Date	Time	Description
27/11/07	1200 hrs	Load MGO 50,000 ltrs.
28/11/07	1755 – 1810 hrs	Loading 3 units N2 tank (8'x6'x8') weight 13 tonnes each.
	2000 hrs	Vessel departed KSB to DLB.
		Departure condition : Draft Fwd : 4.0 m Aft:4.3 m. MGO – 174,143liters, FW-166,400 liters, LO-914 liters, Hydraulic Oil – 600 liters (in drums)
	2000 – 2100 hrs	Routine round check by 3/Engineer including steering gear room and found no abnormalities.

Events Leading to Incident (Con't)		
Date	Time	Description
29/11/07	0700 hrs	2/Officer on duty observed the vessel's mooring rope stowed on deck stbd crash bar was partly washed over the stern. The Master altered course to allow the crew to recover the rope and the vessel resumed passage on original course. Crews noticed cargoes remained intact.

Events Leading to Incident (Con't)		
Date	Time	Description
29/11/07	0915 hrs	2/Officer transmitted the routine vessel's daily report(for 28 Nov. 2008) to Owner
	1000 - 1019hrs	Master on bridge noticed rudder angle indicator showed erratic movement. Master and 2/officer attempted to rectify the fault by changing auto pilot to manual, switching on and off button for steering motor, change over from fwd to aft control, but the fault remained.

Events Leading to Incident (Con't)		
Date	Time	Description
29/11/07	1000 - 1019hrs	In E/room, alarm sounded and E/cadet noticed steering gear fault alarm, steering gear room bilge high level alarm and FO daily tank high level alarm. E/cadet went up to bridge to find out and then instructed by Master to check steering compartment. E/cadet and Oiler proceeded on deck for inspection and noticed the port side stern area below water and portside steering compartment access hatch coaming submerged.

Events Leading to Incident (Con't)		
Date	Time	Description
29/11/07	1000- 1019hrs	Attempted to open the stbd side hatch cover but was unsuccessful because of heavy roll and strong sea wash. Master slowed down M/engine to allow E/cadet inspect the steering room compartment again. Based on discussion between Master, C/E and E/cadet, they suspected steering gear room flooded.

Events Leading to Incident (Con't)		
Date	Time	Description
29/11/07	1000-1019hrs	Master clutched out both M/engines and as a result, sinkage at stern and port list appeared to be more severe At this juncture, few crew members noticed cargo lashings already loose and 3 cargoes started shifting

13

Events Leading to Incident (Con't)		
Date	Time	Description
29/11/07	1000-1019hrs	Immediately, C/E, 3 Engineer, E/Cadet and Oiler in the engine room attempted to dewater the steering compartment. While opening the valves and before they could start the GS pump, a blackout occurred due to tripping of the main circuit breaker. Engineers closed the breakers but each time it tripped.

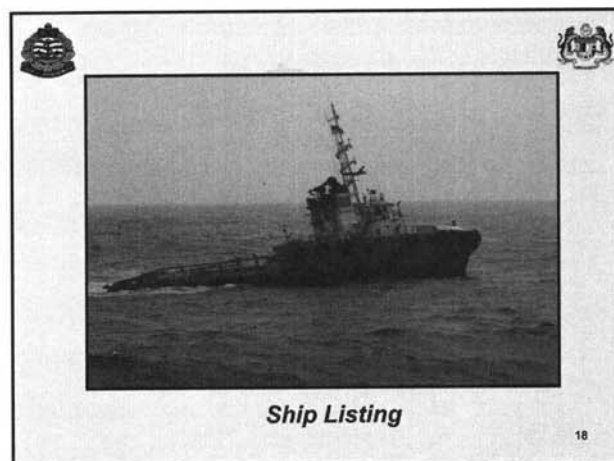
14

Events Leading to Incident (Con't)		
Date	Time	Description
29/11/07	1000-1019hrs	Realizing that they were not able to control the flooding without electrical power, CE notified Master and ordered his engine crew to close up the access doors to accommodation @ main deck and engine room. CE activated the fuel tanks remote closing valves and the Main engines and generator engine later stopped
	1020-1114hrs	2 nd Officer contacted various parties and vessels within vicinity for assistance. Before engine crew left the e/room, they noticed excessive water leaking through the emergency escape access hatch deck port side

Events Leading to Incident (Con't)		
Date	Time	Description
29/11/07	1000-1019hrs	Realizing that they were not able to control the flooding without electrical power, CE notified Master and ordered his engine crew to close up the access doors to accommodation @ main deck and engine room. CE activated the fuel tanks remote closing valves and the Main engines and generator engine later stopped
	1020-1114hrs	2 nd Officer contacted various parties and vessels within vicinity for assistance. Before engine crew left the e/room, they noticed excessive water leaking through the emergency escape access hatch deck port side
	1115hrs	Master ordered vessel to be abandoned. By this time three nitrogen tanks shifted to aft and about to fall overboard
	1130hrs	All 14 crew members in life-raft waiting to be rescued

Events Leading to Incident (Con't)		
Date	Time	Description
29/11/07	1200hrs	MV Osam Manila rescued all 14 crews
	1225hrs	<i>MV Setia Mega sank more or less vertically with stern down</i> <i>Position Recorded :</i> <i>05° 28.8 N / 104° 03.4 E</i> <i>Depth approximately 70 meters</i>

