

**De-Briefing after successful operation:**

**“C/O shall conduct a debriefing after every cargo operation **and** after any event (for example after completed R/U) for which he deems a debriefing to be appropriate**

**Even if there were no issues during the operation, there will still be things to consider.**

**For example:**

- 1. Officer or crew member have observed something that C/O did not notice.**
- 2. If given the opportunity, this team member may be instrumental in bringing about improvement**
- 3. The more junior team members should be given the first opportunity to share their views and asked if there is anything that can be improved upon**

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- 4. If given the opportunity, this team member may be instrumental in bringing about improvement upon**
- 5. Consider, Particularly, for challenging operation (R/U, R/D...) each team member writing down three (3) items that went well, and three (3) items that could be improved and then discussed**
- 6. Play CCTV playback option for easier memory**


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For our Team debriefing discussion,  
please write down at least:

**“ Three (3) Points for  
improvement required and  
HOW to improve ???**

**“ Three (3) BEST PRACTICE  
point (What went well) and  
WHY???**

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**Discussion:**

**“ Anything can be improved in  
our operation and  
communication and HOW?**

**“ Analyze what went well and  
Why you think is best  
practice?**

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## Were **RESOURCE MANAGEMENT PROCESS** followed ?

Step 1 - Definition



Step 2 - Allocation



Step 3 - Consolidation



Step 4 - Leveling

### Step 1 - Definition

Identify the critical resources that need to be planned and managed according to the objective.



### Step 2 - Allocation

Assign or schedule the use of resources to various shipboard activities.



### Step 3 - Consolidation

Interface all resources in the context of the entire shipboard operation.



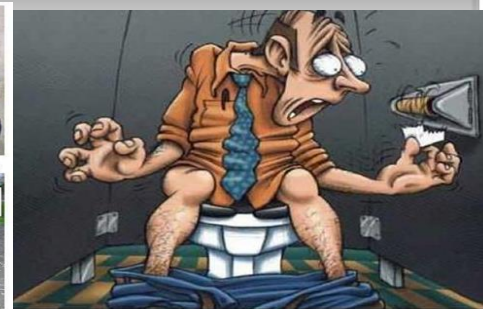
### Step 4 - Levelling

Ensure that available resources will be able to meet prevailing demands and resolve potential conflicts.

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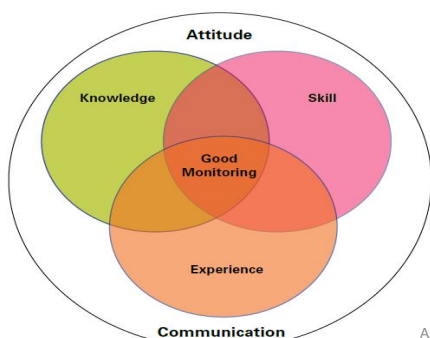


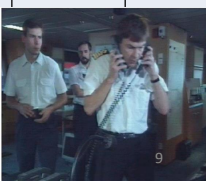
## Were principle of the **RESOURCE MANAGEMENT** shared between team members and understood ?

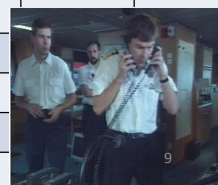


Maritime Management Lesson 8  
Never start a project unless all resources are available

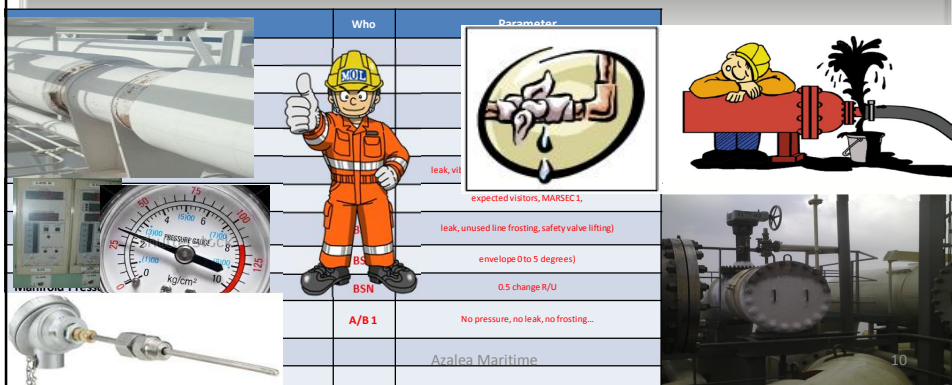




CCR Task	Responsible	Parameter
Monitoring CT levels		
Monitoring CT Pressure		
Monitoring x-over line liquid header pressure		
Reporting Manifold pressure		
IBS / IS pressure – Nitrogen Flow		
Gas Burning (Free flow and or L/D comp.		
LNG Vaporiser (if required)		
Maritime Ballasting operation		



**CREW MEMBERS were FULLY INTEGRATED into CCR team.**  
**Deployment of each crew member was clear ?**  
**Allocation of duties and responsibilities for each crew member?**

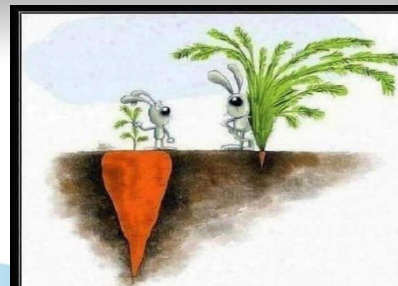


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The experience of the **NEW WATCHKEEPING OFFICERS** and **RATINGS** was **ASSESED?**

1. **SKILL** – how competent are they to do job?
2. **WILL** – how committed are to do job?



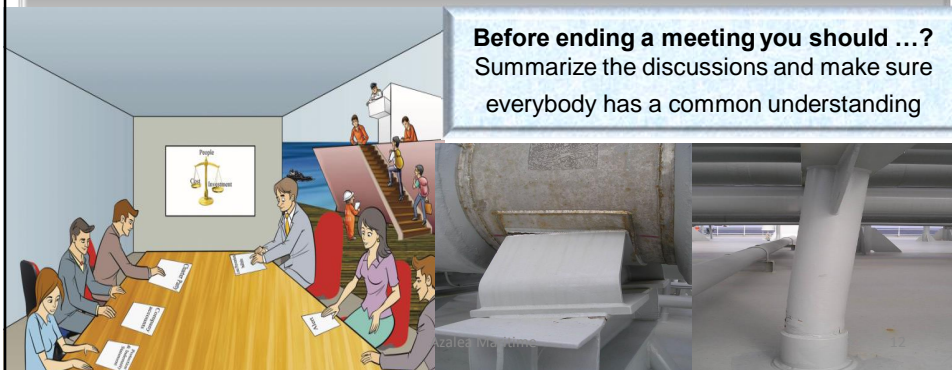
**SUCCESS**  
it's not always what you see

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**BRIEFING WITH ALL OFFICERS** has been held introducing standing orders and specific requirements for particular cargo operation?

Before ending a meeting you should ...?  
Summarize the discussions and make sure everybody has a common understanding



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Was **BRIEFING OPEN AND FRIENDLY**, interactive, responsibilities defined, close loop, positive feedback, operational limits discussed...?

**Briefing guidelines:**

- Make time
- Open & friendly
- Who should run?
- Interactive
- Define responsibilities
- Closed loop
- Keep on course
- Any more questions?

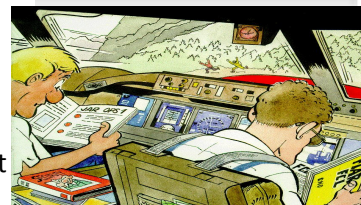


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Was the **CARGO PLAN** understood by all members of CCR team?

- "1. LNG Carrier - Load Plan - Part 1
- "1. LNG Carrier - Load Plan - Part 2
- "1. LNG Terminal Pre Arrival Questionnaire Ship Shore safety Checklist
- "1. Load Terminal Info Cargo Handling Agreement
- "1. Load Ex. 1 - G-Sim Checklist Ves. Final
- "1. Ship-shore safety checklist LNG
- "1. Chief Officer Port Report 01012019



No-one had a clue they had completely different understandings of the same event...



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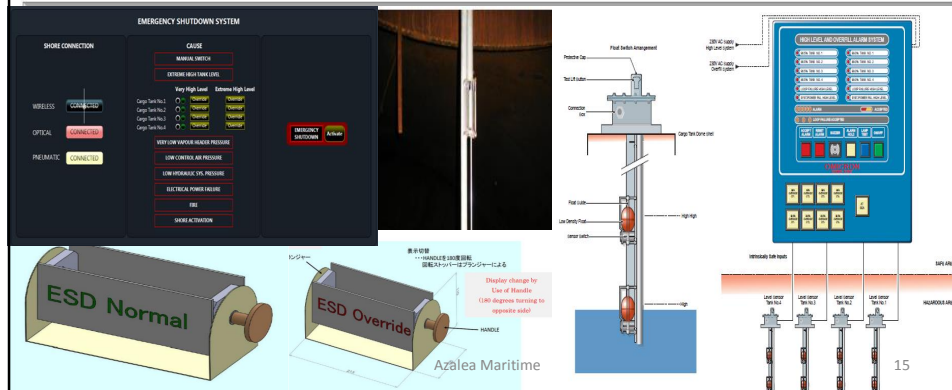
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## Was the **MASTER WITNESSED** the unblocking / blocking TPS and ESD Level Alarms (override or sea mode)?



