

1 Article

2 

# Path analysis of causal factors influencing marine

  
3 

# traffic accident via structural equation numerical

  
4 

# modeling

5 **Shenping Hu<sup>1\*</sup>, Zhuang Li<sup>1</sup>, Yongtao Xi<sup>1</sup>, Xunyu Gu<sup>2</sup>, Xinxin Zhang<sup>1</sup>**6 <sup>1</sup> Merchant Marine College, Shanghai Maritime University, Shanghai 201306, China7 <sup>2</sup> Ship Administration, Pudong Maritime Safety Administration, Shanghai 200135, China

8 \* Correspondence: sphu@shmtu.edu.cn

9

10 **Abstract:** Many causal factors to marine traffic accidents (MTA) influence each other and have  
11 associated effects. It is necessary to quantify the correlation path mode of these factors to improve  
12 accident prevention measures and their effects. In the application of human factors to the accident  
13 mechanisms, the complex structural chains on causes to MTA systems were analyzed combining  
14 the Human Failure Analysis and Classification System (HFACS) with theoretical Structural  
15 Equation Modeling (SEM). First, the accident causation model was established as a human error  
16 analysis classification in sight of MTA, and the constituent elements of the causes of accident was  
17 conducted. Second, a hypothetical model of Human factors classification was proposed applying  
18 the practice of the structural model. Third, with the data resource from ship accident cases, this  
19 hypothetical model was discussed and simulated, and as a result the relationship path dependency  
20 mode between the latent independent variable of the accident was quantitatively analyzed based  
21 on the observed dependent variable of human behaviors. Application examples show that  
22 relationships in HFACS are verified and in line with the path developing mode, and resource  
23 management factors have a pronounced influence and a strong relevance to the causal chain of the  
24 accidents. Appropriate algorithms for the theoretical model can be used to numerically understand  
25 the safety performance of marine traffic systems under different parameters through mathematical  
26 analysis. Hierarchical assumptions in the HFACS model are quantitatively verified.27 **Keywords:** maritime traffic; marine accident; accident causation theory; human factor; structural  
28 equation modeling; HFACS; path dependency

29

30 

## 1. Introduction

31 Marine traffic safety is an important component of economics and trade between different  
32 countries. The volume of ship transportation has, over time, become an important measurement of  
33 the country's economic development. With the growth of China's national economy the shipping  
34 industry has developed rapidly and the scale of transportation has been expanding. With that  
35 growth, the marine traffic accidents (MTA) has consistently called attention to life safety, property  
36 safety and environment protection. Therefore, as a basic issue of safety research, the symptomatic  
37 problems of MTA always get attention by experts (Goerlandt and Montewka, 2015).38 In order to reduce the incidence of MTA, many experts have conducted of research on the  
39 causes of MTA. Marine traffic is a complex system that includes people, ships, and environmental  
40 management. In the past, people focused on improving the safety of ships and equipment. Due to  
41 the continuous development of technology, the safety of ships and equipment has reached a very  
42 high level. Safety experts and scientists agree that the role and status of human factors and  
43 management factors in accidents have been proven. Thus, at present, many scholars believe that the

44 root cause of accidents is management factors, i.e. the direct cause of accidents is the unsafe acts of  
45 personnel(Yang et al 2013).

46 The development of accident causation theory shows that most accidents are not caused by a  
47 single elementary event, but by a series of factors interacting with each other. Therefore, it is  
48 necessary to study the relationship between the different causes of MTA, in order to help  
49 decision-makers better understand the accident and thus fundamentally reduce the occurrence of  
50 such accidents.The analyses of the causes of MTA and the research on the interrelationship of the  
51 causes are being continuously developed. The complexity of the cause of the accident system has  
52 been established, and the chain model associated with the cause of the accident has basically been  
53 consistent(Schröder-Hinrichs et al, 2012; Xi et al, 2018).

54 However, it is still a difficult problem to explore the association pattern and intensity of the  
55 generic causal chain quantitatively. It is possible to use new algorithms to study the interactions and  
56 influence paths of the causes of accidents. In particular, the analysis of the causal chain path of big  
57 data can help us understand the characterization mechanism of accidents and provide scientific  
58 diagnosis of how those accidents occurred. To quantitatively analyze the relationships between the  
59 causes of MTA and clarify the causal mechanism of human factors in an accident and analyze the  
60 logical cause of the accident, this paper will combine with accident data, using the SEM method to  
61 analyze the complex relationship between the causal structures of MTA system.

62 The rest of this paper will be organized as follows. In section 2, the most recent studies about  
63 the cause of accidents and the mechanism of accident factors are reviewed. In section 3, our research  
64 theory and research hypothesis are presented. In section 4, we present the model in causal factors  
65 chain for MTA. In section 5 and 6 our research is applied to a specific case. The relevant data is  
66 collected, analyzed and applied to the model, and the sensitivity of the model tested. In section 7, the  
67 conclusions are drawn based on our research.

## 68 **2. Literature Review**

69 Increasing industry system safety through reducing infrequent events keeps a major challenge  
70 to safety scientists. Accident causation methods were broadly applied in marine traffic field.To  
71 study MTA occurrence mechanism, the first thing is to understand the causes of the accident and the  
72 interaction of the factors that cause the accident. (Pidgeon et al., 2000; Grant et al., 2018). Marine  
73 accidents result from a combination of complex conditions. Japanese scholars proposed using the  
74 marine information structure, holding that independent action and interaction of human and  
75 maritime factors caused most accidents (Fukushima, 1976). The complexity of systems and the  
76 environments in which human operate means that the process of safety is not directly forward or  
77 linear, but instead is driven by a complex network of relationships and behaviors between humans,  
78 technology and their environment. A new risk management framework is put forward to solve a  
79 human control problem and modelling techniques are required to appreciate the direct or indirect  
80 operational requirements of systems. The sequence of events reveals a complex interaction between  
81 all of the levels in a socio-technical system spanning strictly physical factors, the unsafe actions of  
82 individual, inadequate oversight and enforcement(Rasmussen,1997). In comparison to other  
83 accident analysis methods, Systems-Theoretic Accident Model and Processes (STAMP) uses a  
84 functional abstraction approach, to model the structure of a system and describe the interrelated  
85 functions(Leveson, 2004). According to this work-flow, the structure of work systems is hierarchical  
86 which actors, objects and tasks are modeled across levels of the complex system and their  
87 relationships to each other are linked to explain causal connections. Dynamic work-flows are  
88 represented in the framework as inter-dependencies between the vertical integration levels of the  
89 system (Grant et al,2018). The Functional Resonance Accident Model(FRAM) is different from the  
90 traditional model for analyzing accidents from the perspective of internal system operation  
91 mechanism or event causal sequence(Hollnagel, 2012). It does not stick to system structure  
92 decomposition and causal factor analysis, and avoids the analysis of accidents into the orderly  
93 occurrence of a single associated event, or avoids the analysis on hierarchical stacking of multiple  
94 potential factors. Combining Safety-I (accident-error oriented)and Safety-II(safety-health oriented)

95 perspectives broadened understanding of safety management from accident analyses like Causal  
96 Analysis based System Theory(CAST) to hazard analyses like Systems-Theoretic Process Analysis  
97 (STPA) (Hollnagel, 2014; Jones et al, 2018).

98 Reason (1990) put forward the Swiss Cheese Model, the latent and active failures model, and  
99 pointed out, for the first time, that an accident is due to the latent defects or vulnerabilities in each  
100 part of the system, and that when the defects on each part are lined up, the final cause of the accident  
101 can be understood(Fan et al., 2015; Yang et al., 2013). The model has been criticized for being a  
102 reductionist and linear model that fails to account for a holistic representation of systems as dynamic  
103 and adaptive which forms the basis of systems theory (Grant et al,2018). Maintaining the notion of  
104 human error as a central concept in accident causation system disregards the basic fact, which the  
105 relevant performance usually is carried out by human- organization factor rather than by an  
106 individual. Furthermore, it can be shown that about 80% of MTA are related to human factors (Hu et  
107 al, 2007). The applications driven by qualitative accident causation models have been improved to  
108 investigate human factors in accidents. Subsequently, exploration of the correlation between the  
109 causes of the MTA and the consequences of accidents has made significant progress. The main  
110 qualitative research investigated the impact of different factors on the outcome of accidents. The  
111 relationship among causal factors in accidents has also been studied. Hänninen. (2014) used the  
112 directed acyclic graph of the Bayesian network to study the cause of marine accidents. Dai and  
113 Wang. (2011) utilized goal structure notion to analyze the associated rules of human factors to  
114 marine accidents. Graziano et al. (2016) used the tracer taxonomy to study human errors in collision  
115 accidents. Sotirialis et al. (2016) focused on human centered design aspects to incorporate human  
116 factors to ship collisions analysis. Lyu et al. (2018) studied the relationships among safety climate,  
117 safety behavior, and safety outcomes in construction workers. The novel drift into failure  
118 model(DFM) provides a set of philosophies that explain the nature of drift within a complex system.  
119 These embody principles from complexity theory such as path dependence, non-linearity and the  
120 impact of protective structures(Dekker et al, 2012).