17



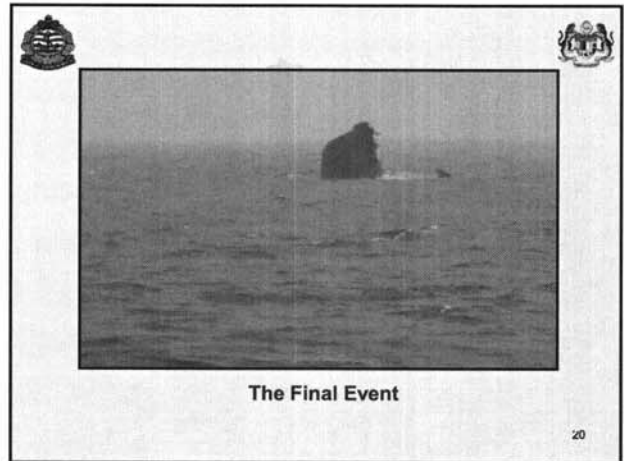
Ship Listing

18



Shipping Water on deck

19



The Final Event

20

Findings

- The ingress of water to the steering gear compartment was affirmed by the high bilges alarm and subsequent failure of the steering gear motor;
- The water ingress that contributed to the failure of the steering gear motor, causing numerous trips to the main breaker resulting in vessel's power outage;
- Neutralizing the engine caused water shipping on deck adding more weight to the vessel causing it to trim further by stern;
- Engine room flooding experienced from ingress of water to the emergency escape hatch;
- Eventual flooding of the engine room resulted in the vessel sinking;

21

Water Ingress

i. Mushroom (Ventilation)

- Crew unawareness
- Least focus for maintenance

22

ii. Hatch Cover

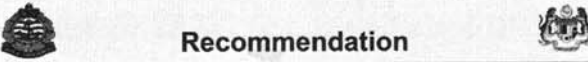
- Left unlocked - 3rd Engineer last to enter

23

iii. Rudder Bush

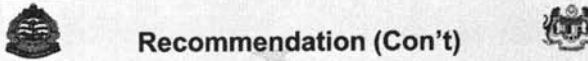
- Can drop and cause water ingress
- Unlikely to happen as at 0700hrs vessel can still change course and maneuvered

24



Recommendation

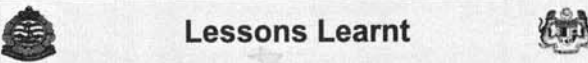
Item	Issue	Action Required	Responsible Party	Short Term/Long Term
1	Training	Provide refresher briefing to vessels' Masters and Officers on action during power outage and critical situation	Fleet Management Division	Short Term & Long Term
2	Procedure	<ul style="list-style-type: none"> Ensure effective pre-departure check by Master through witnessing by the Base Operations Manager Provide briefing to vessels crew on the required pre-departure checks to be conducted 	<ul style="list-style-type: none"> Base Operation Managers Fleet Management Division 	<ul style="list-style-type: none"> Short and Long Term Short and Long Term
3	Recruitment process	Strengthen the recruitment process with focus on job knowledge verification	Crew Management Department & Recruitment Panel	Short and Long Term



Recommendation (Con't)

Item	Issue	Action Required	Responsible Party	Short Term/Long Term
4	Maintenance Day	Periodic adequate maintenance days be provided by Client as per vessel's PMS	Client / AMSB	Short and Long Term


26



Lessons Learnt

- To ensure integrity of water tightness must be verified before each voyage;
- To ensure Pre-departure checklist to be executed by Master and witnessed by the Base Operations Manager at supply bases;
- To ensure steps or methods to keep the vessel afloat must be fully explored and understood by the vessel's crew e.g de-ballasting etc.;
- To ensure personnel should not be overcome by panic;
- To ensure mandatory ship drills are carried out as they are vital during actual emergency;

27



Thank You
(Aligato gozaimasu)

28

(7) モンゴル

MONGOLIA MARITIME ADMINISTRATION

Mongolia Maritime Administration was established in 2007 under the Ministry of Road Transport and Tourism as Government Implementing Agency in order to implement the Government policy on maritime issues and domestic water transport.

Mongolia has passed its national Maritime Law in 1996 and became a member IMO since 1996. Mongolia has ratified over 12 main conventions of IMO and participates in General Assembly meeting of IMO gradually.

Since 2003, Mongolia has established a Joint Venture company "Mongolia Ship Registry" with Singaporean company "Maritime Chain". At present in our registry over 300 ships operates actively around the world.