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## Did the Officers act as an effective **TEAM PLAYER?** (team members cooperate mutually, same goal, same vision)

- Not WHO is right / WHAT is RIGHT
- Support each other
- Share Mental Model Concept evidenced
- Was ONE MAN SHOW avoided
- Was C/O active listener?
- Was C/O respecting other People ideas?
- Share the workload;

Problems arise when the goals of people in the same organisation start to diverge.

### Teamwork & Support

Giving or accepting aid when it is required.

Goals, communication, resources, delegating, offering, accepting.

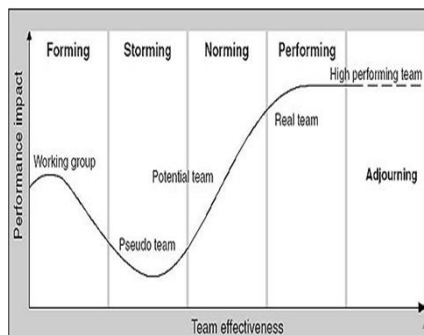
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At what stage of **TEAM BUILDING** you found CCR Team during exercise?  
(**FORMING, STORMING, NORMING, PERFORMING**)



### Teamwork

*How Well Do You REALLY  
Work Together?*

- \*Ensure shared mental model
- \*Beware "group think"
- \*Encourage challenge
- \*You can be in more than one team at a time

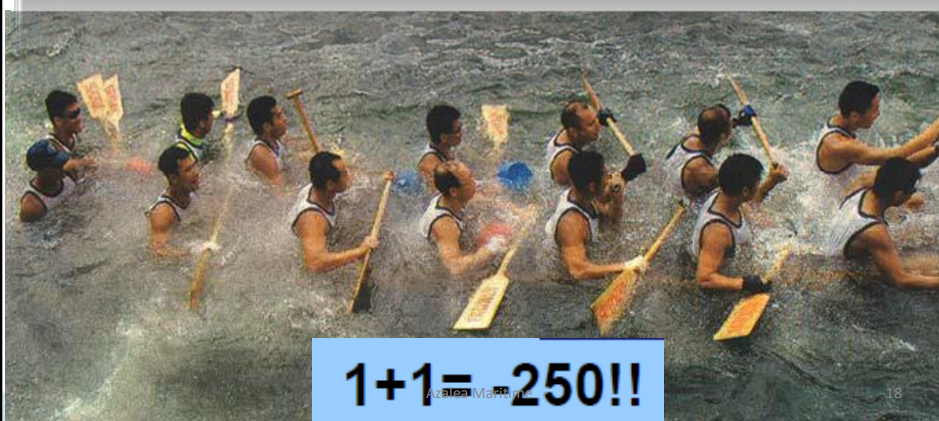
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**TEAM = ONE UNIT**



Was **SINERGY** present and visible  
within CCR Team?



**1+1= 250!!**

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Choose from the list below one of **TEN EFFECTIVE TEAM CHARACTERISTICS** you experience during exercises?

#### Ten Characteristics of an Effective Team

A Clear Purpose: The team has a clear purpose or mission that is accepted by all members.

Relaxed Interaction: The team is relaxed and informal, with no obvious tensions among members.

Participation: There is a lot of discussion between members and everyone participates in decisions and/or activities.

Listening: Each team member actively listens to one another.

Disagreement: Team members are comfortable enough to disagree with one another if the situation calls for it.

Openness: There is full and open communication with no hidden agendas.

Clear Expectations: There are clear expectations about the role of each of the team, and work assignments are fairly distributed among team members.

Shared Leadership: Although there may be a formal team leader, each team member may share leadership responsibilities from time to time as the situation arises.

Relations with Others: The team maintains credibility and good relations with others who may be outside the formal team but who can still affect its functioning.

Team Maintenance: Team members not only focus on their primary goal but spend time recognizing and maintaining the functions of the team itself.

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**ARE THE OFFICERS AWARE of the operator's policy statements, guidance and procedures, including information on maximum loading rates and instructions with regard to safe cargo operations?**



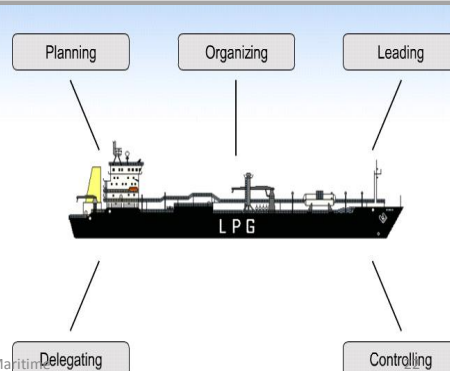
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*"Everybody is a genius. But if you judge a fish by its ability to climb a tree, it will live its whole life believing that it is stupid."* - Albert Einstein



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CCR team members (OOW) had a good understanding and demonstrate **CONFIDENCE IN THEIR OWN EXECUTION?**



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The **OOW IS FULLY AWARE** of when to **CALL C/O** as per standing Orders

" OOW in CON



" Running a modern ship is **NO LONGER** about mere following of orders from superiors officers

" *Subordinates must be capable of working independently*

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Were there **POSITIVE ATTITUDES** towards exercises?  
Was C/O able to control / maintain positive attitude?

#### Coincident or Not ?

If,  
A B C D E F G H I J K L M N O P Q R S T U V W X Y Z  
Equals,  
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26

Then,

$$K + N + O + W + L + E + D + G + E = 96\%$$

$$H + A + R + D + W + O + R + K = 98\%$$

Both are important, but the total falls just short of 100%

But,

$$A + T + T + I + T + U + D + E = 100\%$$

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Was the importance of having an **EFFECTIVE COMMUNICATION** among CCR Team members understood and maintained satisfactory?  
Was barriers eliminated?



#### BARRIERS TO EFFECTIVE COMMUNICATION

MESSAGE



~~UNDERSTANDING~~

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## Was **CLOSED LOOP COMMUNICATION** evident? (Valve name and number used and repeated back)

The Closed Loop

Sender Receiver

Send & confirm Acknowledges

Half of my problems  
are because of the  
**tone of my voice.**  
Everyone thinks  
I'm **arguing**  
when I'm actually  
talking.

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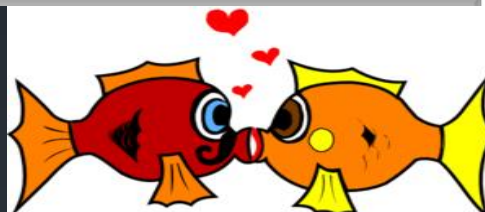
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## **INSTRUCTION / ORDERS** given were **DIRECT / ADEQUATE / CLEAR / SHORT** **/ PRECISE?**

### Communication

- The ability to get people to do what you intend them to do,
- and do so clearly and efficiently,
- and to make sure you hear, and understand, what people are saying to you.
- Changing what one knows, feels, does & thinks.



### **K I S S Principle**

Keep it **SHORT** and **SIMPLE**

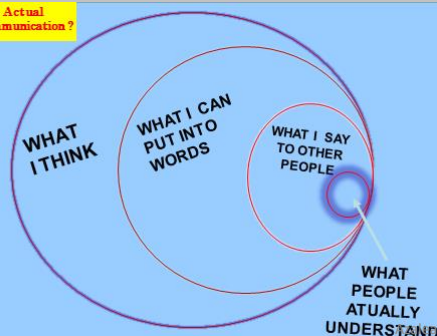
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Was there any breakdown in **COMMUNICATION** resolved without consequences?

Actual Communication?



Preventing communication failures requires action at all organisational levels.

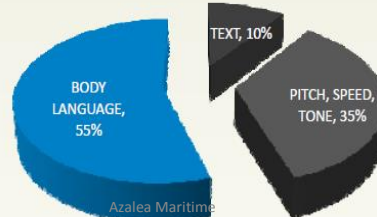
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Was radio communication kept to **ESSENTIAL AND IMPORTANT** only during critical operations?