121 The need to manage human error comes as no great revelation to anyone involved in operations  
122 where the consequences of failure are big serious.Exploring the formation methods and mechanism  
123 models of human error, and obtaining a generalized method for accident investigation, it is a topic  
124 that the industry is constantly studying. Based on the Swiss Cheese Model, the version of Human  
125 Factors Analysis and Classification System (HFACS) was established. HFACS addresses human  
126 error at all levels of the system, including the condition of aircrew and organizational  
127 influences(Shappell and Wiegmann, 2000). This model is a general human error framework  
128 originally developed and firstly tested within the U.S. as a tool for investigating and analyzing the  
129 human causes of aviation accidents(Wiegmann et al, 2001). It has been identified several key safety  
130 factors that require intervention and proved that the HFACS framework can be a viable tool(Gaur.  
131 2005). Krulak. (2004) proposed a maintenance extension of the HFACS method (HFACS-ME), and  
132 proved that human factors have a significant relationship with mishap frequency and severity in  
133 mishaps. Shappell et al. (2007) used HFACS put forward a logical method to analyze the human  
134 factors in the causes of accidents to provide a logical analysis of how accidents occur and how they  
135 can be prevented. Celik et al. (2007) sought to integrate those factors into the HFACS system to  
136 discover design-based human factors in marine accidents.

137 A general accident model describes the unexpected failures caused by characteristics of a  
138 system where interactions between factors behave in unpredictable ways and produce multiple and  
139 unexpected failures. Celik and Cebi. (2009) applied HFACS to qualitative analysis of Human  
140 Organizational factors (HOF) Structure in MTA. Chen. (2013) explored the structural relationship of  
141 human factors combined with “why-because” graphs. HU et al. (2008) used a relative risks model to  
142 analyze and evaluate ship navigation safety using Bayesian belief network. Chen et al. (2013)  
143 successfully studied the application of HFACS in coal mines and flight safety, and produced a  
144 qualitative list of human factors. Wang et al. (2013) first applied complexity theory to analyze the  
145 mechanism of the accident. Within complex systems, the relationships between factors can be  
146 described in terms of the interaction between them. Using multiple indicators to reflect latent

147 variables, and also estimating the relationship between the entire model factors, a way to deal with  
 148 measurement errors is necessary to be proposal which is more accurate and reasonable than  
 149 traditional regression methods and useful to explore the path in accident causation style. It is  
 150 necessary to find the principle of path dependence from complexity theory, which has the  
 151 non-linearity and the impact of protective structures.

152 Structural equation modeling is a method for testing the relationship between assumed latent  
 153 variables by using real data collected by researchers, Seo. (2005) used the Structural Equation  
 154 Modeling method to reveal the mechanisms through which the contributory factors of unsafe work  
 155 behavior influence safety actions of individuals at their workplaces.

156 In this paper, we reviewed the research on the mechanism of MTA. HFACS provides a new  
 157 method for the study of human factors in marine accidents, but the lack of quantitative analysis  
 158 limits its use. SEM method makes it possible to quantitatively analyze the relationships among  
 159 human factors in accidents. Additionally, the lack of a clear path to analyze the causes of MTA  
 160 motivated this paper to propose a correlation model in the causal factors chain for MTA, which is  
 161 expected to explore the impact of human interactions in the mechanism of accidents.

### 162 3. Theoretical and research hypothesis

#### 163 3.1 HFACS in MTA

164 Heinrich classifies the causes of an accident as unsafe behavior of human, unsafe status of  
 165 materials, and unsafe conditions of environment(Marshall et al, 2018). More and more researchers  
 166 have begun to study the influence of human factors on accidents. Human factors refer to the harmful  
 167 effects of human behavior on the normal function or successful performance of the system when  
 168 completing a specific task.

169 HFACS describes human error at each of four levels: the actions of the operators (e.g.,  
 170 bench-level scientists and field investigators in forensics); the preconditions for those actions (i.e.,  
 171 the conditions that influence human behavior); the middle management (i.e., the individuals whose  
 172 role it is to assign work); and the organization itself(Shappell, et al. 2000). In the maritime field, here  
 173 using HFACS for MTA to analyze human factors in marine accident (Chauvin et al., 2013; Wu et al.,  
 174 2017), proposal the basic path of accident formation is described in Category I factors, which  
 175 includes Organizational Influences SL<sub>4</sub> - Unsafe Supervisions SL<sub>3</sub> - Preconditions for Unsafe Acts SL<sub>2</sub>  
 176 - Unsafe Acts SL<sub>1</sub> - Accident SL<sub>0</sub>. Meanwhile, establishing accident causal factors and the  
 177 classification of those factors are defined as shown in Table 1 (Category II factors was described as  
 178 X<sub>i</sub>, i=1,2,...17) . Here the original framework and structure proposed by Shappell (1997) was reserved,  
 179 such as SL<sub>0</sub> (X<sub>17</sub>), SL<sub>1</sub> (X<sub>13</sub>, X<sub>14</sub>, X<sub>15</sub>, X<sub>16</sub>), SL<sub>2</sub> (X<sub>8</sub>, X<sub>9</sub>, X<sub>10</sub>, X<sub>11</sub>, X<sub>12</sub>), SL<sub>3</sub> (X<sub>4</sub>, X<sub>5</sub>, X<sub>6</sub>, X<sub>7</sub>), and SL<sub>4</sub> (X<sub>1</sub>, X<sub>2</sub>, X<sub>3</sub>).

180 Based on CREAM and the theoretical basis for HFACS, a human structural cheese model can be  
 181 constructed for a marine traffic accident. As shown in Figure 1, the following hypotheses were made:

182 Hypothesis H1: SL<sub>3</sub> has a significant effect on SL<sub>4</sub>;

183 Hypothesis H2: SL<sub>2</sub> has a significant effect on SL<sub>3</sub>;

184 Hypothesis H3: SL<sub>1</sub> has a significant effect on SL<sub>2</sub>.

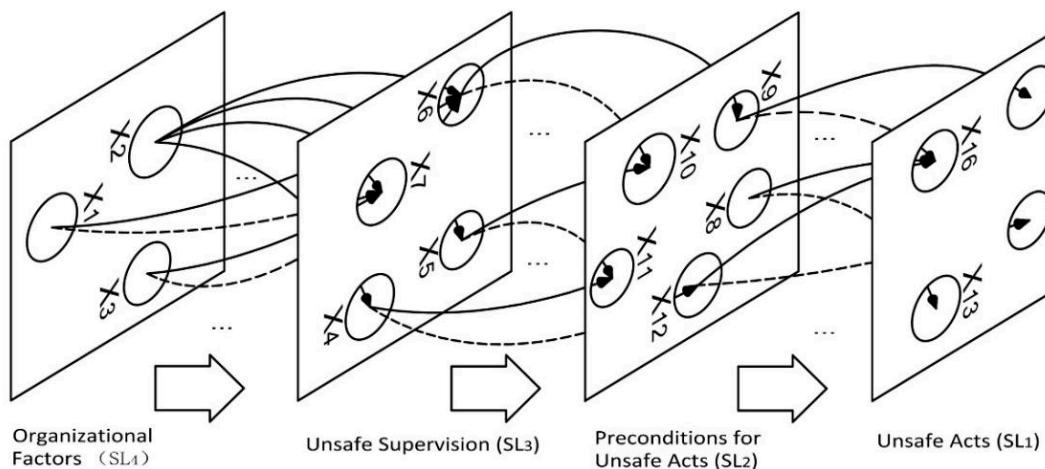
185 The quantitative relationship among human factors in maritime transportation is discussed  
 186 thereafter.

187 **Table 1 Relationship of Causal factors to Marine accident**

Symbol	Item of Causal factors	Symbol	Item of Causal factors
SL <sub>0</sub>	Accident	X <sub>7</sub>	Violation Monitoring
SL <sub>1</sub>	Unsafe Acts	X <sub>8</sub>	Team factors
SL <sub>2</sub>	Preconditions for Unsafe Acts	X <sub>9</sub>	Individual factors
SL <sub>3</sub>	Unsafe Supervisions	X <sub>10</sub>	Material factors
SL <sub>4</sub>	Organizational Influences	X <sub>11</sub>	Natural Environment
X <sub>1</sub>	Resource Management	X <sub>12</sub>	Physical Environment
X <sub>2</sub>	Organizational Climate	X <sub>13</sub>	Slip

$X_3$	Process Safety Control	$X_{14}$	Lapse
$X_4$	Inadequate Oversight	$X_{15}$	Mistake
$X_5$	Unsuitable Execution Plan	$X_{16}$	Violation
$X_6$	Error-Correction Parsing	$X_{17}$	Accident Consequence

188



189

**Figure 1 Path model of causal factors chain to MTA based on HFACS****190 3.2 Causal factors in MTA**

191 The maritime industry stakeholder believes that the human component is a complex,  
 192 multidimensional proposition that affects maritime safety and marine environmental protection,  
 193 and includes crew, shore-based management, legislative and law enforcement agencies, shipyards,  
 194 authorized organizations, and a series of behavioral activities of other relevant parties(Xi et al, 2017).  
 195 All marine accidents will be affected and controlled by human factors, ship factors, environmental  
 196 factors and management factors. However, the manifestations of system factors vary greatly in  
 197 different accidents. In order to assist in the implementation of accident case analysis, an accident  
 198 analysis system needs to be designed to fully define the description and characterization of the  
 199 cause of the accident. This step relies on historical data and subject-matter experts analysis from the  
 200 latent sources, such as databases, experiments, simulations, webs and logical analytical models.  
 201 Detail items are shown in Table 2.