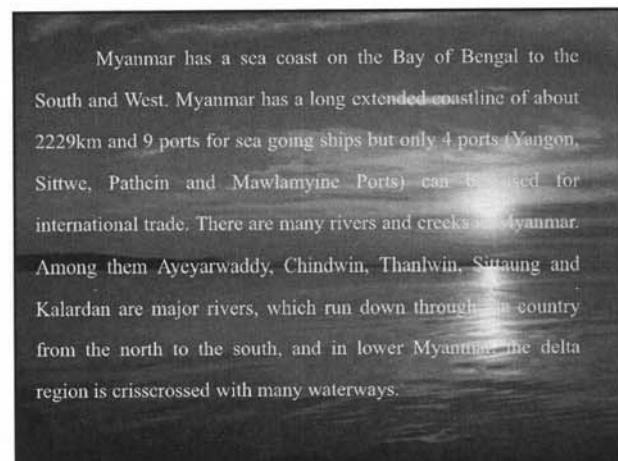
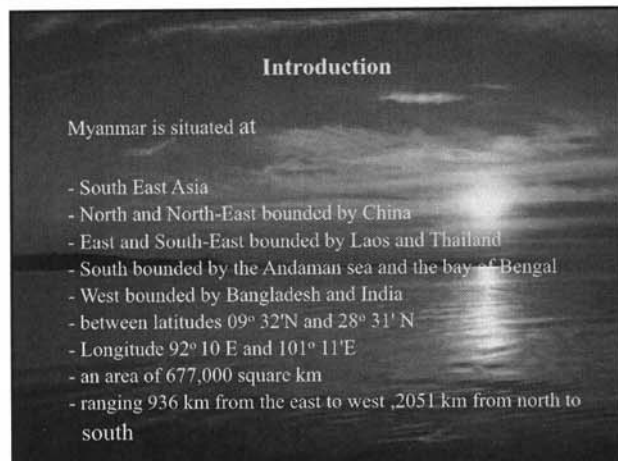
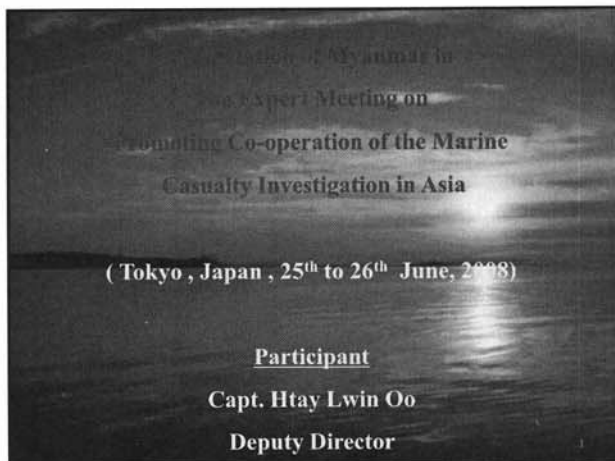
Maritime Administration is in charge of implementing national policy on maritime shipping, ships registry and developing the maritime sector in its country. Despite its location as a landlocked country, Maritime Administration works on accessing to the International Maritime conventions through which country can obtain some advantages from the sea.

Main Activity of Administration

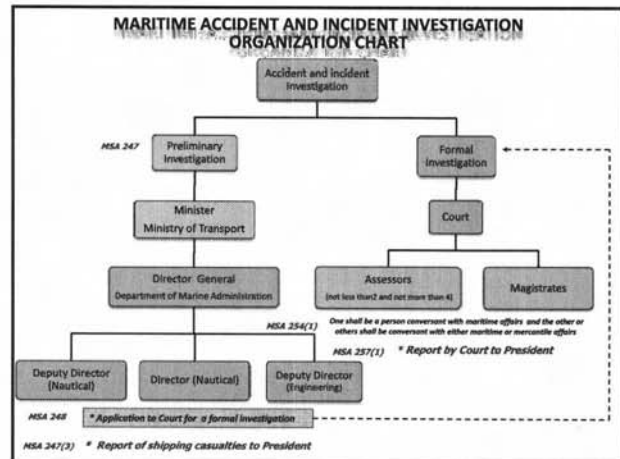
- Implementation of Government policy in maritime sector and also inland water transport;
- Accession in IMO and international conventions;
- Investing and promoting to develop newly established sector in Mongolia, maritime and inland water transport;
- Developing national laws and regulations on the matter;
- Monitoring on implementation of national laws and regulations;
- Maintaining and controlling over Mongolia Ship Registry;
- Working jointly with IMO and other international organizations on training its staff and national officers;
- Assisting and promoting on development of domestic water transport entities by its professional knowledge and training their staff;
- Registration and certification of domestic water transport vehicles;

Maritime Administration
Sukhbaatar District, Chingis Avenue-11
Ulaanbaatar 210628
Tel: +976-70114801
Fax: +976-70114802
e-mail: transdep@mongol.net
web site: www.monmarad.org

(8) ミャンマー



- (xiv) Registration of foreign vessels under the terms of Bare boat chartering
 - (xv) Preparation of explanation on the matters covered by the IMO conventions or instruments and presenting it to the Ministry of Transport and the Attorney General's Office.
- In relation to the qualified and well trained seafarers and educated marine personnel, the DMA works together with the IMT and the MMU.



SPECIAL SHIPPING INQUIRES AND COURTS

- For the purpose of inquires and investigations under this part a shipping casualty shall be deemed to occur when –
 - (a) on or near the coasts of the Union of Myanmar, any ship is lost, abandoned, stranded or materially damaged ;
 - (b) any lost of life ensues by reason of any casualty happening to, or on board of, any ship on or near those coasts ;
 - (c) on or near those coasts, any ship causes loss or material damage to any other ship ;
- * the word "coast" includes the coasts of creeks and tidal rivers.
- Whenever any such officer receives credible information that a shipping casualty has occurred, he shall forthwith report in writing the information to the President of the Union of Myanmar and may proceed to make a preliminary inquiry into the casualty.
- An officer making a preliminary inquiry under this section shall send a report thereof to the President of the Union.