Communication

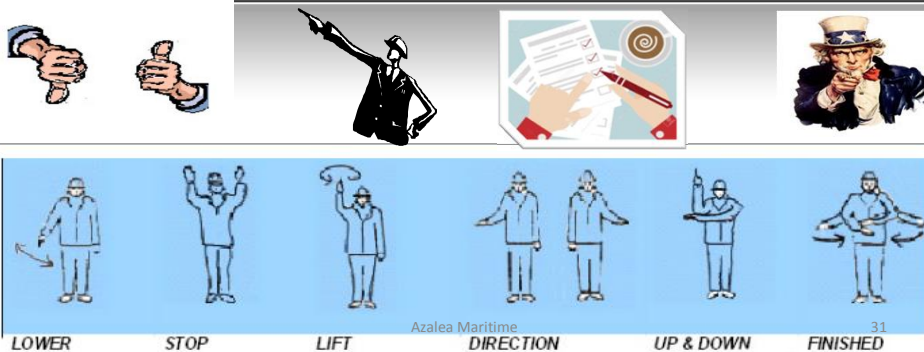


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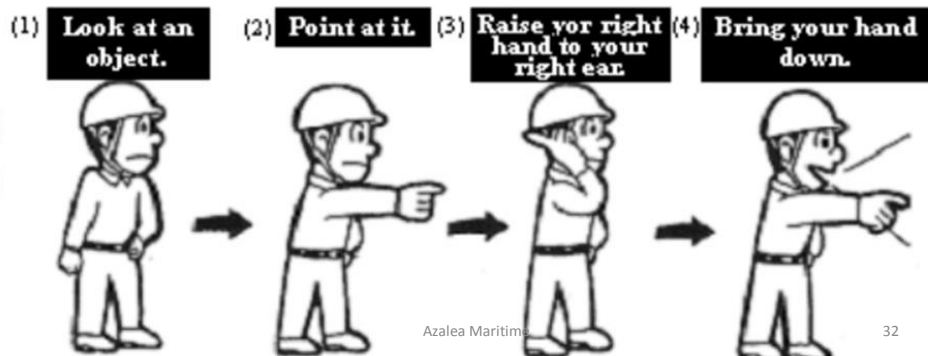
Was  
 " **SIGN LANGUAGE,**  
 " **STANDARD VOCABULARY,**  
 " **WRITTEN ORDERS**  
 used to avoid misunderstand?



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Does trainee carry out the  
**FINGER POINTING and CALLING?**





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## Was **SHIP/ShORE COMMUNICATION** procedures agreed and was operation completed without misunderstanding?

- Radio Communication Test before start critical operation
- Before operating ESD valve / Double shut valve / cool down valve
- Before opening ESD valve / confirm OPTIC position
- After TRIP test – confirm Shore ESD is RESET before change to OPTIC
- Before Starting Ballasting
- Each Cargo Pump START / STOP
- Each Cargo Tank commence discharging
- Before Rate Up / Rate Down / FULL RATE TIME
- Permission for water drain from deck
- Adjusting Deck Lines
- Adjustment of shore gangway required
- Permission to take stores / provision / critical repair work (start / completed )
- If changing to original plan (pump start/ h/d start...)
- Hourly Report
  - Cargo on board, Loading / discharging rate, Commence Ramp down,
  - Completion of Operation
- Wind Direction, Wind Velocity



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## Are the **INSTRUCTIONS & ORDERS** within / from **SUPERIOR** adequate and direct?



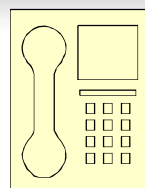
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Does the **C/O INFORM HIS INTENTION** to the OOW in advance when the C/O takes action such as valve, pump, compressor adjustment, start, stop...?



**Success** does not consist in never making mistakes but in never making the same one a second time. ~ George Bernard Shaw



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Were officers aware under what circumstances **TO CALL SUPERIOR?**

## Standard Operating Procedures

It is the glue that holds a team together.

However, also understanding that following SOP's will be right 99,9% of the time, but when it does not, then think outside the box.

RESILIENCE



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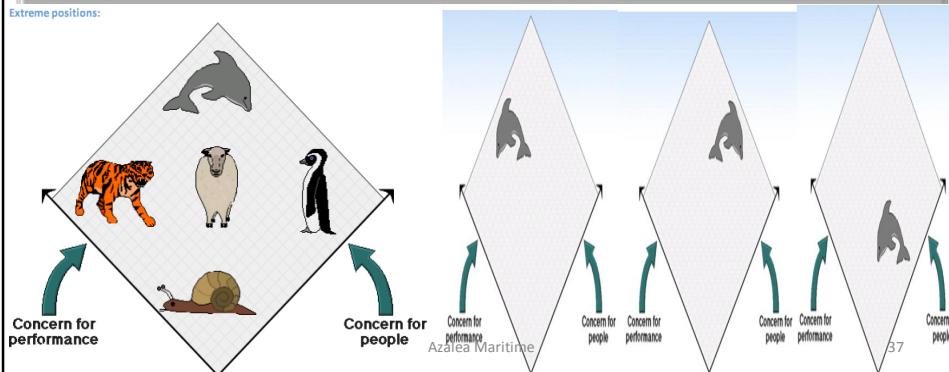
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**MANAGEMENT STYLE** used?  
**What style was mostly present?**  
**(Tiger, Penguin, Snail, Sheep, and Dolphin)**

Extreme positions:



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**Was Team LEADERSHIP** effective?  
**Was leadership by example present?**  
**Were people happy to participate in cargo operation?**



Working with individuals  
 and in teams requires  
 different sets of skills.



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## What **LEADERSHIP STYLE** was used? (Autocratic, Authoritarian, Laid Back, Democratic...)

Autocratic



Authoritarian



Laid Back



Democratic



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## What **LEADER RESPONSIBILITY** you have experienced during exercise?

### Responsibilities of leaders

1. Supervise and coordinate crew activity.
2. Delegate tasks to appropriate crew members.
3. Define crew responsibilities and expectations.
4. Focus attention on critical aspects of the situation.
5. Adapt to internal and external environment changes.
6. Keep crew informed of work-relevant information.
7. Ask crew for work-relevant information and respond accordingly.
8. Provide feedback to crew on performance.
9. Create and maintain a professional atmosphere.
10. Promote teamwork.
11. Effectively manage workload issues/stress.
12. Train and mentor subordinates to be proficient at their tasks.

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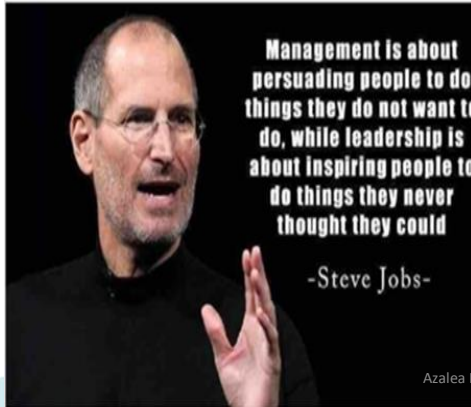


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## Did you experience during exercises **DIFFERENT** between **MANAGER** AND **LEADERSHIP**?

Ideal Manager		
Experience	Learn from mistakes	Self-assess
Knowledge	Fair	Approachable
Use people's abilities	Teacher	Understanding
Open minded	Listener	Decision making
Motivator	Manage conflict	Encouraging
Patient	Leadership	Tolerance
Attitude	Self-motivation	41



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## Has officers the **ABILITY TO ORGANIZE AND MANAGE** his subordinates for the tasks?

Grade

- 5 : He displays excellent leadership qualities and enjoys good relationships, and mutual trust with his subordinates. Excellent team organizer.
- 4 : He displays good leadership qualities and organizes his team well though various meetings.
- 3 : He organizes his subordinates without problems.
- 2 : He has poor leadership qualities and cannot organize his subordinates effectively.
- 1 : No leadership ability. Subordinates complain about his inability to organize and administer.

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## Was **CCR** treated as **RESTRICTED AREA**?

(crew aware that all visitors must report in ship's Office...)

**Cargo Control Room**  
**Authorised personnel only**

LNGC

**LIST OF EXPECTED VISITORS**

PORT: LNG Marine Terminal      DATE: 01.01.2019

#	NAME	RANK/TITLE	Remarks
1	Mr. Saaaaa Szzzzzz	Cargo Surveyor	Ship's office (C-O)
2	Mr. Dssaaa FHH	Cargo receiver	Ship's office (C-O)
3	Mr. Ankksh Coooc	Cargo receiver	Ship's office (C-O)
4	Mr. Yssant Mshh	Terminal representative	Ship's office (C-O)
5	Mr. Mssmm Bssm	Vetting Inspector	Ship's office (Captain)
6	Mr. Pssppp	Gyro technician	Ship's office (C-E)
7	Mr. Zzzzzzz	Spare Parts representative	Ship's office (C-E)
8	Mr. Llllll	Vessel superintendent	Ship's office (Captain)
9	3 x On-supers	Observers	Ship's office (C-O)
10			



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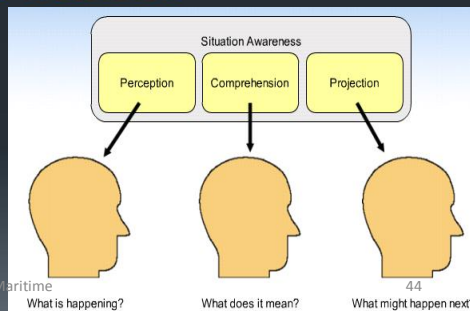


**TEAM SITUATION AWARENESS** has been maintained at all times?  
(were you able to recognized and recover form loose of Team SA)

## Situational Awareness

Knowing what is going on around you, the past, present and future, that can affect the outcome of your intention.

