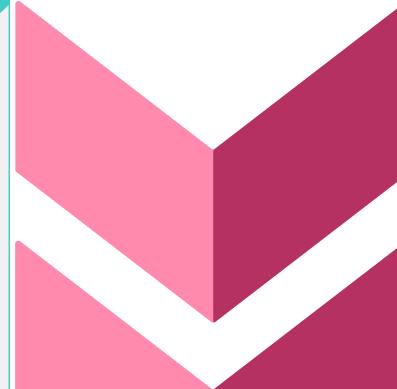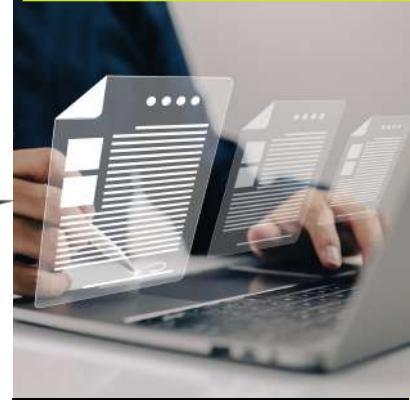# 5 Common SMS Mistakes and **How to Avoid Them**

How to Build a Simplified SMS for the Modern Maritime Company: A Practical Guide from Compliance to Culture

KEEP iT SIMPLE

SAFETY MANAGEMENT SYSTEM

SMART

# Introduction

**Safety Management Systems were created to improve safety — yet too often they become complex, bureaucratic, and ineffective. Instead of helping crews, they create an illusion of safety built on paperwork.**

This guide reveals the 5 most common SMS mistakes and shows how to avoid them. More importantly, it provides a clear path to building a simplified, practical, and effective SMS that supports real safety, engaged crews, and compliant operations.

## 01 The "Paper Tiger" SMS

- The Safety Paradox: Why complexity decreases safety
- Purpose of this guide: from compliance → real safety culture

## 02 The "Spaghetti SMS"

- Symptoms: tick-box mentality, gap between procedures and practice
- How to Avoid It: safety leadership, link safety to business goals, foster safety culture

## 03 The Isolated Crew

- Symptoms: no feedback, low motivation, blame culture
- Root Causes: top-down approach, undervaluing seafarer expertise
- How to Avoid It: Human-Centered Design, feedback loops, risk assessment workshops, Just Culture

## 04 Risk & Accident Analysis

- Symptoms: template risk assessments, blaming "human error"
- Root Causes: lack of tools (RCA, HFACS), blame culture
- How to Avoid It: Swiss Cheese Model, HFACS, treat "human error" as a symptom, train investigato

## 05 Ineffective Documentation

- Symptoms: outdated documents, missing records, version chaos
- Root Causes: bloated SMS, weak accountability, compliance mentality
- How to Avoid It: digitization (DMS, PMS), link maintenance to risk, internal audits focused on effectiveness

# The "Paper Tiger" SMS

# The "Paper Tiger" SMS

## THE PROBLEM: COMPLIANCE WITHOUT SAFETY

The most destructive mistake in maritime safety management is reducing the SMS to a bureaucratic exercise. On paper, the company looks safe: thick manuals, dozens of forms, complete binders ready for audits. In practice, however, this system is a "Paper Tiger" — strong in appearance but powerless in reality.

Crews quickly recognize when procedures are created only for inspections. They learn to "play the game" — ticking boxes, signing forms, preparing ships for audits — while in daily operations, real safety practices drift away from the documented system. This gap creates the illusion of safety, which is far more dangerous than openly acknowledging risk.

## SYMPTOMS OF A PAPER TIGER SMS

You can recognize this problem by observing how people use the system on board:

- Tick-box mentality: Checklists are filled in after tasks are completed, or worse, filled without verification, just to "have the paperwork ready."
- Disconnect between procedures and practice: Crew follow their own methods, because procedures are unrealistic, outdated, or impractical.
- Lack of management commitment: Senior managers rarely talk about safety unless an audit is coming.
- Safety is not part of daily dialogue: On board, conversations about safety sound formal, staged, or absent altogether.

When SMS paperwork becomes more important than SMS practice, accidents are only a matter of time.

# The "Paper Tiger" SMS

## ROOT CAUSES

Why do companies fall into this trap?