The officer appointed under MSA 246(3), whether he has made a preliminary inquiry or not, may, and where the President of the Union so directs, shall make an application to a Court empowered under section 249, requesting to make a formal investigation into any shipping casualty ; and the Court shall thereupon make such investigation.

A Court making a formal investigation shall constitute as its assessors not less than two and not more than four persons, of whom one shall be a person conversant with maritime affairs and the other or others shall be conversant with either maritime or mercantile affairs.

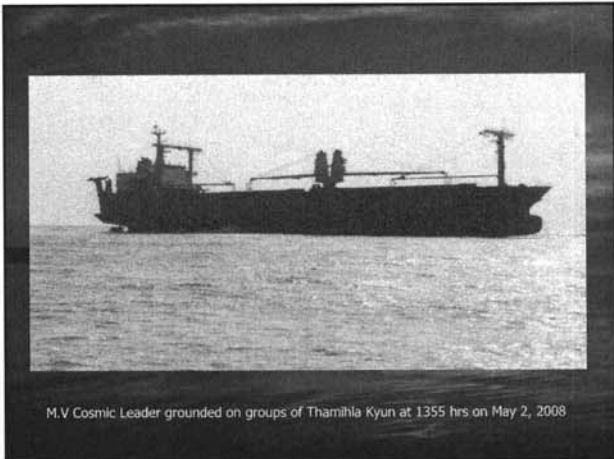
The Court shall, in the case of all investigation under this part, transmit to the President of the Union a full report of the conclusions at which it has arrived, together with the evidence.

In cases in which, under the Merchant Shipping Acts, the Court is required to send a report to the Board of Trade, the report shall be sent through the President of the Union and the transmission of the report to the President of the Union shall be a sufficient compliance with this sub-section.

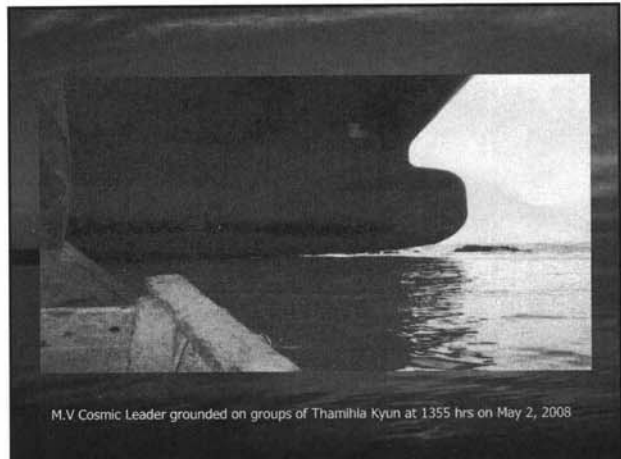
CASE STUDY OF

"M.V COSMIC LEADER GROUNDING"

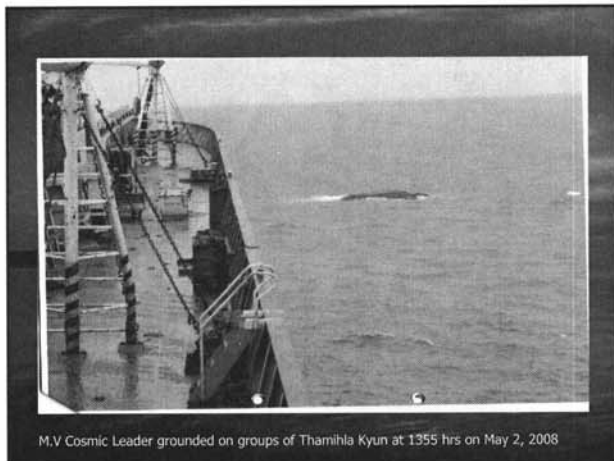
- Panama Registered vessel mv. Cosmic Leader, IMO No. 9011040, GT. 8889 was grounding due to hitting by Cyclone "Nargis" about 1355hrs on 02/05/2008 within Myanmar internal water in psn: Lat. 15 50.4 N , Long. 094 16.0E on the way from Port of Patheingyi to safer place for avoiding Cyclone. All crew and Phillipino were saved by Myanmar SAR.