202

**Table 2 Definition of Causal factors to Marine accident**

No:	Item	Description and Observation character
$X_1$	Resource Management	Ship resource allocation, the allocation of ship resources, including operators, equipment and facilities, information support and monitoring, embodied in the suitability of personnel, the seaworthiness of the ship, and the suitability and effectiveness of external supporter.
$X_2$	Organizational Climate	The organizational climate can be shown that influence employees' events, activities, and procedures, as well as those that may be rewarded, supported, and expected. It can be divided into employees' internal perceptions and team climates
$X_3$	Process Safety Control	Process safety refers to how to prevent accidental loss of control and possible traffic accidents caused by installations and facilities during navigation, berthing and operation process, resulting in damage to employees and ships, environmental damage and property loss. .
$X_4$	Inadequate Oversight	No finding in operation arrangements or process issues Insufficient staff training time, VTS monitoring failure
$X_5$	Unsuitable Execution Plan	Improper arrangement of berths and anchorages, Operation plan negligence, Operation plan rationality defect

X <sub>6</sub>	Error-Correction Parsing	Repeat the same nature accident
X <sub>7</sub>	Violation Monitoring	Limit cause from Draught, weather, ship scale, etc.
X <sub>8</sub>	Team factors	Crew member's mistake; Tug crew error; Communication and cooperation negligence
X <sub>9</sub>	Individual factors	Illness or bad physiological state; Alcoholic beverage; Continuous operation, fatigue etc.
X <sub>10</sub>	Material factors	Equipment defects, Structural defects, Cargo defects, latent defects, Overload
X <sub>11</sub>	Natural Environment	Natural disasters, Poor visibility, Wind currents, Tides, Surges, Navigational environments, Waterway bends, Navigation aids, Navigable waters, Fishing areas
X <sub>12</sub>	Physical Environment	Channel curvature; Obstacle (including dock or anchorage restrictions) Navigation aid; Navigation density; Navigable water depth; Navigable water width
X <sub>13</sub>	Slip	Precaution to the natural conditions of the fairway; Precaution on ship traffic conditions; Precaution to encountering ship behavior; Visual hope negligence; Navigation instrument not used correctly
X <sub>14</sub>	Lapse	Navigation operation; Avoidance collision behavior; Manipulation judgment
X <sub>15</sub>	Mistake	Emergency treatment; Manipulating behavior(an anchorage, by mooring)
X <sub>16</sub>	Violation	Violation operation (relevant ship); Violation operation (assisting tugboat); Violation operation (pilot); Deviation (pilot)
X <sub>17</sub>	Accident Consequence	Degree of the consequences of the accident, including near miss

203 *3.3 Relationship of causal factors in MTA*

204 The relationship of factors has many pieces. When studying the correlation of human factors in  
205 the causes of MTA, the following aspects are mainly considered:

206 (1) Positive or negative factors of the correlation coefficient

207 If the correlation coefficient is positive, there is a positive correlation of the factors; if the  
208 correlation coefficient is negative, then there is a negative correlation of the factors.

209 (2) Scale of the correlation coefficient

210 For correlation coefficient, the greater the absolute value, the stronger the correlation of the  
211 factors is; if the minimum value is 0, at that time, in general, the factors do not depend on each other.

212 (3) Rank in Correlation of factors

213 The interaction of factors is reflected in the relationship of the factors, so some are directly  
214 associated, indicating that the factors are direct and influential, but some are indirect showing  
215 secondary effects.

216 The above associated accident analysis can form the path of the factors. The main content of  
217 path analysis is to solve: (a) Path direction; (b) Variable relationships of indicators; (c) Path load  
218 capacity; and (d) Whether the model hypothesis is actually matched.

219 *3.4 Path analysis on causal factors of the MTA system*

220 According to the complex network theory, the combination of accident factors and their  
221 associated relationships is called the accident network SOBIESKI J S. (2006). The node characteristics  
222 and associated characteristics in the accident network determine the main performance of the  
223 accident network.

224 The occurrence of complex system safety incidents is not caused by a single risk factor, but is  
225 the result of multiple risk causal factors. Corresponding to the accident network, the causal factors of  
226 the MTA system are generally not a single node, but an accident chain composed of multiple  
227 associated nodes, or an accident network consisting of an accident chain. Therefore, taking into  
228 account the dynamic nature of the risk, the accident is related to the accident path. However, the  
229 accident does not happen overnight, but needs to undergo a series of processes such as risk

230 emergence, risk transfer, risk coupling, and accident emergence. In this process, there are many risk  
 231 transfer paths, and the final accident path may be any one of them. One can analyze the risk  
 232 transmission path of the complex accident system before the accident occurs, and identify the  
 233 important parameters that affect the risk transfer. In an accident network, a path with more nodes is  
 234 a critical path, and a path with fewer nodes is a non-critical path.

235 The causal path of the accident system includes two parts: the causes of the accident and the  
 236 relationship of the causes. The path of the maritime causal system can show the beginning and  
 237 ending of the MTA causal path, namely to express the direct and root causes in the MTA. It can show  
 238 the causal path of a series of factors interacting with each other before the accident and help better  
 239 explain the transmission process of the accident cause, reveal the evolution mechanism of the  
 240 accident, and further help people to take effective measures based on the causal path of vulnerable  
 241 defects.

#### 242 4. Correlation model in causal factors chain for MTA

243 Usually, to study the safety of complex systems, it is impossible to test the actual system to  
 244 observe the accident behavior; therefore, one must construct a theoretical model of the complex  
 245 system. By constructing the corresponding simulation model for the theoretical model, computer  
 246 simulation can be used to gain an in-depth understanding of system performance under different  
 247 parameters. Traditional multivariate analysis methods such as complex regression, factor analysis,  
 248 multivariate analysis of variance, correlation analysis, etc. can only test the relationship between a  
 249 single independent variable and dependent variable at the same time, and these analytical methods  
 250 often have deficiency in theoretical assumptions and application. Factor analysis can reflect the  
 251 relationship between muti-variables, but it can not further analyze the causal relationship between  
 252 variables. While path analysis can analyze the causal relationship between variables, the actual  
 253 situation is difficult to meet the basic assumptions that the measurement error between the  
 254 variables is zero, the residuals are irrelevant, and the causality is one-way function. In this paper, a  
 255 novel method to analysis the causal factors is introduced via the network structural equation.

256 The Structural Equation Model(SEM) is a statistical method that analyzes the relationship  
 257 among different variables by using a co-variance matrix of variables. The structural equation model  
 258 integrates path analysis, confirmatory factor analysis and general statistical test methods to analyze  
 259 the causal relationship between variables, including the advantages of factor analysis and path  
 260 analysis. At the same time, it makes up for the shortcomings of factor analysis, taking into account  
 261 the error factors, and does not need to be limited by the assumptions of path analysis. Based on this,  
 262 we propose the strong and weak associated path of accident cause to quantitatively describe the  
 263 mechanism of the accident.

264 The purpose of this paper is to find the path to the causes of the accident by finding the  
 265 relationship among the causes of the accident. This differs from traditional statistical methods  
 266 because in addition to quantitatively analyzing the effect of a cause on the results, the structural  
 267 equation model also can quantitatively analyze the relationship between causes, so this paper will  
 268 use the structural equation modeling method to decipher the relationships in the causes of the  
 269 accident.

##### 270 4.1 Methods and Models

271 The Structural Equation Model includes both the measurement model and the structure model  
 272 (Crowley and Fan, 1997; Zhang et al., 2016). The measurement equation is used to describe the  
 273 relationship between the observed dependent variable and the latent independent variable. The  
 274 equation matrices of the measurement model are:

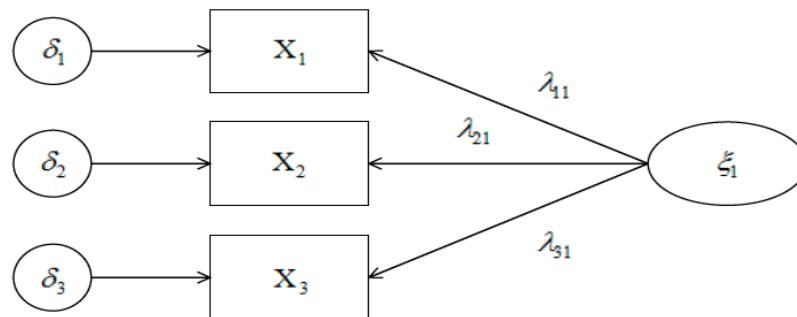
$$275 \quad x = \lambda_x \xi + \delta \quad (1)$$

$$276 \quad y = \lambda_y \eta + \varepsilon \quad (2)$$

277 Where among them,

278 x ---- Vector consisting of observed variables from exogenous latent variables

279 y ---- Vector consisting of observed variables from endogenous latent variables  
 280  $\lambda_x$  ---- The strength of association from exogenous observed variables.  
 281  $\lambda_y$  ---- The strength of association from endogenous observed variables  
 282  $\xi$  ---- Unobserved exogenous latent variables  
 283  $\eta$  ---- Unobserved endogenous latent variables  
 284  $\delta$  ---- The error items of the exogenous variables  
 285  $\epsilon$  ---- The error items of the endogenous variables  
 286 The measurement model is shown in [Figure 2](#).