Assessment, consequences, relevance, negotiability, prioritising, briefings (initial and mini briefs), shared mental models



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Did you find any team member with **LACK OF SITUATIONAL AWARENESS** due to  
*“Inability to answer simply job oriented questions” (i.e. what is rate, what is pressure..) or being “limited by Standard procedures” (notice manifold pressure dropped down but not checking actual rate due still time to full hour and rate check)*



### Situational Awareness *Do You REALLY Know What's Happening?*

- \*The Big Picture AND fine detail
- \*Constantly update your awareness
- \*Actively seek input from others
- \*Never assume another's intentions
- \*WHIM – ask: “What Have I Missed?”



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### Were **PHYSICAL & MENTAL DISTRACTIONS** present?

Sensor failure, indications, valve failure, level gauge stuck, security/stores, new crew, Fatigue, Terminal calls...)

## Distractions

The ability to pause, deal with the “distraction”, rewind and play again.

Distraction vs Attraction, attention, task switching, re-assessing, acceptance, balancing, situational awareness,



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### **NON – OPERATIONAL DISTRACTIONS kept away?**

Unauthorized Personnel in CCR, Newspapers, magazine, Mobile Phones, Off duty crew chatting, VISITORS Distractions, Vetting Inspectors, PSC, Flag State, Agents, Provisions, Spare Parts, Shore Technician, Crew Change



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**Was the CCR Team handling DISTRACTION in proper manner?**

**Was distractions kept away from the team?**

**Was Master stand by ready to assist during critical operation (ramp/up; ramp/down)?**

### **Distractions Multi-Tasking OR Dangerously Distracted?**

- \* It happens very easily
- \* Personal as well as job distractions
- \* Use checklists and “Red Zone” techniques
- \* If distracted – go back 2 steps
- \* Be assertive – insist on calling back when convenient

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## Was **COMMERSIAL AND SELF PRESSURE** present in CCR?



**Pressure**  
*Just Busy*



***OR Dangerously Overloaded?***

- \* Good pressure can improve performance
- \* Too much leads to stress – always bad
- \* Don't let pressure lead to taking short cuts
- \* Ensure adequate resources – people, time, tools

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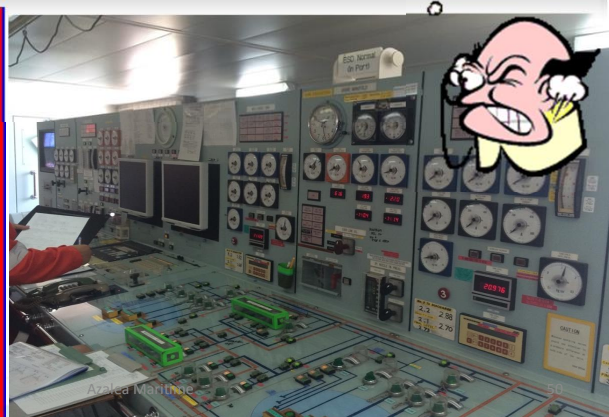


## Was **UNCERTAINTY or CONFUSION** apparent, how they overcome situation?

 **Stop Work Authority**  
Stop any work or behavior you deem unsafe to yourself or your coworkers.



You will **never** be penalized for stopping unsafe work or speaking up about hazards and injuries.



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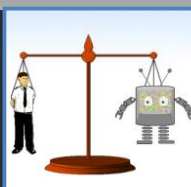
## AUTOMATION DISTRACTIONS (Simulator)?

### Automation

Delegating monitoring tasks to the “machine” which humans are not very good at monitoring themselves.

Awareness, delegating, understanding, knowledge, prediction, expectation, intervention, anticipating,

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“Automation creates new human weaknesses ... and amplifies existing ones”  
Lüchhoff & Dekker (2002)<sup>1</sup>

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**Was AUTOMATION part of Team?**  
**Was evidence shown on overreliance on automation?**  
**Were team members aware of next step of automation and understand outcome from?**

“ How you felt towards AUTOMATION?

- » As **SUPERIOR** – you know better than automation
- » As **INFERIOR** – you over trust in automation, overconfidence in automation

“ Was AUTOMATION process double / cross checked by OOW?

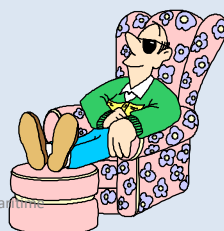
“ Was AUTOMATION process challenged regularly, to confirm expected and real situation are matching?

“ Was AUTOMATION part of CCR Team?

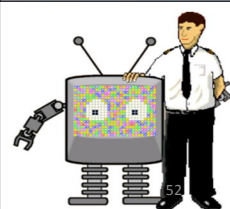
“ Was AUTOMATION affecting your workload?

- » **RELAX** to **PANIC (overload) MODE**
- » There is **NO DIPLOMATIC** with AUTOMATION

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**IF YOU UNDERSTAND  
AUTOMATION =  
THERE IS NO BLOCKS /  
BARRIARTOR AND  
OPEARTOR AND  
MACHINE**



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**Did the candidate regularly check for understanding and resolve **AMBIGUITY**?**

**Disagreement**  
between two or  
more sources of  
information  
**Team members do**  
**not agree**



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**Was **ALERTNESS** present at all times?**

**Alerting**  
***Do You REALLY Speak Up***  
***When You Should?***

- \*Vital skill – use it effectively – encourage it
- \*Be positive and constructive – propose solutions
- \*Some may find it difficult to do
- \*It's not a threat – it's good teamwork
- \*Be assertive – it can save lives!

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Were all CCR Team members having **SAME INTERPRETATION FOR SITUATION** which CCR team faced during cargo operation?

## Judgement

- The ability to assess a situation and predict the mostly likely outcome or result.



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Were all team members aware of an **UNPLANNED DEVIATION?**  
(Loading arms not being used as planned, reduced rate, shore operational problems...)

## Risk Management

Evaluating the probability of something going wrong and determining the consequences, if it does go wrong.

Assessment, evaluation, prediction, estimating, severity, consequence, probability



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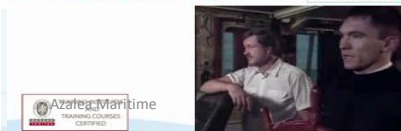
How Team was dealing with various **TROUBLES** occurring ?  
Was the Team Members **ACTIVE** during TROUBLESHOOTING?



Learning from real life  
See Captain good examples



Master is motivating to  
control the emergency



Junior officer has  
grown in confidence

Azalea Maritime  
training courses  
centered

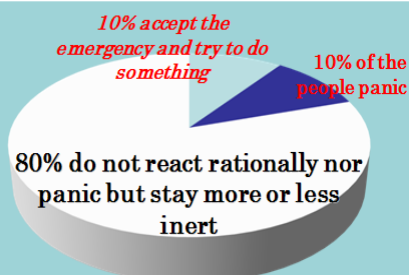
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Did the **CCR LEADER** demonstrated **SELF\_CONFIDENCE** in leading his team during **TROUBLES** occurring in cargo operation?

### Leadership in Emergency



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Was the intentional line up by C/O and G/E **DOUBLE CHECKED** by Team members and same recorded in the Log?

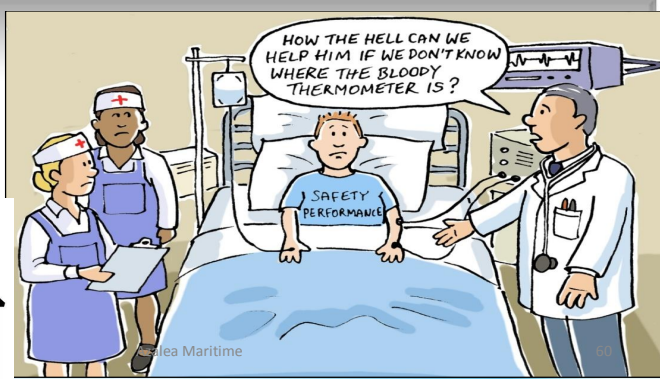
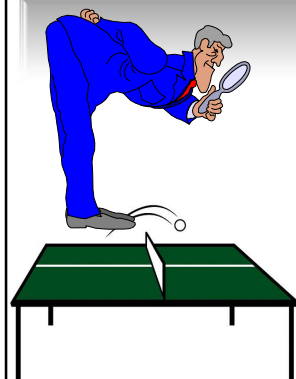


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Was **DOUBLE CHECKING** being carried out for operations, ramp up, ramp down, topping off etc.?