1. **Viewing SMS as a cost, not an investment -** *Many managers focus on minimum compliance. They see SMS only as something "you must have" to pass audits and avoid detentions. They miss the fact that an effective SMS reduces accidents, downtime, and insurance costs.*
2. **Weak leadership example -** *When management doesn't actively participate in safety discussions, the crew receives a clear message: safety is not really valued.*
3. **Bureaucratic safety culture -** *Safety meetings are focused on paperwork, not risks. Reporting near misses is seen as extra work instead of a tool for learning.*
4. **Fear-driven mentality -** *The organization cares about "what auditors think" rather than "how safe our people are." This leads to systems designed for inspections, not for reality.*

## HOW TO AVOID THE PAPER TIGER TRAP

**1. Active Leadership from the Top**
- Senior managers must visit ships, talk to crews, and participate in safety reviews.
- Allocate proper resources: budget for training, time for drills, and support for improvements.
- Make it visible: leadership presence is the most powerful message.

**2. Link Safety to Business Success**
- Demonstrate how reducing incidents saves costs and improves reputation with clients and charterers.
- Include safety KPIs (e.g., reporting rate, incident reduction, audit findings) in management reviews alongside financial results.

**3. Promote a Genuine Safety Culture**
- Encourage open communication: mistakes and near misses should be shared without fear of blame.
- Recognize and reward proactive safety actions, not just compliance with paperwork.
- Turn safety into a daily conversation — short briefings, toolbox talks, informal reminders.

**4. Simplify the System**
- Remove procedures no one uses or understands.
- Focus on clarity and usability, not volume.
- Teach crew that the SMS is a support tool, not an obstacle.

"Safety is not in the paperwork.
It's in the actions
of people who
believe in it."

# Procedural Overload: The "Spaghetti SMS"

# Procedural Overload: The "Spaghetti SMS"

## THE PROBLEM: WHEN MORE MEANS LESS

In many companies, every audit finding, every minor incident, and every new regulation triggers the same reaction: "Add another procedure." Over time, the SMS grows into a monster — hundreds of pages long, filled with cross-references, appendices, and forms.

Instead of guiding crews, the system confuses them. This is the "Spaghetti SMS": tangled, heavy, and almost impossible to navigate. Ironically, the attempt to cover every possible risk in writing often creates new risks, because the crew can't find or follow the right procedure when it matters.

---

## SYMPTOMS OF PROCEDURAL OVERLOAD

A company suffering from "Spaghetti SMS" usually shows:
- Excessive documentation: manuals with hundreds of pages that nobody fully reads.
- Illogical structure: information for one task is scattered across multiple chapters, appendices, and checklists.
- Overcomplicated language: passive voice, legal jargon, and filler words make texts hard to understand.
- Confusion between checklists and procedures: checklists become instruction manuals, procedures remain vague, and neither really helps the crew.

When the SMS is too big to use, people stop using it.

# Procedural Overload: The "Spaghetti SMS"

## ROOT CAUSES

Why do companies fall into this trap?

1. **Reactive content growth** - *Instead of reviewing and updating, companies add more and more material "just in case."*
2. **Lack of editorial strategy -** *No rules for how procedures should be written, structured, or simplified. Every contributor writes in their own style.*
3. **Fear of removing content -** *Managers worry that deleting procedures will look like non-compliance during audits, so outdated and redundant material stays forever.*
4. **Audit-focused mindset -** *Documentation is designed to impress auditors, not to support seafarers.*

## HOW TO AVOID PROCEDURAL OVERLOAD

**1. Restructure the System Around Workflows**
- Organize procedures in the same sequence as operations happen on board.
- Put all steps for one activity (e.g., departure) in one place, not scattered across multiple documents.
- Avoid abstract categories like "Resources" or "General Operations" that don't reflect daily work.

**2. Apply "Text Washing"**
- Use simple, active voice: "*The Master checks the charts*" instead of "*Charts are checked by the Master.*"
- Eliminate jargon, formalistic phrases, and unnecessary words.
- Make text scannable with bullet points, headings, and bold key terms.

**3. Define Clear Roles for Documents**
- Procedures: detailed instructions for reference and training.
- Checklists: short verification tools with links to procedures.
- Never let one replace the other.

**4. Establish a Content Review Cycle**
- Every new procedure added must trigger a review of existing ones.
- Outdated, duplicated, or unused content must be deleted without fear.

# Example: **A Maritime Case**

**Once a large maritime operator realized their SMS had become too complex, here's how they approached simplification:**

**EXAMPLE**

**STEP 01**

**Identify the Problem**
The company discovered that its navigation procedures had expanded to nearly 100,000 words — overwhelming for crews and rarely used in practice.

**STEP 02**

**Restructure and Simplify**
They launched a project to restructure content into clear workflows, cutting duplication and removing unnecessary text.

**STEP 03**

**Test and Implement**
After simplification, the documentation was reduced by half and tested with crews, who confirmed it was now clear, practical, and easy to follow.