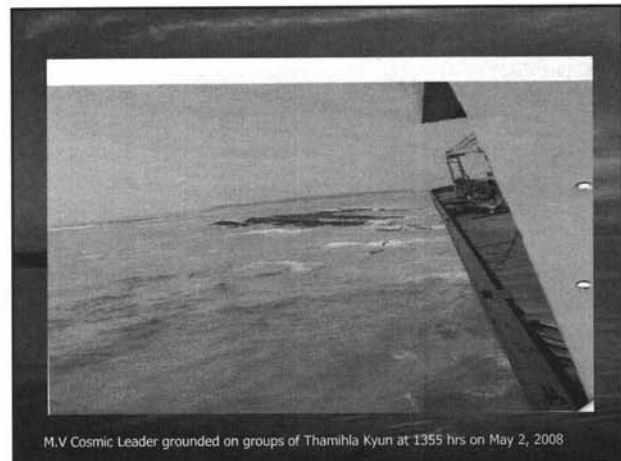
M.V Cosmic Leader grounded on groups of Thamihla Kyun at 1355 hrs on May 2, 2008



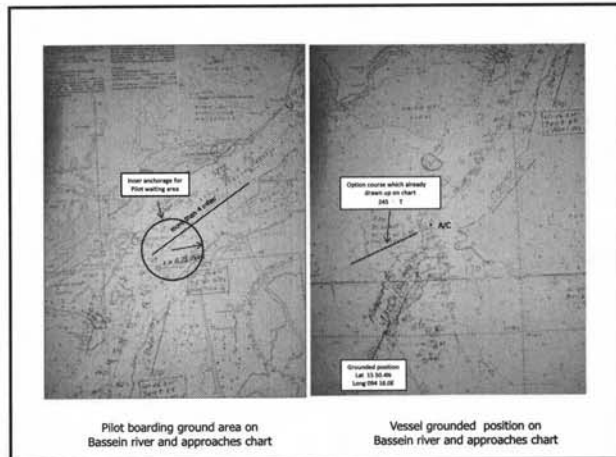
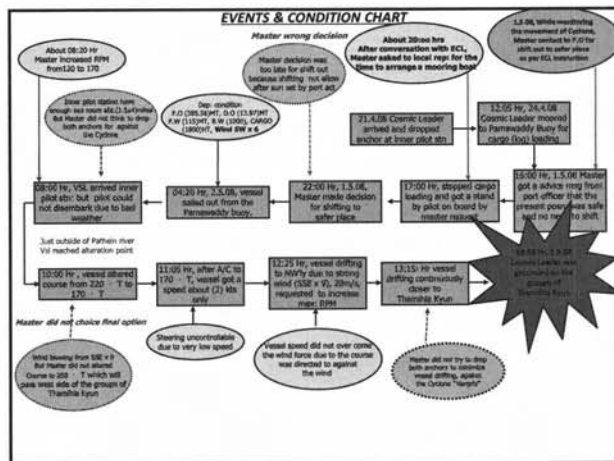
M.V Cosmic Leader grounded on groups of Thamihla Kyun at 1355 hrs on May 2, 2008



M.V Cosmic Leader grounded on groups of Thamihla Kyun at 1355 hrs on May 2, 2008



M.V Cosmic Leader grounded on groups of Thamihla Kyun at 1355 hrs on May 2, 2008



INVESTIGATION INTO CASUALTIES

when ever-

- (a) any inland steam-vessel has been wrecked, abandoned or materially damaged : or
- (b) by reason of any casualty happening to, or on board of, any inland steam-vessel, lost of life has ensued : or
- (c) any inland steam-vessel has caused loss or material damage to any other vessel

The master of the steam-vessel shall forthwith give notice of the wreck, abandonment, damage, casualty, or loss to the officer in charge of the nearest police-station

If a formal investigation into the facts of any case reported under section 32 appears to the President of the Union to be expedient, the President of the Union may-

- (a) appoint a special Court and direct the Court to make the investigation at such place as the President of the Union may fix in this behalf ; or
- (b) direct any principal Court of ordinary criminal jurisdiction or the Court of any District Magistrate to make the investigation.

A special Court appointed under clause (a) of sub-section (1) shall consist of not less than two nor more than four persons, of whom one shall be a Magistrate, one shall be a person conversant with maritime affairs and the other or others (if any) shall be conversant with either maritime or mercantile affairs or with the navigation of inland steam-vessels.

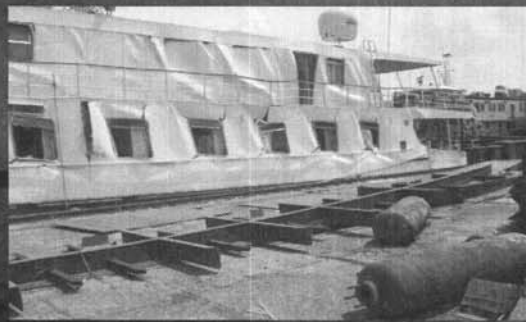
CASE STUDY OF

"M.V ROAD TO MANDALAY GROUNDING"

- Myanmar Registered inland vessel mv. Road to Mandalay, Off No. 8199, GT. 1916 was grounding due to hitting by Cyclone "Nargis" about 55hrs on 03.05.2008 within Myanmar (Yangon) river in psn: Lat. 16 49.51 N , Long. 096 06.9E while she waiting to enter the Sinmalaik Dockyard at mooring buoy. All crew ,19, Myanmar were saved alive.



M.V road to Mandalay portside alongside at Sinmalaik Dockyard after grounded by Cyclone "Nargis"



M.V road to Mandalay portside alongside at Sinmalaik Dockyard after grounded by Cyclone "Nargis"

Necessity of Maritime Causality Investigation in Myanmar

The necessity to be fulfilled for accident and incident causality investigation in Myanmar are as follow:-

- (i) Extend a new set up as a branch of Department of Marine Administration.
- (ii) Formulate the national legislation accordance with the implementation of Marine Casualties and Incident Code
- (iii) Provide facility for site investigation within Myanmar territorial water and Inland water
- (iv) Need more training for well trained personal

Our country always adopted formulated rule and regulations from IMO, and International Convention; and we are ready to perform co-operation with neighboring countries.