287

288 **Figure 2 The measurement model**

289 Structure equations are used to describe the relationship among latent variables. Equation  
 290 matrix form of the structure model is:

$$291 \eta = \beta\eta + \gamma\xi + \zeta \quad (3)$$

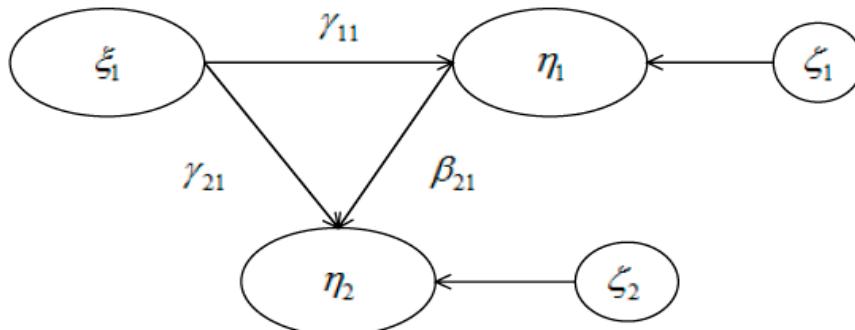
292 Where among them,

293  $\beta$  ---- the relationship between endogenous latent variables

294  $\gamma$  ---- the relationship between exogenous latent variables

295  $\zeta$  ---- the residual term of the equation, and it represents the portion of the endogenous latent  
 296 variable that is not interpreted in SEM.

297 The structural model is shown in Figure 3.



298

299 **Figure 3 The structural model**

300 The above three equations can form a general structural equation model (Byrne, 2009; Seo et al.,  
 301 2015). Each line segment in the SEM has a path coefficient that characterizes the association between  
 302 the two variables connected by the limit. After the path coefficients have been normalized, the  
 303 values range from -1 to +1. In addition, the values by path factor can be divided into three categories:

304 (1) When  $0 < \text{path coefficient} \leq 1$ , it means that there is a positive correlation between variables or  
 305 one variable has a positive effect on another variable, that is, the function between variables is  
 306 monotonically increasing;

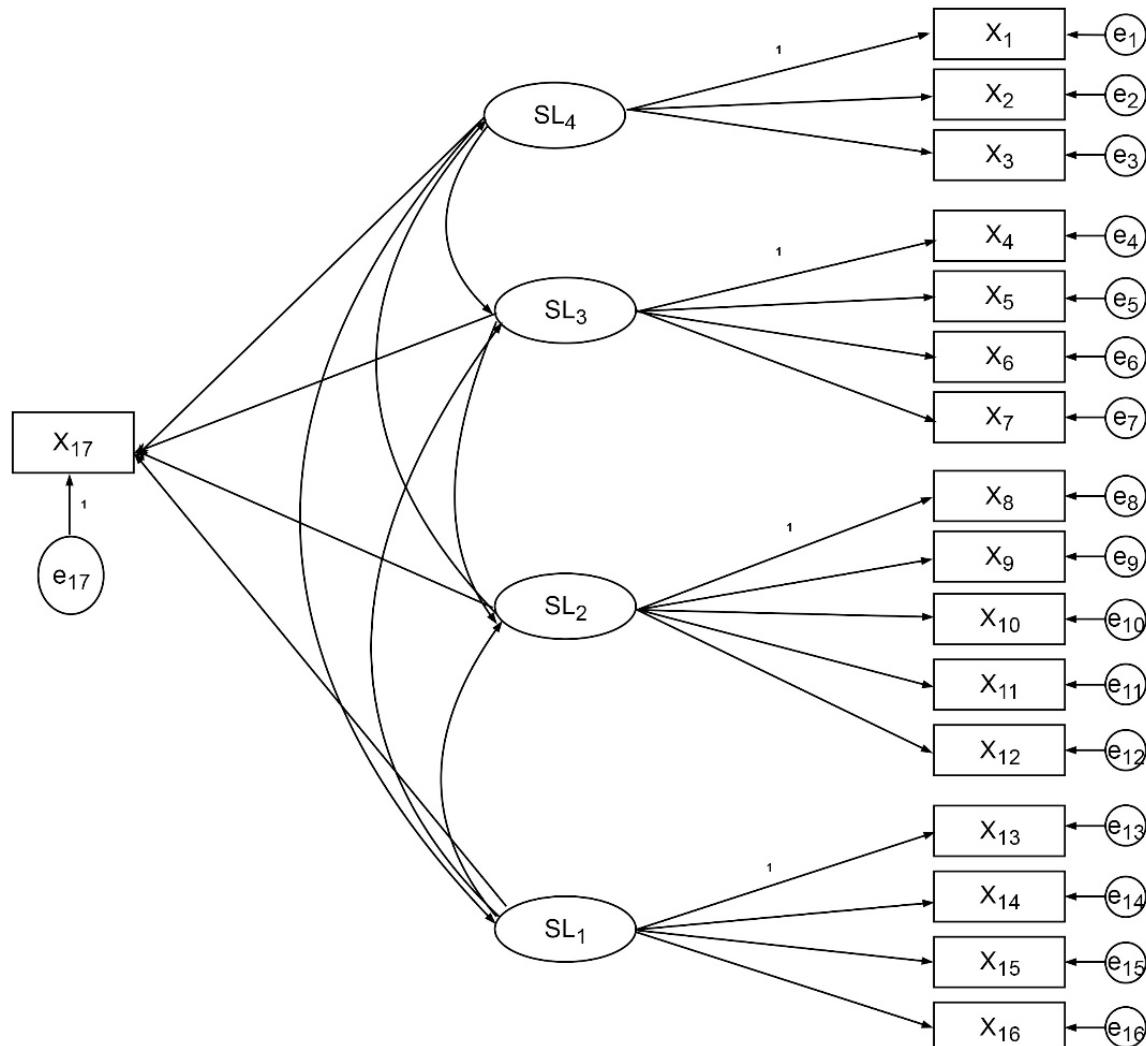
307 (2) When  $-1 \leq$  path coefficient  $< 0$ , it means that there is a negative correlation between variables  
 308 or one variable has a negative effect on the other variable, that is, the function between variables is  
 309 monotonously decreasing;

310 (3) When the path coefficient is equal to 0, it means that the variables are independent of each  
 311 other and not related to each other.

312 *4.2 Hypothesis Structure model for the human factors of MTA*

313 Use Category I factors of the human factors in section 1 as latent variables (indicated by  
 314 ellipses), and use the corresponding Category II factors as observation variables (indicated by  
 315 boxes), drawing a hierarchical classification and hypothesis model of human factors.  $e_i$  is the  
 316 observation error. As shown in Figure 4.

317



318

319 **Figure 4 Structural Hypothetical Model of HFACS-MTA**

320 **5. Case study**

321 This paper uses the accident case database from 2000 to 2009 in a certain area as an analytic  
 322 sample (Hu et al., 2012; Huang et al., 2018), through the screening and extraction of the database,  
 323 combining with the SEM hypothesis model and algorithm to apply to the model.

324 *5.1 Accident samples analysis*

325

**5.1.1 Accident sample scale**

326 Taking the human error in the area of MTA as the research object, a total of 894 samples of  
 327 accidents were introduced.  $X_{17}$  "Accident" as an observation variable is used to examine the effects of  
 328 different factors on the consequences of the accident. Use of the score of consequences of the accident  
 329 depends on the actual level of the collection, including five levels: incidents, minor accidents,  
 330 general accidents, major accidents, and serious accidents. They correspond to different accident  
 331 consequences scores, as shown in Table 3.

332

**Table 3 Accident consequence score table**

Rank	value	Description
incidents	1	_ Near miss
		_ hazard
		_ An event considered to be worthy of attention
minor accidents	2	_ Failure that can be readily compensated by the crew
		_ No significant harm to people, property or the environment
general accidents	3	_ Local damage to ship
		_ Marginal conditions for, or injuries to crew
major accidents	4	_ Major casualties excluding total loss
		_ Single fatality or multiple severe injuries
serious accidents	5	_ Total loss (actual loss and constructive total loss)
		_ Many fatalities

333

**5.1.2 Formatting causal factors of the accident**

334 Among these samples, there were all kinds of consequence which included 12 incidents, 520  
 335 minor accidents, 148 general accidents, 123 major accidents, and 91 serious accidents. The cause  
 336 analysis of the accidents is the process of determining the cause of the accident and measuring the  
 337 impact of the accident.

338 As to HFACS, human factors are those factors related to people in the operation of the system.  
 339 Human factors are beneficial to the safety side (such as people exert their own ingenuity, overcome  
 340 the adverse effects of mechanical equipment or harsh environment, etc.), but also can have a  
 341 negative effect. As a research object of human factors in MTA, the negative impact on human safety  
 342 due to human factors, namely Human Error was more important. The detailed information about  
 343 the observed characters in accident reports were structured and formatted(also shown in Table 2).