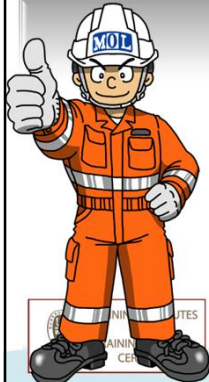


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When valves altered or pumps started /stopped was the **DESIRED EFFECT BEING CHECKED and CONFIRMED?**  
(Filling valve open/shut; pump started stopped...)



*There are no quick fixes, only years and years of patient and very hard work on the part of everybody in an organisation!*

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Was there used **TRUST** but Verify method?



A good rule is to **TRUST BUT VERIFY.**  
Insist that other team members do the same for your actions and decisions

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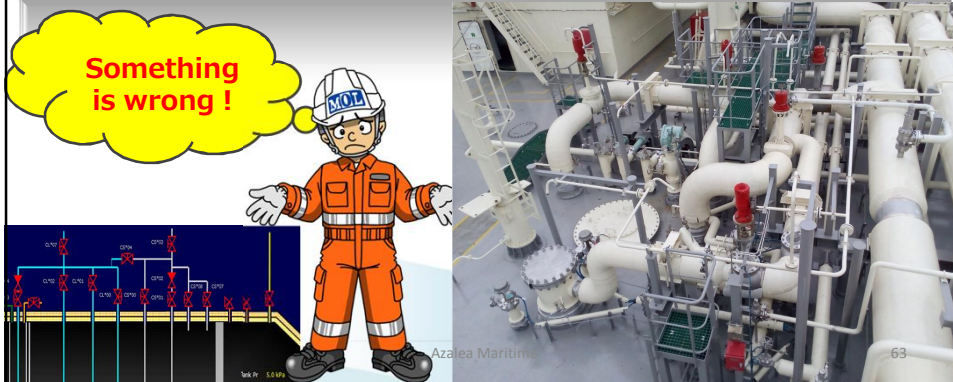
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**DURING RAMP UP DISCHARGE PORT**  
is the G/E (experience officer) stand-  
by on the liquid domes?

Something  
is wrong !



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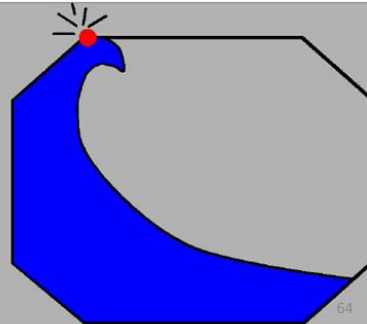


Was **SAFE PARAMETERS LIMITS** being  
monitored throughout operation and same  
**REPORTED** to the Superior when coming  
close to pre-defined limits agreed?

(CT pressure, manifold pressure, sloshing limits, liquid and vapour  
transfer rate, Liquid temperature, Vessel draft, trim, list, wind,  
vapour arm angle, mooring line tension, compressor parameters... )

Date		Safe Criteria (Min / Max)
Time		
Pressure Manifold (kPa)	No.1	max. 500
	No.2	max. 500
	No.3	max. 500
	No.4	max. 500
Pressure Vapor Manifold (kPa)		53kPa = Alarm; 99 kPa = ESD-1 Max flow 50,000 m3/hr
Vapor Arm Angle		3 degree = Alarm; 5 degree = ESD-1; 7 degree = ESD-2
Vapor Return from Ship (Nm3/hrs)		3 degree = Alarm; 5 degree = ESD-1; 7 degree = ESD-2
Vapor Flow to GCU or DFDE		Min Flow 500 m3/hr Max Flow 5000 m3/hr Min Temp + 20 Max Temp + 50

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## Was procedure adequate when dealing with **ALARMS (BUZZER AND FLICKER STOP PROCEDURE)**

Any alarm overridden was approved by SUPEROR?  
Was new alarm shared with Team and action taken?

### Procedures



Future IMO Standards – General part:

Alerts are classified into the following “priorities”:

#### Emergency alarm

- Immediate danger to life or ship.
- Audible signal until acknowledged.
- Example: fire alarm.



#### Alarm

- Immediate attention needed to avoid hazard and maintain safe state of the ship.
- Audible signal until acknowledged.
- Example: collision/ ARPA alarm.

#### Warning

- Not immediately hazardous, but may become so.
- Single audible signal
- Example: equipment failure.



#### Caution

- Informative. Condition or situation that the officer should be aware of.
- No audible signal
- Example: Sailing on un-official charts (Non-ENC's) in ECDIS

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## Was Deck Team encouraged in **PROACTIVE REPORTING**

(local gauge readings, liquid and spray line safety valves lifting, unexpected area frosting, vapour or liquid leaks...)



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Was **MOORING LINES** monitored  
**REGULARLY**, properly adjusted?

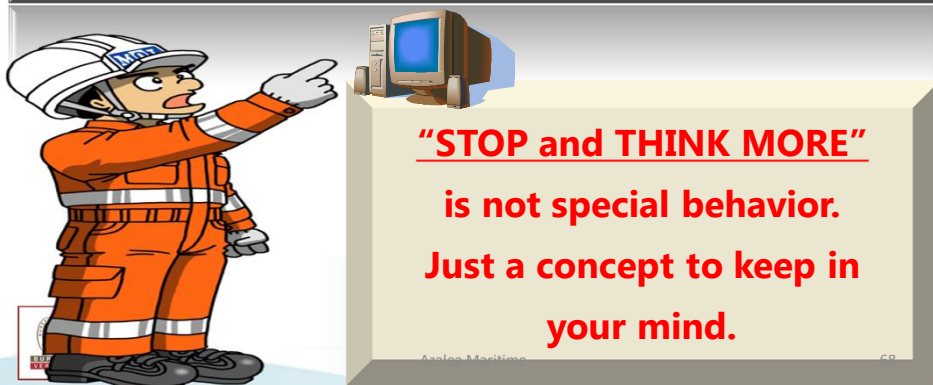
*Was crew aware of High and Low Water  
timings, wind criteria, squall warnings,  
lightings signs...*



62



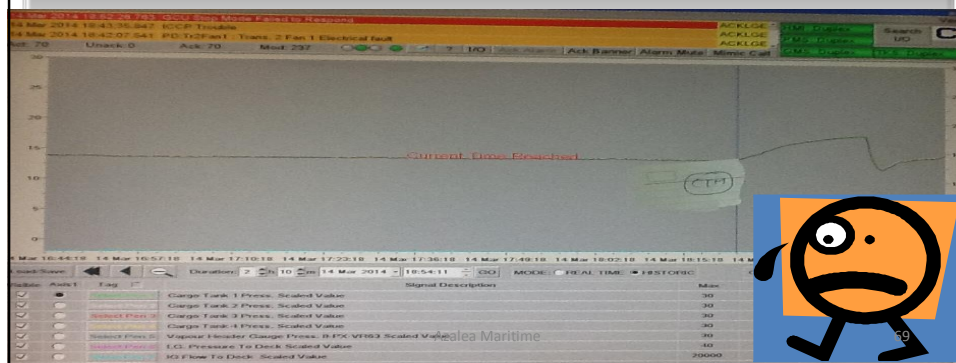
Was appropriate operating and  
**MONITORING SCREENS** been utilized  
as per plan?



63



Was **TREND SCREEN** has been fully utilized?



64



Does the **SUPERIOR** inform their **INTENTIONS** to other Team members in advance of any operation or adjustment (starting pumps, opening valves...)?



I DO

Competence

I WILL

Motivation

I CAN

Ability

I KNOW

Knowledge



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**Do all team members monitor their activity including **HUMAN ERROR** check for each other, irrespective of who has the con?**

**Best People  
make the worst  
mistakes**

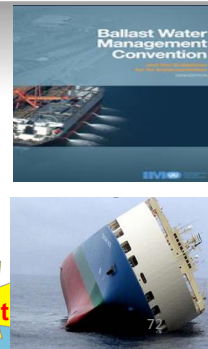
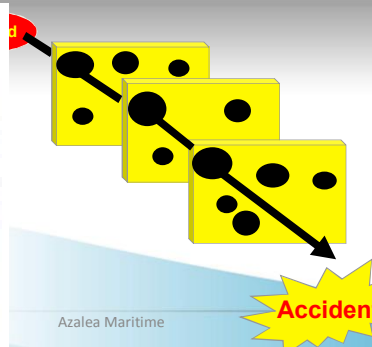


66



**DURING EACH PHASE OF OPERATION,  
I know what the C/O and/or G/E and/or  
other officer intends to  
do regarding the cargo / vapour / ballast  
handling?**

It takes 10 years to  
become an expert – and  
there are no short-cuts.





