**Title-**-Example of LFI

**Target audience for the LFI-**--Charterers
-Owners
-Vessel crew
-Industry

**What happened-**-Demonstration of the tool

**Why it happened-**-To demonstrate the tool

-**What investigation steps were carried out-**•The following steps were carried out
•List steps
•More steps

-**What was focused on-**Checking for bugs

-**Why was this focused-**To get the TECHOP tool working

-**What was the outcome-**The tool seems to be working

-**Confidence level on outcomes-**High

-**Basis of confidence-**Testing

**Lessons learned-**-Following lessons were learned:
- Lesson A
- Lesson B
- Lesson C

**Recommendations-**-The following remedial actions are proposed

-**Short term remedial actions-**Fix the problem, find out root cause

-**Medium term remedial actions-**Check company wide, does similar problem exist? Fix, verify root cause was correctly identified

-**Long term remedial actions-**Remove the root cause from design if possible, else mitigate. Future designs shouldn't repeat. Spread to industry.

**Additional notes-**-None

**-**-

**-**-

**Results breakdown-**-The chart below shows the breakdown of the causal and contributory factors as defined within the four criteria of Design, Operations, People and Process.

**-Design-**7

-**Operations-**6

-**People-**5

-**Process-**11

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**Design sub topics-**-

**-**Ergonomics- was a causal or contributory factor

-Commonality- wasn't a causal or contributory factor

-External Interfaces- weren't a causal or contributory factor

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The above Design sub topics have been found to be causal or contributory factors in many learning from incidents and are thus highlighted separately-

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