344 Each sample analysis for the causes of the accident is based on observed characters items, such  
 345 as management software , ship (cargo) hardware, environment(including natural conditions,  
 346 geographical conditions, traffic conditions), and liveware (Xi et al., 2017). In research of human  
 347 factors in marine traffic safety, the following four interfaces should be analyzed:

348 1) Liveware- liveware interface (L-L): The interaction between people in the system, such as  
 349 leadership, management, communication and cooperation between people.

350 2)Liveware-hardware interface (L-H): The relationship between people and ships, equipment  
 351 and other hardware, such as whether the design or layout of the ship or equipment conforms to  
 352 human characteristics, whether it is convenient for people to manage and maintain the hardware,  
 353 use or operate the hardware.

354 3) Liveware-software interface (L-S): The relationship between people and software, such as  
 355 whether the information is complete and easy to follow as well as the ease of the operation of the  
 356 software.

357 4) Liveware-environment interface (L-E): The relationship between humans and the  
 358 environment, such as whether working conditions limit human's behavior and whether external  
 359 conditions affect people's judgments.

360 In the case of structured accidents' documents, the observed characters in causes of the  
 361 accidents are divided into the following 7 categories:

362 (1) Management items: maritime administration limit, company management limit;

363 (2) Natural items: natural disasters, poor visibility, wind, tides, surges;

364 (3) Channel or terminal items: navigation loops, channel bends, aids to navigation, navigable  
 365 waters, chart publications, fishing areas;

366 (4) Traffic items: navigation order, traffic accident, berth anchorage, navigation management;

367 (5) Ship cargo items: structural defects, equipment defects, cargo defects, latent defects, over  
 368 workload;

369 (6) Personnel involved items: the tugboat operator, the ship operator, and the outboard  
 370 operator.

371 (7) Crew items: violation operation, negligence of route planning, negligence of navigation  
 372 operation, negligence in avoidance of collision, negligent manipulation, emergency-handling,  
 373 communication and cooperation negligence.

374 According to the different effects of the observed character on the outcome of these accidents,  
 375 the factors influence level are divided into four grades:

376 Level I, the factor may not impact the accident outcome, *no effect*

377 Level II, the factor may partly impact the accident outcome, *involved*

378 Level III, the factor may mainly impact the accident outcome, *mainly*

379 Level IV, the factor may apparently impact the accident outcome, *directly*.

## 380 5.2 Data acquisition and reliability analysis

381 In order to enable the fitting of the collected data into the hypothesis model, the collected  
 382 accident factors must be quantified according to the level of impact on the consequences of the  
 383 accidents. In this paper, to evaluate and synthesis the samples collected, a workshop was conducted  
 384 with subject-matter experts in accident analysis and systems thinking. Furthermore the data in  
 385 accident causation are measured by the "Likert scale", using a five-level scale.

386 First, quantitative data assignment is used for the extent of each factor's effect. According to the  
 387 Level of impact, the rating is separately defined. Such as *no effect*, 5; *involved*, 4; *mainly*, 2; *directly*, 1.  
 388 As to how the accident is described, for example, those which are described as a general accident,  
 389 the detail influence factors which result to a certain accident includes observed characters such as  
 390 "non finding in operation arrangements or process issues", "Insufficient staff training time" and  
 391 "VTS monitoring failure" (variable in Table 2). These factors effect the accident at different levels of  
 392 influence as discussed above, namely, "directly", "involved" and "no effect" respectively. That  
 393 means the score is 1, 4, 5 respectively. Each accident sample can be described by the influence factors.

394 Second, the score of the  $x_i (i=1,2,\dots,16)$  accident causal factors depends on the minimum score  
 395 among the corresponding observed characters collected. As to the case statemented above, those 3  
 396 observed characters involved "Inadequate oversight" were numerical analyse, and the lowest score  
 397 is measured as 1, which means "directly". Therefore,  $x_4$  "Inadequate oversight" is measured as 1. All  
 398 the structured observed characters in accident reports were formattted to numerical analysis data.  
 399 The tested data statistics are shown in Table 4.

## 400

Table 4 Tested data from accident database

Case No :	X1	X2	X3	X4	X5	X6	X7	X8	X9	X10	X11	X12	X13	X14	X15	X16	X17
1	5	4	4	5	1	5	1	1	1	4	2	4	1	4	4	1	3
2	4	4	5	5	5	5	5	5	1	5	2	4	1	4	4	5	5
3	4	5	5	5	4	4	4	1	1	5	4	5	1	4	4	5	4
4	4	4	4	5	5	4	5	5	5	5	4	5	4	5	5	4	4
5	5	5	4	4	5	5	4	1	1	5	5	4	1	4	5	4	4

6	4	4	5	4	5	4	4	1	1	5	2	4	1	4	5	4	4
7	4	5	4	5	5	4	5	4	5	5	5	5	5	5	4	4	4
8	5	4	5	4	5	4	5	5	1	4	2	5	1	4	4	4	5
9	5	5	5	5	1	5	1	1	1	4	5	5	1	4	5	1	3
10	5	5	5	4	1	4	1	1	1	5	4	5	1	5	4	1	3
<hr/>																	
891	4	5	4	4	5	5	5	1	1	2	4	4	1	4	4	4	2
892	4	5	4	5	5	5	5	1	1	2	5	5	1	4	5	4	2
893	4	4	4	4	1	5	1	1	1	5	2	4	1	5	5	1	1
894	4	5	5	5	1	4	1	1	1	5	4	4	1	4	5	1	1
$\mu$	4.1	4.2	4.1	4.2	4.0	4.1	2.7	2.9	2.3	4.1	3.7	4.4	2.1	4.5	4.5	4.0	4.3
$\sigma$	0.8	0.7	0.7	0.7	1.3	0.8	1.3	1.7	1.7	0.9	1.1	0.4	1.6	0.4	0.4	1.3	1.1

401 The collected accident factors were categorized according to the literature (Celik and Cebi,  
 402 2009), and finally the data was integrated into the 16 major accident factors. Thereby, a scoring of the  
 403 16 accident factors (variable in Figure 6) depends on the corresponding minimum score among the  
 404 accident factors collected.

405 In addition to the correlation of factors in different MTAs, the impact of different factors on the  
 406 consequences of the MTA is also analyzed. Therefore, the observation variable "Accident  
 407 Consequence"( $X_{17}$ ) is added to examine the influence of different factors on the consequences of  
 408 accidents.

#### 409 5.3 Model fitting and correction

410 The paths that do not conform to the SEM hypothesis are as follows: (a) the path of the error  
 411 term of the observed variable to the latent variable; (b) the path of the observed variable to other  
 412 observed variables; (c) the error term of the observed variable for other observations The path of  
 413 influence of the variable; (d) the path of the error term of the observed variable to the error term of  
 414 other observed variables.

415 When the model is changed, the researcher should add new paths one by one instead of adding  
 416 multiple paths all at once. The processed data are fitted with the hypothetical model, and modify the  
 417 model with the output of the modification indices. The resulting path dependency is shown in  
 418 Figure 5.

#### 419 5.4 Reliability analysis in path dependency

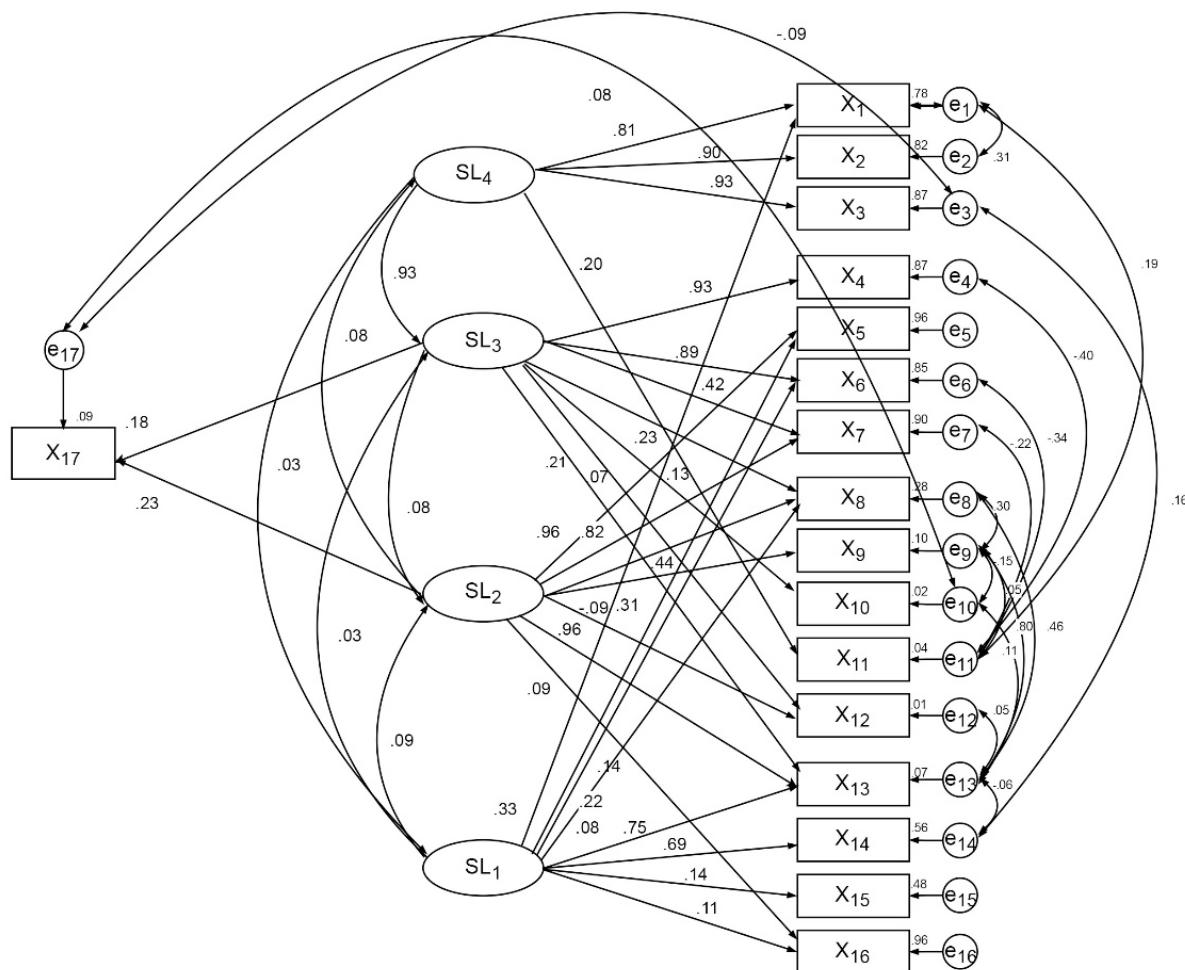
420 An analysis of the reliability of the sample data table should be performed before fitting the  
 421 sample data to the hypothetical model(Byrne, 2009). Cronbach's Alpha coefficient (CA) is a measure  
 422 of the intrinsic consistency of a set of data used to determine whether the set of data represents the  
 423 same attitude tendencies and whether it can form an attitude measurement index.