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## Was **ASSERTIVNESS** evident within Team as appropriate?

(junior officers assertive / honest/confident to say opinion, able to switch between leader to ratings and between CCR team member )

### Assertiveness

Being honest (truth & facts), about what is relevant and not negotiable.

Assessing, asking, suggesting, insisting, intervening, convincing.



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## Was **ASSERTIVNESS** understood by Senior officer in positive manner and applied as required (any example during operation?)



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**Has the OOW CHALLENGED Superior regarding any of his concerns as: tank level, tank pressure, manifold pressure planned action... without hesitation?**

*"The principles underlying BRM can be applied to any control room environment the objective being to ensure that the actions of no one man alone can precipitate disaster"*

#### Challenge & Response Blocks

- quiet
- lack confidence
- not be assertive
- high Power Distance
- not understand the system
- not accept responsibilities
- interpersonal conflicts
- bad experiences

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**Does the OOW await the RESPONSE on CHALLENGE from C/O about his suggestion? (ACCEPT or DENY based on facts)**

#### CONCEPT

Acknowledge

Order

#### CHALLENGE

Verification and Confirmation

#### RESPONSE / ACCEPT

#### Captain to OOW:

"Visibility is getting worse,  
We will change course at the 4<sup>th</sup> buoy"

#### OOW to Captain

"OK, at the 4<sup>th</sup> buoy"

#### Captain give order:

"027"

#### OOW to Captain

"But, we are still one more buoy to go?"

#### Captain is verifying and looking for confirmation:

"You are right"

#### Captain is ACCEPTING

#### Challenge:

"Port 20"



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**71** **WHAT IF ???** **AZALEA MARITIME**

**Did **SELF CHALLENGE** was present (**WHAT IF** pump not start, stop, valve not close, shore not respond...)**


Prepared	←	Unprepared
Anticipated	←	Unanticipated
Slow reaction	←	Fast reaction

**EXPECT THE UNEXPECTED!**

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**Were the **SUPERIOR** created an atmosphere that the Team members can effectively **REPORT ANY DOUBT?****



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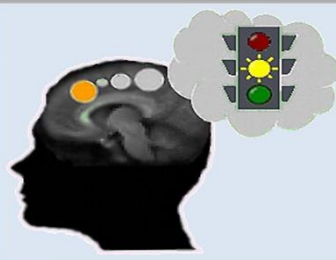
73



Was **ASSUMPTIONS** present in CCR?

When you ASSUME

You make an [ASS] out of [U] and [ME]



Question yourself, monitor yourself, be  
aware of your own situation  
**Do Not Assume. CHECK !**

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Was **SHORTCUTS** used by any CCR  
and were all team members aware of  
same?

hab·it (noun)

1. A recurrent, often unconscious  
pattern of behavior that is acquired  
through frequent repetition.



**LOCAL PRACTICES**





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## Were **SHORTCUTS** turn into ROUTINE?



### Local Practices *Efficiency* *OR Dangerous Shortcut?*



- \*Don't cut corners
- \*Follow procedures – they are there for a reason!
- \*Beware local norms becoming the "new standard"
- \*Poor or inadequate procedures? – report them
- \*Efficient or not thorough enough?

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## Was enough information available for effective **DECISION MAKING** process? Was decision making effective?

### Steps for Making Decisions



1. Stop, Relax and Think!
2. Define the problem. Try saying it in one sentence. (Remember to include your role.)
3. Think of a list of ideas. Don't worry about which will work and which won't just come up with a long list.
4. Narrow down the list. Ask yourself which ideas make sense.
5. Think of the positive and negative parts of each idea. Try to think of each part and how it might work.
6. Choose the best idea. Ask yourself which idea makes the most sense and feels the most comfortable to you.
7. Make a plan and try it! Think the plan through. Ask yourself who can help me with this problem? What do I need to do? Where do I begin? When will I work on this problem?

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## What type of **DECISION MAKING** was experience within team

- (1. Closed Autocratic) (2. Open Autocratic;  
(3. Individual Consultation)  
(4. Group Consultation) (5. Collaborative)

Open  
autocratic

You ask other people for information or opinion without telling your intention.

Group  
consultation

You tell your intention to the group and solicit information or suggestion from them.

Individual  
consultation

You tell your intention and ask the individuals involved for certain information or opinion.

Collaborative

You follow the decision of the majority.

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## Were all resources being used in CCR and reassessed in light of **PRIORITY**?

1. How important is the task?  
2. How urgent is the task



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Was there any sigh of **HAZARDOUS THOUGHTS ?**

It won't happen to me!

Do not tell me what to do !!!

We've always done it that way

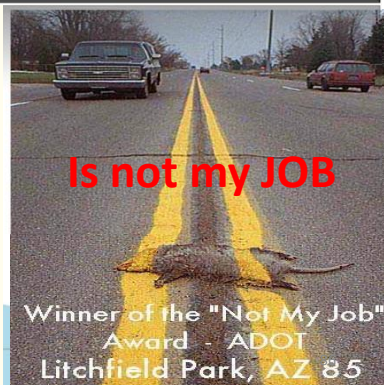
It's not my job.

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Was there any sigh of **CARELESSNESS ?**

*Overconfidence & Carelessness*



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Was there any sing of  
**OVERCONFIDENCE or COMPLACENCY**)

### CAN YOU READ THIS?

7H15 M3554G3 53RV35 70 PROV3  
HOW OUR M1ND C4N DO AM4Z1NG  
7H1NG5! 1N 7H3 B3G1NN1NG!  
17 W45 H4RD BU7 YOUR M1ND  
15 R34D1NG 17 4U70M471C4LLY  
W17H0U7 3V3N 7H1NK1NG 4B0U7 17,  
B3 PROUD! ONLY C3R714N P30PL3  
C4N R34D 7H15.

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Was CCR Team able to deal with  
**OVERCONFIDENCE** issues?

### Complacency

*Is Everything REALLY OK?*

- \*Never assume all is OK
- \*Follow procedures – they work!
- \*Use checklists
- \*Seek input from others
- \*Early action avoids later difficulties
- \*Check your situation - **CONSTANTLY**

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## Was Specific **Operational CHECK LIST** been used?

What method was used (read > do, do> read)?

There is more than one way to approach use of a checklist

**1. READ - DO - RESPONSE** ("cookbook")

**2. DO - CONFIRM - RESPONSE**

**3. Combined**

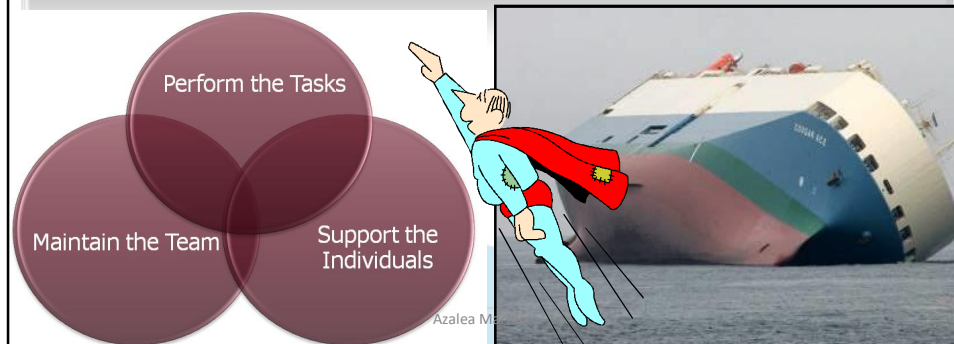
MOI	MOI	MOI
1. Check engine oil level (if required)	1. Check engine oil level (if required)	1. Check engine oil level (if required)
2. Check engine oil level (if required)	2. Check engine oil level (if required)	2. Check engine oil level (if required)
3. Check engine oil level (if required)	3. Check engine oil level (if required)	3. Check engine oil level (if required)
4. Check engine oil level (if required)	4. Check engine oil level (if required)	4. Check engine oil level (if required)
5. Check engine oil level (if required)	5. Check engine oil level (if required)	5. Check engine oil level (if required)
6. Check engine oil level (if required)	6. Check engine oil level (if required)	6. Check engine oil level (if required)
7. Check engine oil level (if required)	7. Check engine oil level (if required)	7. Check engine oil level (if required)
8. Check engine oil level (if required)	8. Check engine oil level (if required)	8. Check engine oil level (if required)
9. Check engine oil level (if required)	9. Check engine oil level (if required)	9. Check engine oil level (if required)
10. Check engine oil level (if required)	10. Check engine oil level (if required)	10. Check engine oil level (if required)
11. Check engine oil level (if required)	11. Check engine oil level (if required)	11. Check engine oil level (if required)
12. Check engine oil level (if required)	12. Check engine oil level (if required)	12. Check engine oil level (if required)
13. Check engine oil level (if required)	13. Check engine oil level (if required)	13. Check engine oil level (if required)
14. Check engine oil level (if required)	14. Check engine oil level (if required)	14. Check engine oil level (if required)
15. Check engine oil level (if required)	15. Check engine oil level (if required)	15. Check engine oil level (if required)
16. Check engine oil level (if required)	16. Check engine oil level (if required)	16. Check engine oil level (if required)
17. Check engine oil level (if required)	17. Check engine oil level (if required)	17. Check engine oil level (if required)
18. Check engine oil level (if required)	18. Check engine oil level (if required)	18. Check engine oil level (if required)
19. Check engine oil level (if required)	19. Check engine oil level (if required)	19. Check engine oil level (if required)
20. Check engine oil level (if required)	20. Check engine oil level (if required)	20. Check engine oil level (if required)



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## Was **JUNIOR OFFICERS** adequately **SUPERVISED**?