(10) ロシア

Investigation of Marine Casualties in the Russian Federation.

Proceeding from the assumption that Practice of investigation of Marine Casualty in every country is differ from practice in others, it is advisable to show particulars in the Russian Federation practice to the participants of the Meeting.

Marine Casualties in Russian ports are investigated according to Rules of investigation of Marine Casualty.

Marine Casualties are classified to:

1. Shipwreck;
2. Casualty;
3. Event with elements of casualty;
4. Operation incident.

Shipwreck means that involved ship is totally lost or the ship is damaged to such an extent that subsequent operation of it became impossible.

Casualty applies in cases of death of person connected with casualty and when a passenger ship loses even if one of nautical characteristic.

Event with elements of casualty - means that a cargo ship loses even if one of nautical characteristic. The classification society takes final decision in disputable cases.

Operation incident means insignificant damages when no one of nautical characteristic is lost.

Preliminary classification is carried out by Captain of the ship, final by the Harbour Master.

The objective of Marine Casualty investigation is to prevent such casualties in the future. Investigations identify the circumstances of the casualty under investigation and establish the causes and contributing factors, by gathering and analyzing information and drawing conclusions. It is not the purpose of such investigations to determine liability or apportion blame. All items violated (if any) should be indicated in Act of investigation.

Preliminary investigation of each Marine Casualty is carried out by the Captain of involved vessel. Captain is responsible to investigate Operation incident fully. The main purpose of Captain's investigation is to establish that risk admitted by him does not exceeded permissible limit. Risk is admitted warranted, that should be showed in the process of investigation, if:

- risk corresponds the aims;
- the aim could not be reached by ordinary not connected with risk actions;
- risk does not turn into deliberate damage;
- the life should be the object of risk

If Operation incident occurs in a port, full investigation is carried out by the Harbour Master.

If a Marine Casualty with Russian ship happens on the high seas, the Harbour Master of first port of call investigates the case.

Marine Casualty investigation is given the same priority as criminal or other investigations established to determine responsibility or blame.

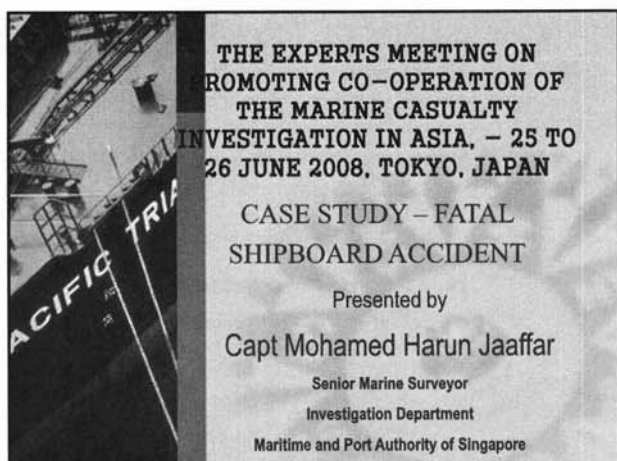
Marine Casualty investigation is a process held for the purpose of casualty prevention which includes the gathering and analysis of information, drawing of conclusions, including the identification of the circumstances and the determination of causes and contributing factors and, appropriate, the making of safety recommendations.

It is necessary to harmonize Rules of investigation of Marine Casualty in the Russian Federation to Code adopted in May 2008. Nowadays a new draft of Rules of investigation of Marine Casualty is being worked out.

In the Russian Federation the main person who investigates marine Casualty is the Harbour Master. He in some cases (if he considers indispensable) organizes special committee for Casualty investigation and heads it. After the case is investigated all materials are sent to the Ship-owner, procurator and to Rostransnadzor (Structure of Transport ministry of the Russian Federation, which controls and supervises in sphere transport). Rostransnadzor makes the final Decision. If Rostransnadzor does not agree with any part of investigation, Act is returned to the Harbour Master for the revision. If agree, forwards to ship- owners and IMO. In addition publish in booklet.

June 11 2008.

(11) シンガポール



The following is a joint investigation report with the United Kingdom Marine Accident Investigation Branch (MAIB) and the Maritime and Port Authority of Singapore (MPA). The MAIB has taken the lead role pursuant to the IMO Code for the Investigation of Marine Casualties and Incidents (Resolution A.849(20))



Vessel details
Type : Panamax crude oil tanker
Built : 2006 in Jingjiang, China
Construction : Double hull/steel
Length overall : 228.6m
Gross tonnage : 42,010
Deadweight : 74,065 tonnes
Service speed : 15.5 knots
Approximate sailing freeboard of 6.6m

Accident details
Time and date : 1220, 11 November 2006
Location: Latitude 58° 45.1'N Longitude 003° 11.01'W
off Scapa Flow
Persons on board : 24
Injuries/fatalities : Two fatalities and one serious injury
Damage : Minor damage to Suez light davit and to both windlass gear wheel guards


SYNOPSIS

On 11 November 2006, at 1220 hrs -
bound from Scapa Flow and
transiting the Pentland Firth, the 74,065
twt Singapore registered tanker,
Venture, shipped two large waves over
her bow. This resulted in the death of
two ABs and serious injuries to an OS,
all of whom were working on the
forward mooring deck. The waves also
caused minor damage to the ship.