## LESS IS MORE. SIMPLICITY BUILDS STRONGER SAFETY CULTURE.

Simplification does not mean lowering safety standards. In fact, cutting unnecessary words and overly complex procedures strengthens the system. When crews can easily read, understand, and follow the SMS, safety becomes real instead of remaining a theory in binders.

A shorter, clearer SMS reduces confusion, eliminates duplication, and gives seafarers exactly what they need at the moment they need it. The result is fewer mistakes, stronger compliance, and better confidence during operations.

**The lesson is simple:** every page removed makes the system lighter, sharper, and closer to its true purpose — protecting people, ships, and the environment.
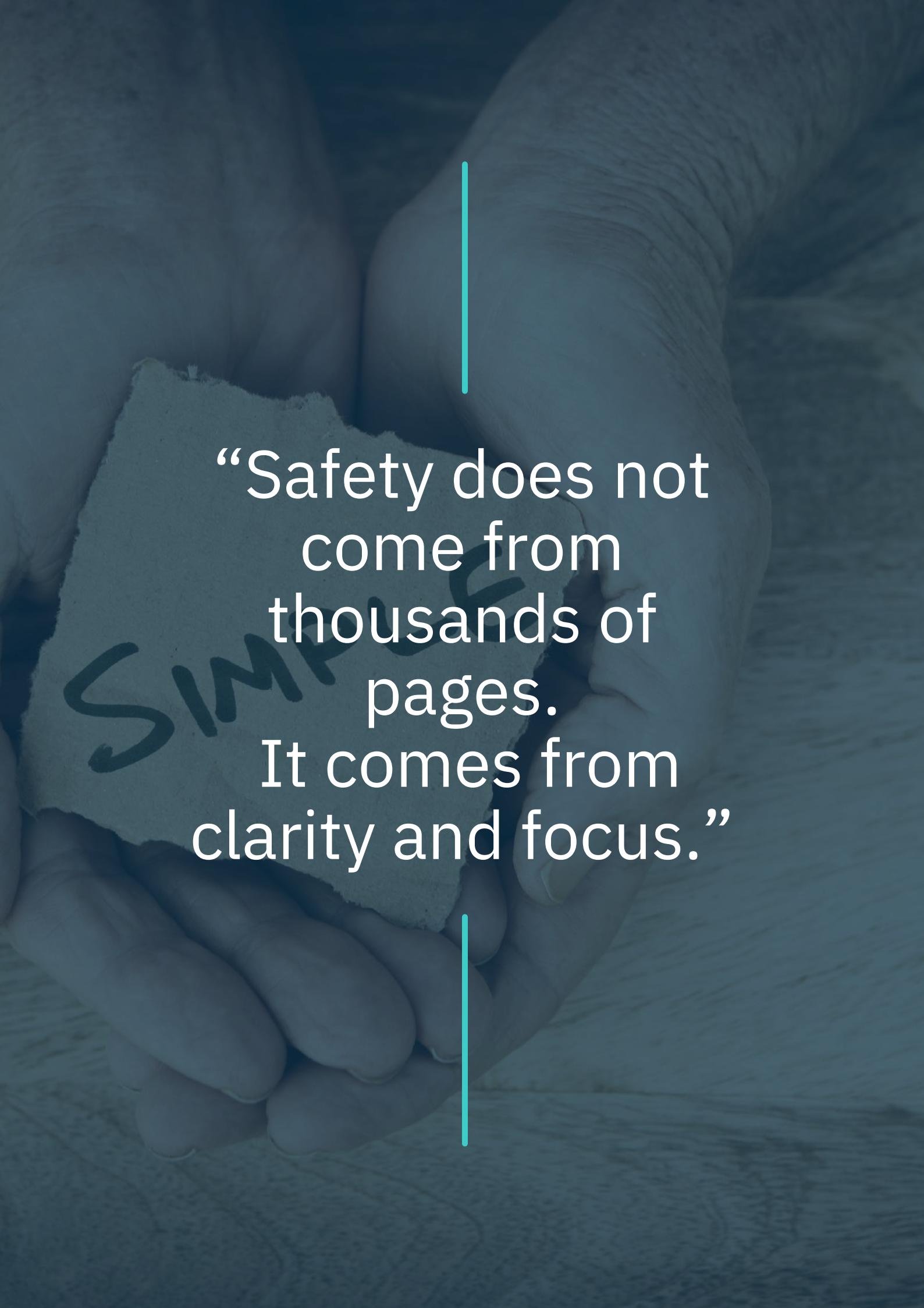
"Safety does not come from thousands of pages.
It comes from clarity and focus."
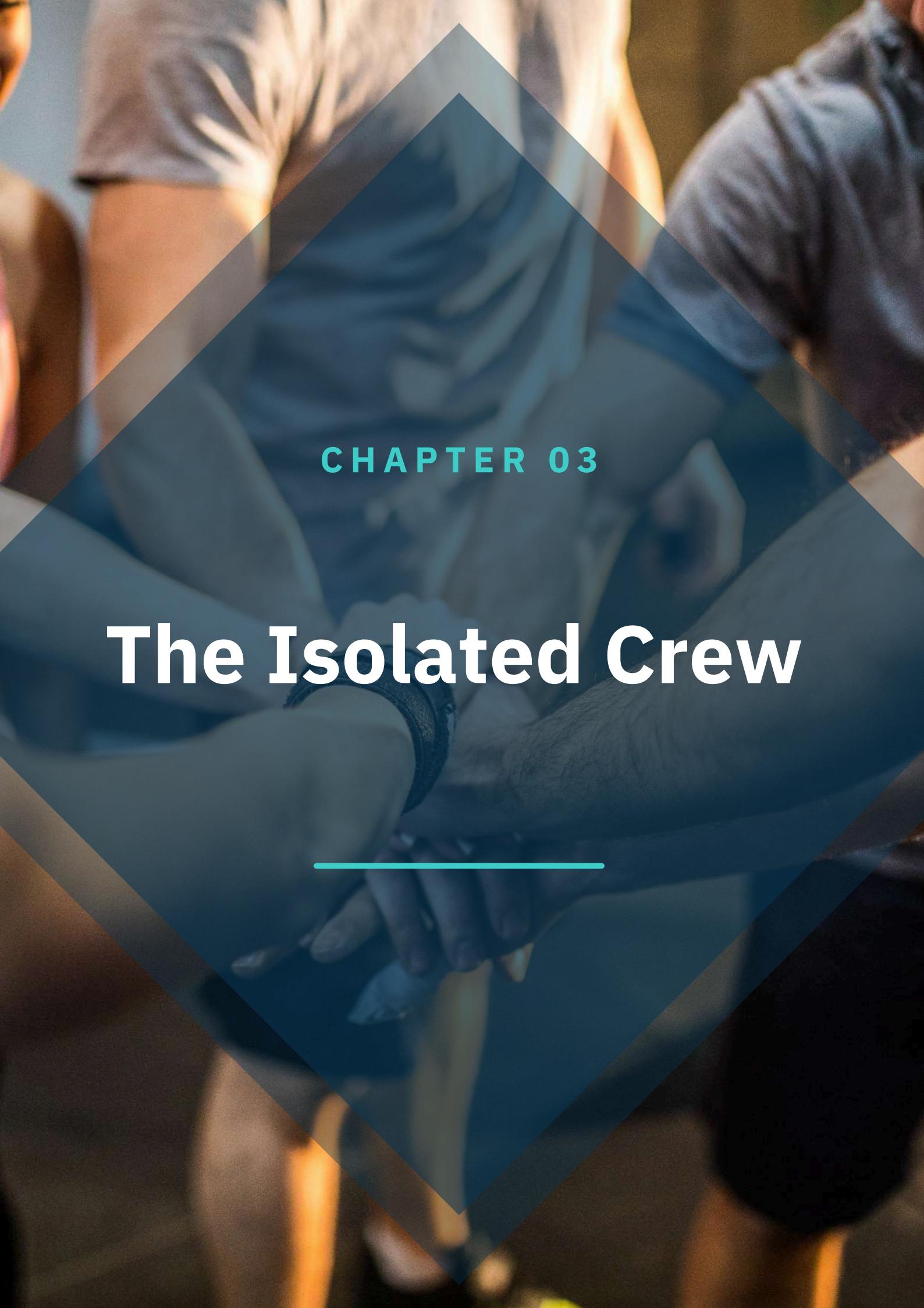
# The Isolated Crew