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Was **LOG BOOK RECORDS** correctly filled in with adequate details?



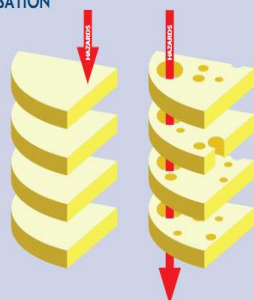
86



Was pre-agreed **CARGO CRITICAL POINTS** (ramp up / ramp down) treated as such?  
Were all team members aware of same?

#### ACCIDENT CAUSATION

An ideal SMS looks like this



Companies develop layers of defences between the hazards and people/property at risk from operations

The reality is more like this, with possible holes in the barriers, like the holes in a swiss cheese

When 'holes' in every side line up, a poor system provides a trajectory for an accident to occur

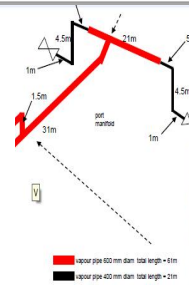
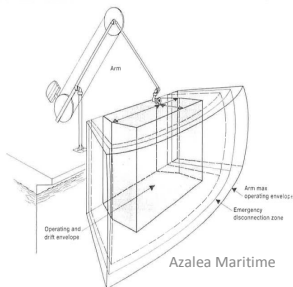


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## Did **CARGO PLAN** included following items and understood by all Officers:

*Safe parameter Criteria for aborting Operation, Draft Restriction, UKC Restriction, Weather Criteria, ESD1 & ESD 2 criteria, Emergency response...*



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## Was **ENGINE TEAM** been part of pre-arrival, pre-departure, BRIEFING within CCR Team?

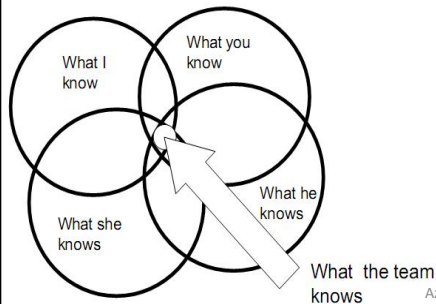


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## Was **Engine Room Team** aware of Terminal **RESTRICTIONS AND REQUIREMENTS?**

(SECA Area, Garbage/MARPOL Special Area, Engine Readiness, Shore Leave, Any restrictions, , Starting and Completion Time, Updates Cargo Orders, Draft/Load Line Restrictions....)



With no shared plan, they couldn't help each other.



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## Did the **CCR TEAM INFORM THE ENGINE ROOM** in advance when the big electric consumer is to be altered / started / stopped ?

(WB Pumps, Cargo pumps, Compressors,..)



It's not enough to transmit a signal. It's about facilitating its interpretation, too.



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Were **ENGINE TEAM MEMBERS** aware (re-briefed) with any alternation in the original cargo plans?

(Compressor number in use, ballast pumps, cargo pumps, ETC, Pilot booking, weather condition changed...)

A team is not a group of people who work together. A team is a group of people who trust each other. -



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Was any predicted **PROBLEMS IN ENGINE ROOM or CCR** affecting original plan was shared between team?

A team is not a group of people who work together. A team is a group of people who trust each other. -



98

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**Was ballast operation supervised / double checked to avoid **WATER HAMMERING** in ballast system?**

**Pay attention to WATER HAMMER**  
(Refer to SMS)

Case 6: Damaged Parts



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**Was all team members appeared to be **INTERESTED AND MOTIVATED** in conducting of exercises?**



100

95

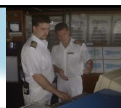


Was **ENGLISH LANGUAGE** used by ship's staff at all times?

- “ **Communications within the CCR team need to be understood.**
- ” **Communications between multilingual team members, and in particular with ratings, should either be in a language that is common to all relevant CCR team members or in English.**

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Was **WATCH HANDOVER** procedure effective, adequate with all relevant information being handed over?

- Was **HANDOVER** procedure adequate ?
- Was **CON** transfer properly carried out ?
- Was treated as an independent two person check on the vessel situation
- Oncoming officer should go an independent assessment (if available check list) of important factors
- Off-going officer should than provide a detail briefing of the vessel situation
- Any discrepancy should be resolved prior to completion of the handover
- Obtain third person check if needed
- Wait for reliever to acknowledge the handover is completed
- Write down important info (*call C/O when, advise shore, reduce rate, observe vapor return temperature, watch manifold pressure, compare gauges hourly, CTM issues, temperature sensor failed – manual measuring...*)
- Develop a routine for passing information (*ship/shore check list, load/discharge plan sequence, cargo operational check list, C/O night order book, ....*)

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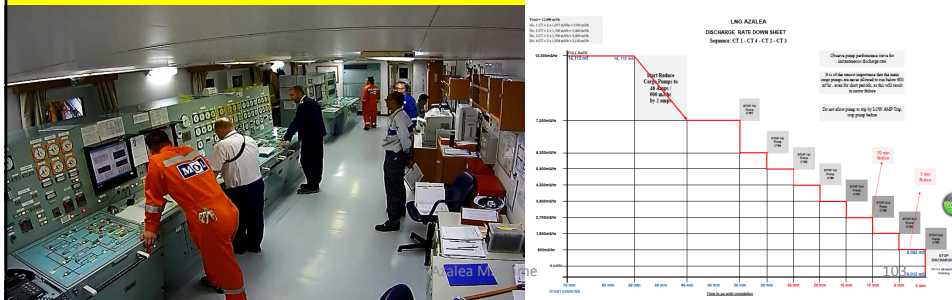
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Was **CON** transfer properly carried out and announced to CCR team and Deck crew?

**WHEN THINGS DO NOT GO AS EXPECTED, TAKE OVER**



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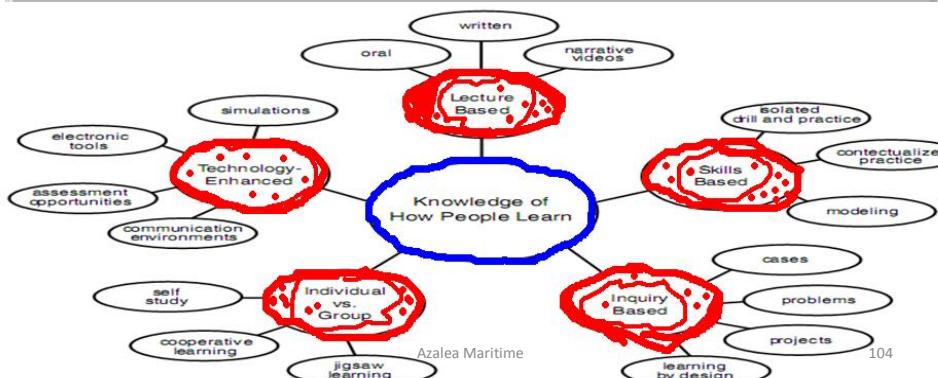
CONFUCIUS 451 B.C.

- What I HEAR / Forget
- What I SEE / Remember
- What I DO / Understand



Was senior officer performing **MENTORING / COACHING** to junior officer?  
**(“EXPERIENTIAL KNOWLEDGE”)**

**(Starting of cargo, spray, ballast pumps, float gauges, gas instruments...)**





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## Was **PA** made for starting and completing critical operations?



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Was there any **CONFLICT** among CCR team?  
 Was C/O able to handle **CONFLICT** ?  
 Was C/O able to stay calm and resolve situation?

## Conflict Management

The ability to realise that one of you has to remain calm.