Scapa Flow is a small inland sea within the Orkney Islands.

Oil terminal on island of Flotta, where crude oil is received from oil fields by pipeline, and loaded into tankers. Used for **ship-to-ship transfer**

Scapa Flow is entered through **Sound of Hoxa**, the narrowest part





Sequence of events

10 to 11 November, *FR8 Venture* carried out a ship-to-ship transfer with another tanker and loaded a full cargo of crude oil.

11 Nov – 0536 hrs - Loading operations were completed the daughter vessel cast off and left Scapa Flow.

1054hrs - *FR8 Venture* weighed anchor to depart.

- After weighing anchor, the bosun and AB1 secured the port anchor, and began stowing mooring lines down into the forward storeroom.

Sequence of events

AB2 and an OS were stowing loose mooring lines at the aft.

1136 hrs - Pilots disembarked near the entrance to Scapa Flow.

The wind was west to west-north-west and near gale force, with waves of about 4 to 5m high.

- The ship's freeboard was about 6.6m and spray was being shipped on board.
- The tidal stream was flowing generally in the same direction as the wind.

Sequence of events

1210 hrs, C/O told AB2 and the OS to go forward and help the bosun.

AB2 joined AB1 on the starboard winch platform to lash canvas covers around the mooring wires.

- The bosun instructed the OS to place a securing wire through the starboard anchor cable.

Sequence of events

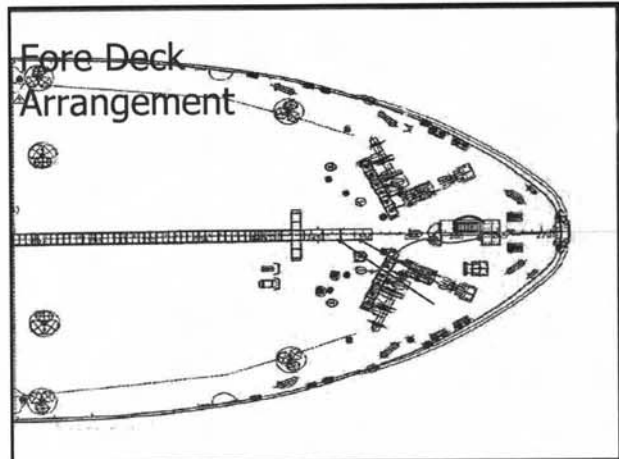
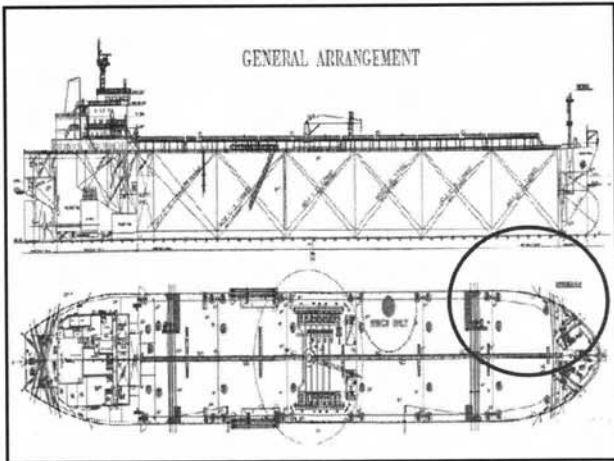
At about 1220 hrs, just as the OS turned towards the anchor cable, a large wave was shipped over the bow. The ship pitched into the following trough and then a second larger wave was shipped on board.

- The two ABs were swept aft, towards and under the flying bridge.

Sequence of events

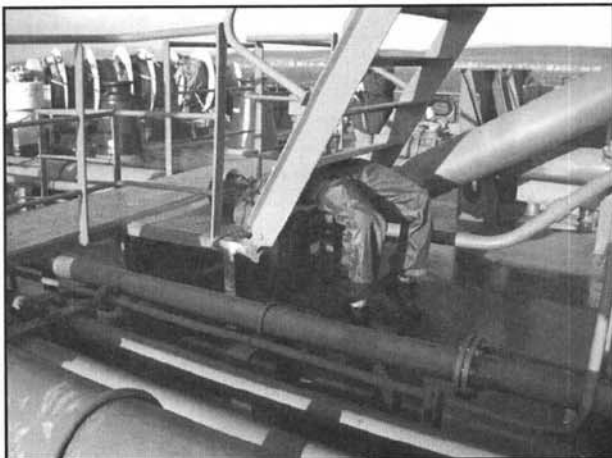
The OS was swept aft and came into contact with a protection plate for the forward liferaft.

The bosun had managed to cling onto the storeroom door when the first wave was shipped, and then onto the ladder rungs of the foremast as the second wave swept over the foredeck, he remained uninjured.



Sequence of events

- The bridge team saw the seas being shipped on deck.
- The third officer released a MOB marker from the bridge wing.
- The general alarm was sounded and the crew mustered at the emergency station.
- The OS managed to walk aft until he reached amidships, where he collapsed.
- All three injured were taken to the accommodation.