424 The Cranach's Alpha test was performed on observation variables to measure a set of  
 425 hypothetical "internal consistency" coefficients (Byrne, 2009), so as to judge whether this group of  
 426 hypotheses represents the same tendency of attitude and whether it can constitute an attitude  
 427 measurement index.

428 In general, if the CA is greater than 0.7, this indicates that the data has good reliability. When  
 429 the CA is below 0.7, the entries in the data may represent different dimensions and need to be  
 430 filtered.

431 The results show that after deleting some of the items, the check coefficient values of the  
 432 observed variables are all above 0.7, and the overall reliability value reaches 0.797, indicating that  
 433 this figure has good reliability.

434



435

436

Figure 5 Path Diagram of MTA Forming using SEM simulation

437 Data statistics are shown in Tab 4, which is shown mean and standard variation of each  
 438 variable.

439 Since the modified model used in this paper has some differences with the theory, it is  
 440 necessary to test the sensitivity of the model in order to verify whether the modified model used in  
 441 this paper is applicable to different types and sizes.

442 The critical ratio (C.R.) is used to test the significance of evaluation of the parameter in the  
 443 model (Crowley and Fan, 1997). The critical ratio is the proportion of the evaluation of the parameter  
 444 estimate to its standard deviation. When the significance level is 0.05, it means that the parameter  
 445 evaluation is not equal to 0 significantly, and the null hypothesis can be rejected if the absolute value  
 446 of C.R. is greater than 1.96. The calculation results are presented in Table 5.

447

Table 5 Statics data of critical ratio on variable

Hypothesis	Estimate value	Critical ratio	Conclusion
H1: SL <sub>3</sub> →SL <sub>4</sub>	0.944	33.727	Exist significant influences , defined hypothesis is true
H2: SL <sub>2</sub> →SL <sub>3</sub>	0.077	2.175	Exist significant influences , defined hypothesis is true
H3: SL <sub>1</sub> →SL <sub>2</sub>	0.125	2.921	Exist significant influences , defined hypothesis is true

448 The goodness-of-fit index of the amended model was shown in Table 6. From Tables 5 and 6, it  
 449 is shown that the goodness-of-fit index of the model meets the criteria, indicating that the model and  
 450 the data fit well.

451

Table 6 Statics data of variable via SEM simulation

Evaluation index	Estimate Value	Adaptation standard
<i>Absolute index</i>		
$\chi^2$ Significant probability value	0.281	>0.05
Goodness-of-fit index (GFI)	0.989	>0.90
Adjusted goodness-of-fit index (AGFI)	0.980	>0.90
Root mean square residual (RMR)	0.031	<0.05
Root mean square error of approximation (RMSEA)	0.010	<0.05
<i>Relative index</i>		
Normal fit index (NFI)	0.993	>0.90
Relative fitness index (RFI)	0.988	>0.90
Incremental fit index (IFI)	0.999	>0.90
Tracker—Lewis index (TLI)	0.999	>0.90
Comparative-fit index (CFI)	0.999	>0.90
<i>Parsimony index</i>		
Parsimony goodness-of-fit Index (PGFI)	0.552	>0.50
Parsimony-adjusted (PNFI)	0.629	>0.50
$\chi^2 / nf$ (NC) indicating the degree of minimalist fit	1.088	1<NC<3

452 It can be seen from Table 5 that the path coefficient of  $SL_4 \rightarrow SL_3$  is 0.94 and the  $t$ -check value is  
 453 33.727; the path coefficient of  $SL_3 \rightarrow SL_2$  is 0.08 and the  $t$ -check value is 2.175; the path coefficient of  
 454  $SL_2 \rightarrow SL_1$  is 0.13 and the  $t$ -check value is 2.921. These indicate that the  $H1$ ,  $H2$ , and  $H3$  hypotheses are  
 455 true and have a significant positive relationship. This proves the correctness of the HFACS-MTA  
 456 framework from a quantitative point of view.

457 *5.5 Sensitivity analysis of HFACS-MTA based on SEM model*

458 Sensitivity analysis is used to qualitatively or quantitatively analyze changes in model results  
 459 when model parameters or samples change. It classifies the collected documented cases according to  
 460 different types of accidents (such as collisions, grounding, fires, etc.), which fit different types of  
 461 accident data to the revised model of Figure 5, and carry out model analysis of the changes in the  
 462 goodness-of-fit index and estimated parameters, in order to test the reliability and stability of the  
 463 model. The post-test data prove that: although the significance level of the chi-square value obtained  
 464 by fitting the modified model with the test sample did not reach the goodness-of-fit index, other  
 465 fitness indexes met the requirements, and most of the path coefficients shown by the model were  
 466 consistent. Therefore, the modification model of the MTA cause path is stable and suitable to be  
 467 applied to samples under different conditions, and can provide guidance in those situations.

468 There are some differences between the model results and HFAC-MTA in the corresponding  
 469 relationship of the Category I factors and Category II factors, as presented in Table 7.

470

Table 7 factors correlation characters via SEM simulation

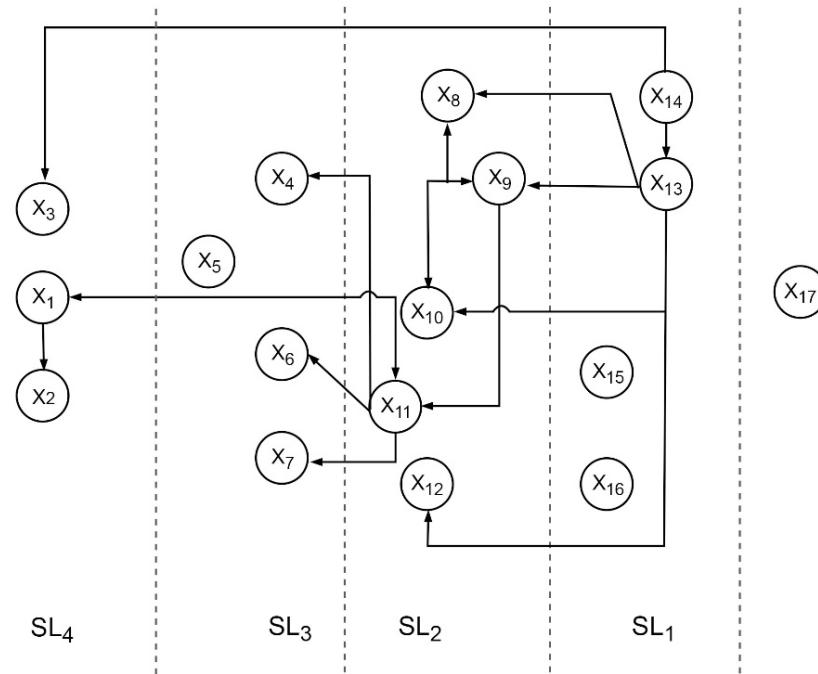
Correlation Mode			Standardized path coefficient
SL <sub>4</sub>	->	X <sub>11</sub>	0.24
SL <sub>3</sub>	->	X <sub>5</sub>	No significant effect

		X <sub>13</sub>	0.21
SL <sub>2</sub>	->	X <sub>5</sub>	0.94
		X <sub>7</sub>	0.82
SL <sub>1</sub>	->	X <sub>1</sub>	0.27
		X <sub>5</sub>	0.16
		X <sub>6</sub>	0.23
		X <sub>8</sub>	0.08
		X <sub>10</sub>	0.09