Values, beliefs, resources, pride, status, ego, emotions, goals, self stress, opinions, Misunderstandings,

**A conflict is constructive when it ...?**

- “ Causes authentic communication
- “ Involves people in resolving issues important to them

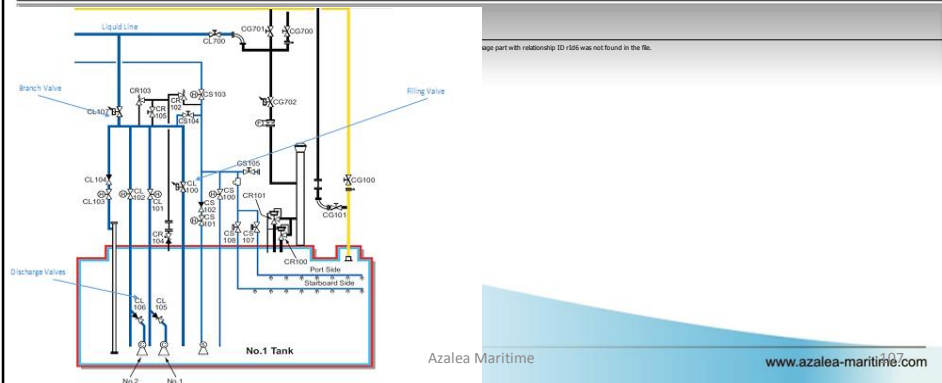
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## Was CCR Team fully familiar with the **INITIAL ACTIONS IN RESPONSE TO AN EMERGENCY?**



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## Who was **LEADER** in **EMERGENCY Situations?**



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**Are all officers and ratings aware of the carriage requirements including **EMERGENCY PROCEDURES FOR LNG** and are officers' familiar with the vessels cargo system, including emergency discharge arrangements?**



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**Power Distance, **CULTURE** difference issues**

Cultural differences increase  
the likelihood of different  
interpretations of the same event

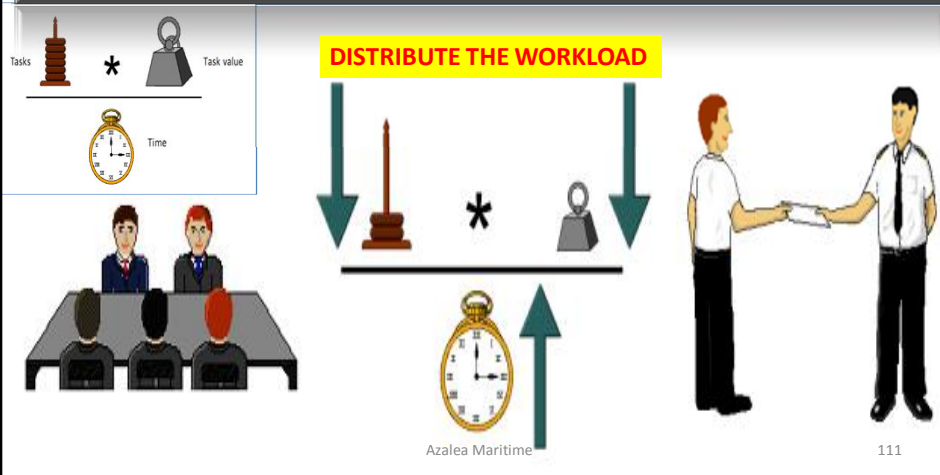
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## How do you recognise an **OVERLOAD** situation?



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## Did the officer display any form of **STRESS** ?

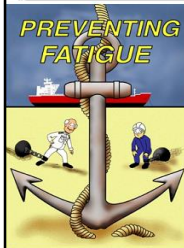




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## Did the officer display any form of **FATIGUE** ?



***“Fatigue denotes a state represented by a loss in efficiency and a general disinclination to work”***

*(Grandjean, 1988. Human Factors Journal, 1994)*



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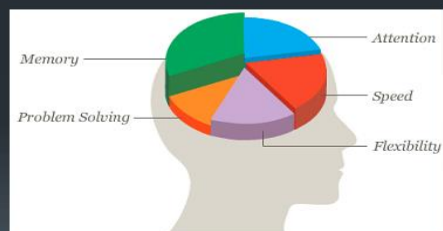
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## COGNITION?

### Cognition

Understanding the process of the brain and how this affects our perception of reality.

Short-, Long-, Working - & Procedural memory, filtering, conscious, subconscious, shared mental model, internal distractions.



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Do you have any **NEAR MISS** situation to report?

*"Very often much more can be learnt from a well reported and analysed 'near-miss' than can be learnt from the real thing – there is after all no one to blame"*

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Was there lack of **TEHNICAL KNOWLEDGE**?  
Was all deck officers knowledgeable in normal loading and discharging operations?

Lack of knowledge / experience etc.,



People are always learning. Organisations just need to make sure it's the right thing.

How to avoid errors due to lack of Knowledge ???

- **Understand** each step of what you are doing or...
- If you don't have the knowledge, **talk** to someone who does
- **Seek** training on the type of work to be performed
- Always **use** current procedures and work instructions
- **If it's new-** don't be **afraid** to ask!

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## Was **DE-BRIEFING** carried out after exercises was successful?

**Minutes of Meeting**

- "Improvements, Comments, Details,
- "Suggestions, Responsibilities,
- "Delegated duties,
- "Action to be taken





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**SOED Model**

**CORRECTIVE Feedback**

**SANDWICH Model**

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## What is your **CORRECTIVE FEEDBACK** and what method are you going to use? (SOED or SANDWICH)

4) Demand = "In the Future, I would like you to...."

3) Effect = What happens when you do this is that....

2) Observation = "The other day, I observed that...."

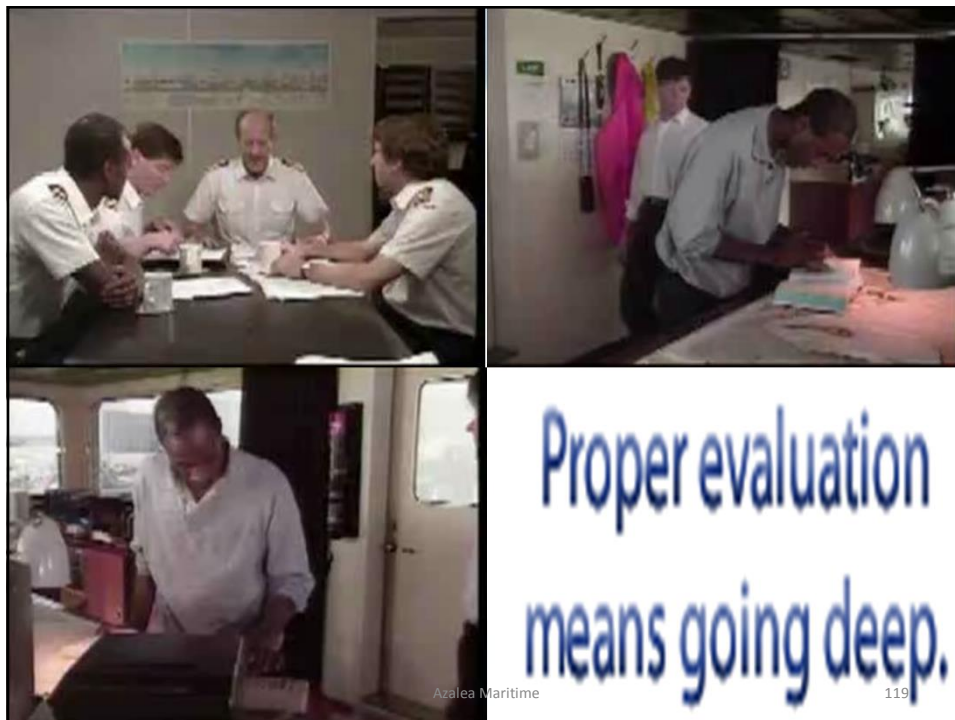
1) Subject = I would like to talk to you about....

**Layer 1 = three positive things**

**Layer 2 = changes you would like to see**

**Layer 3 = quick positive comments**

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**What you will be **YOUR** SUBJECTS AND POINTS TO IMPROVE** for next exercise?

LET'S DISCUSS

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## Simulator Training benefits?

Full simulation allows whole task coverage plus safe practice in rare circumstances – but it's not for novices.



**TEST REALITY Before REALITY TEST YOU**

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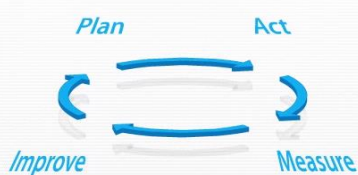
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What points you are going to remembers and take to your **NEXT SHIP IN ORDER TO IMPROVE CCR RM?**



"Our performance TODAY is better than yesterday and our performance TOMORROW is better than today!"



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## Was **CCR RM OBJECTIVE** reached?



When organisations invest in training, they take control of their own future.

How to profit from training

1. Analyse needs.
2. Design content.
3. Evaluate results.
4. Go to Step 1.

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“ Thank you



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