Events following the incident

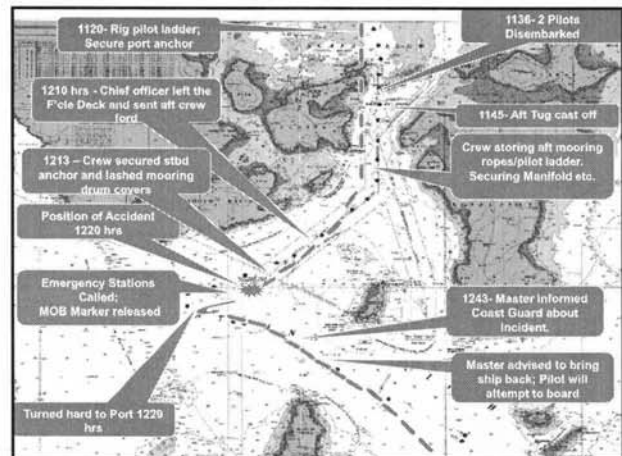
- *FR8 Venture* called Orkney Harbour Control to report the accident and requested for medical assistance.
- Orkney Harbour Control then informed Shetland Coastguard of the tanker's emergency.
- Shetland Coastguard arranged a radio telephone link between the ship's master and a doctor at Aberdeen Royal Infirmary.

Events following the incident

- The Longhope RNLI lifeboat took the local doctor out to meet the ship, but the rough seas prevented the doctor from boarding the ship from the lifeboat.
- However, the Stornoway Coastguard rescue helicopter was able to transfer her to *FR8 Venture*.
- Once onboard the vessel, the doctor determined that the two ABs had died of their injuries and the OS should be taken to hospital.

Events following the incident

- The helicopter returned to the ship, landed an Orkney Harbour pilot and lifted the doctor and the OS to Aberdeen Royal Infirmary.
- The ship returned to Scapa Flow and anchored there at about 1800.



PRE-CONSULTATION ACCIDENT REPORT

The close rapport was enhanced between MAIB and MPA in the course of this investigation. MPA gave inputs in the analysis to determine the contributory causes and circumstances of the accident as a basis for making recommendations to prevent similar accidents occurring in the future.

PRE-CONSULTATION ACTION REPORT

The analysis focuses on determining whether the shipping of such waves should have been expected and, if so, why the crew members were placed in an area of danger and what precautionary measures should have been taken.

Findings & Recommendations

- The two large waves that were shipped over the bows should have been expected in the prevailing weather conditions.
- The master should have delayed the sailing so that the ship could have been secured for sea in sheltered waters.
- Having decided to leave the shelter of Scapa Flow before the decks were secured, a risk assessment should be made and an effective plan of action considered.

Findings & Recommendations

- The plan could have concentrated the crew securing the forward area first, leaving the stowing of the aft ropes later.
- The plan should have prompted the need for precautionary measures, such as considering the option of turning the ship away from the weather, when safe and practicable to do so, to secure the anchor.

Action Taken FRB Shipmanagement

- The ship managers have reviewed and amended their company's SMS procedures for working on deck in heavy weather. This is to ensure that crew on deck are not exposed to the elements for the least possible time.

Maritime and Coastguard Agency

- The MCA has issued a Safety Alert, which gives a brief outline of the accident and draws attention to the contents of chapter 3 of the Admiralty Sailing Directions (NP52) North Coast of Scotland Pilot. This warns mariners of strong tides, with large waves that frequently occur in the area of Pentland Firth

Safety Alert

November 2006

Two Deckhands Killed in Pentland Firth

1. On 11 November 2006, a laden tanker of 74,000 tonnes deadweight was proceeding out of Scapa Flow into the Pentland Firth, heading for the United States East Coast after having completed a ship to ship cargo transfer.
2. The tanker was approximately 3-4 miles west of the island of Swona in the Pentland Firth and four crew members were on the forecastle head securing the anchors, when it was hit by a number of abnormal waves in succession.
3. Three of the crew were carried aft along the maindeck by the force of the first wave. Two men received injuries which proved fatal. The third is now recovering from spinal and head injuries in hospital.
4. The weather conditions forecast at the time of this incident were westerly gales of 40 to 50 knots and heavy seas. The tide was also flooding from the west.
5. Ship Masters and Deck Officers on vessels transiting the Pentland Firth should be aware of the information given in the Admiralty Sailing Directions North Coast of Scotland Pilot (NP 52) chapter 3, in particular section 3.110 which describes the Merry Men of Mey forming off St John's Point and extending the whole way across the firth to Tor Ness. "The most violent part... lies over a large sandwave field 3.5 miles west of Stroma. With a west sea or swell the entire race becomes very violent; large waves form suddenly and from varying directions, making them difficult to anticipate or counter."
6. Masters must take the above into serious consideration so as not to jeopardise the safety of their crew when transiting the Pentland Firth. Further advice may be sought from Aberdeen or Shetland Coastguard Rescue Centres if required.

Maritime and Coastguard Agency of the Department for Transport

- 
- **End of Presentation**
 - **Thank You for your attention.....**