471 Table 7 shows that:

472 (1) Organizational Influences SL<sub>4</sub> are not only related to the three types of human factors in the  
473 theory, but also related to the Natural Environment.474 (2) There is no significant correlation between Unsafe Supervisions SL<sub>3</sub> and Unsuitable  
475 Execution Plan X<sub>5</sub> in HFACS theory, but there is a correlation with Slip X<sub>13</sub>.476 (3) The Preconditions for Unsafe Acts SL<sub>2</sub> are related to Unsuitable Execution Plan X<sub>5</sub> and  
477 Violation Monitoring X<sub>7</sub>.478 (4) There are correlations between Unsafe Acts SL<sub>1</sub> and Resource Management X<sub>1</sub>, Unsuitable  
479 Execution Plan X<sub>5</sub>, Error-Correction Parsing X<sub>6</sub>, Team factors X<sub>8</sub>, and Material factors X<sub>10</sub>.480 **6. Path analysis and discussion**

481 Path analysis is used to test the hypothesis relationship of observation variables or indicator  
482 variables. The purpose of path analysis is to check the accuracy and reliability of the hypothetical  
483 model and analyze the relation intensity of different variables. Figure 5 mainly shows the path  
484 diagrams of latent variables and latent variables with their corresponding observed variables.  
485 However, the relationship among observed variables cannot be obtained, and there is a correlation  
486 in measurement error items of the model. The correlation between the two measurement error items  
487 indicates that there is a certain degree of latent correlation between the corresponding two  
488 measurement variables. From this, the MTA causal system path diagram can be as shown in Figure 7  
489 (Only select the part that normalized path coefficients greater than 0.2 between Category I factors  
490 and Category II factors).

491  
492 **Figure 6 Path and trace representation of MTA network**

493 Figure 6 presents some path dependencies that may lead to accident, such as:  
494 Path dependency I (PD-I): Resource Management - Natural Environment - Individual factors -  
495 Slip;

496 Path dependency II (PD-II): Organizational Climate - Resource Management -Natural  
497 Environment - Error-correction Parsing.

498 Decision-makers can find the influence and mode of action in the causes of MTA based on these  
499 path dependencies. For example, PD-I link indicates that there is interaction between the "Resource  
500 Management" & "Natural Environment", "Natural Environment" & "Individual factors", "Individual  
501 factors" & "Slip" and these interactions eventually result in accidents.

502 

- The "Natural Environment" is the important reason for the entire accident system, and it is  
503 the key link between the previous factor and the next.
- "Resource Management" has a prominent position in the Organizational Influences level  
505 (root cause) and is highly relevant.
- "Process Safety Control" directly affects the "Slip" of human unsafe acts.

507 Therefore, the decision-maker can strengthen the control and management of the four  
508 structural factors for the causal path to avoid interaction and ultimately prevent the accident from  
509 occurring. It is also possible to intervene in only some of the key items, so as to cut off the  
510 progression of the causal path and eventually avoid the accident.

511 (1) The Organizational Influences  $SL_4$  corresponding to Category II human factors are Resource  
512 Management, Organizational Climate, Process Safety Control, and Natural Environment. Category  
513 II human factors corresponding to Unsafe Supervisions are: Error-Correction Parsing, Inadequate  
514 Oversight, Violation Monitoring, Team factors, and Slip.

515 (2) The Preconditions for Unsafe Acts  $SL_2$  corresponding to Category II human factors are  
516 Violation Monitoring, Team factors, Unsuitable Execution Plan, Individual factors, and Violation.

517 (3) The Unsafe Acts  $SL_1$  corresponding to Category II human factors are Resource Management,  
518 Error-Correction Parsing, Lapse and Mistake. Among them, Resource Management,  
519 Error-Correction Parsing, Team factors, and Violation Monitoring distribution are related to two  
520 Categories I human factors.

521 (4) Comparing the four levels of the HFACS framework, Organizational Influences  $SL_4$ ,  
522 Preconditions for Unsafe Acts  $SL_2$ , and Unsafe Acts  $SL_1$  were detected to have almost strong  
523 contributions to marine accident risks. This implies that organizational and individual factors  
524 should be emphasized instead of Unsafe Supervisions  $SL_3$  considerations. This study has further  
525 identified that the factors at the Preconditions for Unsafe Acts level are most influential to marine  
526 accident risks among all factors at the HFACS levels, and the Unsafe Supervisions level has the  
527 rather influence to marine accident consequence.

528 (5) From the path of the accident, there are simple chains, complex chains and system networks.  
529 The accident path is a simple chain described by the Domino model, Swiss cheese mode and  
530 HFACS. The Domino model considers that the accident causes the dominoes represented by each  
531 module to fall down one after another so that the accident will occur. This logic mode was clear, but  
532 the simple linear description cannot truly reflect the present nonlinear interactions of various  
533 factors under complex social technology systems. The path of the accident described by the  
534 trajectory crossover model is a complex chain, which in this model two parallel paths are proposed  
535 to lead to the accident. In the path of describing the system network about accident, via involved  
536 the thinking mode of system theory on HFACS, .it is considered that there are both hierarchical and  
537 causal relationships between the causes of accidents, and the interactions are mixed to form a  
538 network, which is closer to the real material world.

## 539 7. Conclusion

540 The formation of MTA is complex, but the degree of influence and the mode of action of factors  
541 in the cause system are different. The strength of the correlation of the factors determines the path of  
542 the accident. Example verification shows that there are different correlations of various factors in  
543 HFACS, and the observed variables manifest form conforms to the path dependency mode.

544 Resource management factors in the sub-hierarchy of Organizational Influences have a prominent  
545 position in the accident formation and a strong correlation to same.

546 (1) The HFACS-MTA generic texture hypothesis paradigm based on the SEM can develop  
547 system pathway maps between the latent (independent) variable and observed (dependent) variable  
548 , which could quantitatively study the interrelationships in the various causes. The hypothesis  
549 model application shows that the relationship of human factors in the MTA is consistent with  
550 HFACS, and the direction of human error in the MTA is in the order of Organizational Influences,  
551 Unsafe Supervisions, and Preconditions for Unsafe Acts, and finally passed on to Unsafe Acts. The  
552 mutual influences in factors of the accident causes are obviously different.

553 (2) Structural equation modeling is a powerful research tool in the field of safety sciences, but  
554 the establishment of related models relies on the knowledge of relevant scientific fields. The setting  
555 of the implicit variables of the structural equations of accident causation theory and the setting of the  
556 relationship between hidden variables have the theoretical knowledge base of the maritime field.  
557 The setting and measurement of the measured variables corresponding to the hidden variables also  
558 have their theoretical basis. The structural equation model is only a mathematical expression of the  
559 theoretical knowledge base of the relevant scientific field, and it provides a tool for us to study  
560 related safety sciences.

561 (3) We have seen that in recent times, the theory of safety-oriented causation based on system  
562 theory has greatly changed and developed the understanding of traditional accidents forming. In  
563 particular, the characteristics of safety is seen as the emergence of systems, with safety issues as a  
564 matter of control. The cause of the accident is not only to describe the components in system  
565 structure, but also to explain the interaction and coupling between the causal factors. This paper  
566 believes that a certain mathematical algorithm is used to analyze the degree of cross-linking between  
567 factors, describe the process of controlling between factors, and then determine the path of accident  
568 formation. This is a quantitative demonstration of the cheese model, revealing the path dependence  
569 of management defects in the field of marine safety affecting human behavior.

570 We also see that, to study the safety problems of the complex marine traffic system, it constructs  
571 a theoretical model of a complex system and proposes an accident cause structural hypothesis.  
572 Appropriate algorithms for the theoretical human-machine-control model can be used to  
573 understand the safety performance of marine traffic systems under different parameters through  
574 mathematical analysis. Accident databases providing manifold data unfortunately have been only  
575 measured but subjective especially in relation to the assessment of human failures and the question  
576 of how consistent is a data base remains a critical issue. Combined with big data ideas and intelligent  
577 prediction theory, it provides an important basis for risk pre-warning and accident prevention. This  
578 will be a problem that will require further research.

579 **Author Contributions:** conceptualization, H.U.S. and GU.X.; methodology, H.U.S. and XI.Y.; software, GU.X.;  
580 validation, H.U.S. and ZHANG.X.; writing—original draft preparation, LI.Z.; writing—review and editing,  
581 H.U.S and PAN.L.

582 **Acknowledgments:** This work was supported by the Shanghai International Port (Group) Co., Ltd. Technology  
583 Innovation Project (2017) (Pilot Station\_17KY-04B-31Z). And we appreciate the data support from Fujian  
584 Maritime Safety Administrator (MSA), China. We would also like to acknowledge the insight contributions  
585 from two anonymous reviewers whose thoughtful comments have helped to improve an earlier version of this  
586 paper.

587 **Conflicts of Interest:** The authors declare no conflict of interest.

## 588 **References**

- 589 1. Byrne, B. M., 2009. Structural equation modeling with AMOS: Basic concepts, applications, and  
590 programming.. *Routledge*.
- 591 2. Crowley, S. L., Fan, X., 1997. Structural equation modeling: basic concepts and applications in personality  
592 assessment research. *Journal of Personality Assessment*, 68(3), 508.

593 3. Celik, M., Er, I.D., 2007. Identifying the potential roles of design-based failures on human errors in  
594 shipboard operations. In: *7th Navigational Symposium on Marine Navigation and Safety of Sea Transportation*,  
595 20–22 June, Gdynia, Poland, pp. 617–621.

596 4. Celik, M., Cebi, S., 2009. Analytical HFACS for investigating human errors in shipping accidents. *Accident  
597 Analysis & Prevention*, 41(1), 66–75.

598 5. Chauvin, C., Lardjane, S., Morel, G., Clostermann, J. P., Langard, B., 2013. Human and organisational  
599 factors in marine accidents: analysis of collisions at sea using the HFACS. *Accident Analysis & Prevention*,  
600 59(5), 26–37.

601 6. Chen, S. T., Wall, A., Davies, P., Yang, Z., Wang, J., Chou, Y. H., 2013. A human and organisational factors  
602 (HOFs) analysis method for marine casualties using HFACS-marine accidents (HFACS-MA). *Safety  
603 Science*, 60(12), 105–114.

604 7. Chen, Z. B., Dong, ., 2013. Analysis of human factors in coal mine accidents based on HFACS. *China Safety  
605 Science Journal*, 23(7), 116–121.

606 8. Dekker, S., Cilliers, P., Hofmeyr, J.-H., 2011. The complexity of failure: Implications of complexity theory  
607 for safety investigations. *Safety Science*. 49 (6), 939–945.

608 9. Dekker, S., Pitzer, C., 2016. Examining the asymptote in safety progress: a literature review. *International  
609 Journal of Occupational Safety and Ergonomics*. 22 (1), 57–65.

610 10. Dai, T., Wang, H., 2011. The human factors analysis of marine accidents based on goal structure notion.  
611 1883–1887.

612 11. Fan, Y. X., Ming, L. U., Zhi, L. I., Pei, J. J., 2014. A review of accident modelling approaches based on  
613 factors of hazards. *China Safety Science Journal*.

614 12. Gaur, D., 2005. Human factors analysis and classification system applied to civil aircraft accidents in  
615 India. *Aviation Space & Environmental Medicine*, 76(5), 501–505.

616 13. Grant, E. , Salmon, P. M. , Stevens, N. J. , Goode, N. , & Read, G. J. . 2018. Back to the future: what do  
617 accident causation models tell us about accident prediction?. *Safety Science*,104(April 2018), 99-109.

618 14. Graziano, A., Teixeira, A. P., Soares, C. G., 2016. Classification of human errors in grounding and collision  
619 accidents using the tracer taxonomy. *Safety Science*, 86, 245–257.

620 15. Hu, S., Fang, Q., Xia, H., Xi, Y., 2007. Formal safety assessment based on relative risks model in ship  
621 navigation. *Reliability Engineering & System Safety*, 92(3), 369–377.

622 16. Hu, S., Zhang, J., 2012. Risk assessment of marine traffic safety at coastal water area. *Procedia Engineering*.  
623 45. 31–37. 10.1016/j.proeng.2012.08.116.

624 17. Hu.S, Huang, C., Deng, H., Huang, D., 2017. Markov chain model for the dynamic simulation of process  
625 risk in ship pilotage at harbor. *Journal of Harbin Engineering University*, 38(9), 1391–1398.

626 18. Huang, C., & Hu, S. 2018. Factors correlation mining on maritime accidents database using association rule  
627 learning algorithm. *Cluster Computing*(4), 1–9.

628 19. Hänninen, M., 2014. Bayesian networks for marine traffic accident prevention: benefits and challenges.  
629 *Accident Analysis & Prevention*, 73, 305–312.

630 20. Hollnagel, E., 2012. FRAM: The Functional Resonance Analysis Method: Modelling Complex  
631 Socio-Technical Systems. *Ashgate Publishing Ltd*.

632 21. Hollnagel, E., 2014. Safety-I and Safety-II: The Past and Future of Safety Management. *Ashgate Publishing  
633 Ltd*

634 22. Krulak, D. C., 2004. Human factors in maintenance: impact on aircraft mishap frequency and severity.  
635 *Aviation Space & Environmental Medicine*, 75(5), 429–432.

636 23. Jones, C., Phipps, D., & Ashcroft, D. (2018). Understanding procedural violations using safety-I and  
637 safety-II: the case of community pharmacies. *Safety Science*, 105, 114–120.

638 24. Leveson, N. G. 2004. A New Accident Model for Engineering Safer Systems. *Safety Science*, 42(4), 237–270.

639 25. Leveson, N., 2015. A systems approach to risk management through leading safety indicators. *Reliability  
640 Engineering & System Safety*. 136, 17–34.

641 26. Lyu, S., Ckh, H., Chan, A., Fkw, W., Javed, A. A., 2018. Relationships among safety climate, safety  
642 behavior, and safety outcomes for ethnic minority construction workers: *International Journal of  
643 Environmental Research & Public Health*, 15(3), 484.

644 27. Marshall, P., Hirmas, A., & Singer, M. (2018). Heinrich's pyramid and occupational safety: a statistical  
645 validation methodology. *Safety Science*,101, 180-189.

646 28. Pidgeon, N., O'Leary, M., 2000. Man-made disasters: why technology and organizations (sometimes) fail. *Safety Science*, 34(1–3), 15–30.

647 29. Reason, J.T., 2008. The Human Contribution: Unsafe Acts, Accidents and Heroic Recoveries. *Ashgate Publishing Ltd.*

648 30. Rasmussen, J. .1997. Risk management in a dynamic society: a modelling problem. *Safety Science*, 27(2), 183–213.

649 31. Rasmussen, J., 2000. Human factors in a dynamic information society: where are we heading? *Ergonomics* 43 (7), 869–879.

650 32. Salmon, P.M., Cornelissen, M., Trotter, M.J., 2012. Systems-based accident analysis methods: a comparison of Accimap, HFACS, and STAMP. *Safety Science*. 50 (4), 1158–1170.

651 33. Schröder-Hinrichs, JU., Hollnagel, E. & Baldauf, M. 2012. From Titanic to Costa Concordia: A century of lessons not learned. *WMU Journal of Maritime Affairs* (2012) 11: 151.

652 34. Seo, D. C., 2005. An explicative model of unsafe work behavior. *Safety Science*, 43(3), 187–211.

653 35. Seo, H. C., Lee, Y. S., Kim, J. J., Jee, N. Y., 2015. Analyzing safety behaviors of temporary construction workers using structural equation modeling. *Safety Science*, 77, 160–168.

654 36. Shappell S A , Wiegmann D A .1997. A Human Error Approach to Accident Investigation: The Taxonomy of Unsafe Operations. *The International Journal of Aviation Psychology*, 1997, 7(4):269–291.

655 37. Shappell, S. A., Wiegmann, D. A., 2000. The human factors analysis and classification system-HFACS. *American Libraries*, 1(1), 20–46.

656 38. Shappell, S., Detwiler, C., Holcomb, K., Hackworth, C., Boquet, A., Wiegmann, D. A., 2007. Human error and commercial aviation accidents: an analysis using the human factors analysis and classification system. *Human Factors*, 49(2), 227–242.

657 39. Sobieski J S, 2006. Integrated system-of-system synthesis. *11th AIAA/ISSMO Multi-Disciplinary Analysis and Optimization Conference*, 6–8.

658 40. Sotirialis, P., Ventikos, N. P., Hamann, R., Golyshev, P., Teixeira, A. P., 2016. Incorporation of human factors into ship collision risk models focusing on human centred design aspects. *Reliability Engineering & System Safety*, 156, 210–227.

659 41. Wiegmann, D. A., Shappell, S. A., 2001. Human error analysis of commercial aviation accidents: application of the human factors analysis and classification system (HFACS). *Aviation Space & Environmental Medicine*, 72(11), 1006.

660 42. Wang, H., Jiang, H., Yin, L., 2013. Cause mechanism study to human factors in marine accidents: towards a complex system brittleness analysis approach. *Procedia - Social and Behavioral Sciences*, 96, 723–727.

661 43. Wu, B., Yan, X., Wang, Y., Soares, C. G., 2017. An evidential reasoning based CREAM to human reliability analysis in marine accident process. *Risk Analysis*.

662 44. Xi, Y. T., Yang, Z. L., Fang, Q. G., Chen, W. J., Wang, J., 2017. A new hybrid approach to human error probability quantification–applications in maritime operations. *Ocean Engineering*, 138, 45–54.

663 45. Yang, Z. L. , Wang, J. , & Li, K. X. . (2013). Maritime safety analysis in retrospect. *Maritime Policy & Management*, 40(3), 261–277.

664 46. Yang, Z. L., Bonsall, S., Wall, A., Wang, J., Usman, M., 2013. A modified CREAM to human reliability quantification in marine engineering. *Ocean Engineering*, 58(1), 293–303.

665 47. Zhang, Y., Shao, W., Zhang, M., Li, H., Yin, S., Xu, Y., 2016. Analysis 320 coal mine accidents using structural equation modeling with unsafe conditions of the rules and regulations as exogenous variables. *Accident Analysis & Prevention*, 92, 189–201.

666 688