# The Isolated Crew

## A SYSTEM WITHOUT ITS USERS

A Safety Management System created only in the office is destined to fail. When procedures are written by shore staff and handed down to ships without input from seafarers, the result is predictable: documents that are impractical, ignored, and often bypassed.

The people who use the SMS daily — the crew — are rarely asked for feedback. As a result, they see the system as "management's rules" rather than our system. This lack of ownership kills motivation and makes the SMS an obstacle rather than a tool for safe work.

## SYMPTOMS OF AN ISOLATED CREW

- **No consultation channels** – procedures arrive ready-made from the office, with no chance for crew input.
- **Low engagement** – seafarers comply only when forced, treating SMS as paperwork, not guidance.
- **Blame culture** – mistakes are pinned on individuals instead of being seen as system flaws.
- **Silent feedback loop** – near misses and practical issues are not reported, because "nothing will change."

## ROOT CAUSES



An SMS without the crew is like a ship without its engines — it exists, but it cannot move.

**Top-down management style**
- Hierarchical structures discourage open communication and give little value to operational expertise.

**Undervaluing seafarer knowledge**
- Office staff forget that those at sea are the true experts in daily operations.

**Fear of speaking up**
- In a blame culture, reporting a mistake feels dangerous. Silence becomes the safe option.

**Separation of office and shipboard realities**
- Procedures reflect theoretical requirements, not practical conditions on board.

# How to Avoid **Crew Isolation**

## ✓ APPLY HUMAN-CENTERED DESIGN (HCD)

- Involve seafarers in procedure design, testing, and improvement.
- Use workshops and onboard sessions to co-create workflows.

## ✓ CREATE REAL FEEDBACK LOOPS

- Provide simple channels: dedicated email, onboard forms, or digital apps.
- Most importantly: act on feedback. Show the crew that their input leads to real changes.

## ✓ ENGAGE CREW IN RISK ASSESSMENT

- Run risk workshops with officers and ratings.
- Capture the real hazards they face — far more valuable than templates written ashore.

## ✓ BUILD A JUST CULTURE

- Distinguish between mistakes and willful violations.
- Promote incident reporting as a learning opportunity, not as a blame exercise.



### PRACTICAL EXAMPLE

A medium-sized shipping company noticed poor crew engagement with their SMS.

They introduced monthly "Safety Dialogues" via video calls where masters and officers could directly share concerns with the DPA. Within six months, near-miss reports doubled, and procedure updates were made based on crew feedback. Morale improved, and internal audits showed a system that reflected real operations, not just office theory.

**ATTENTION! IMPORTANT** *If the crew doesn't own the SMS, the SMS doesn't work.*
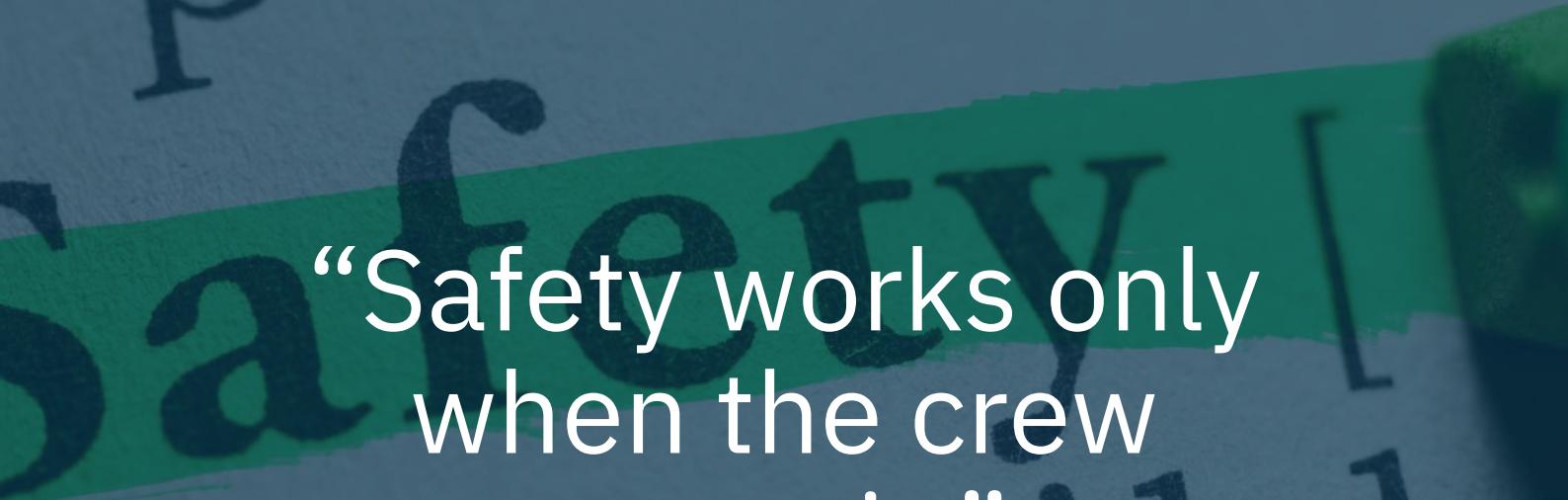
"Safety works only when the crew owns it."
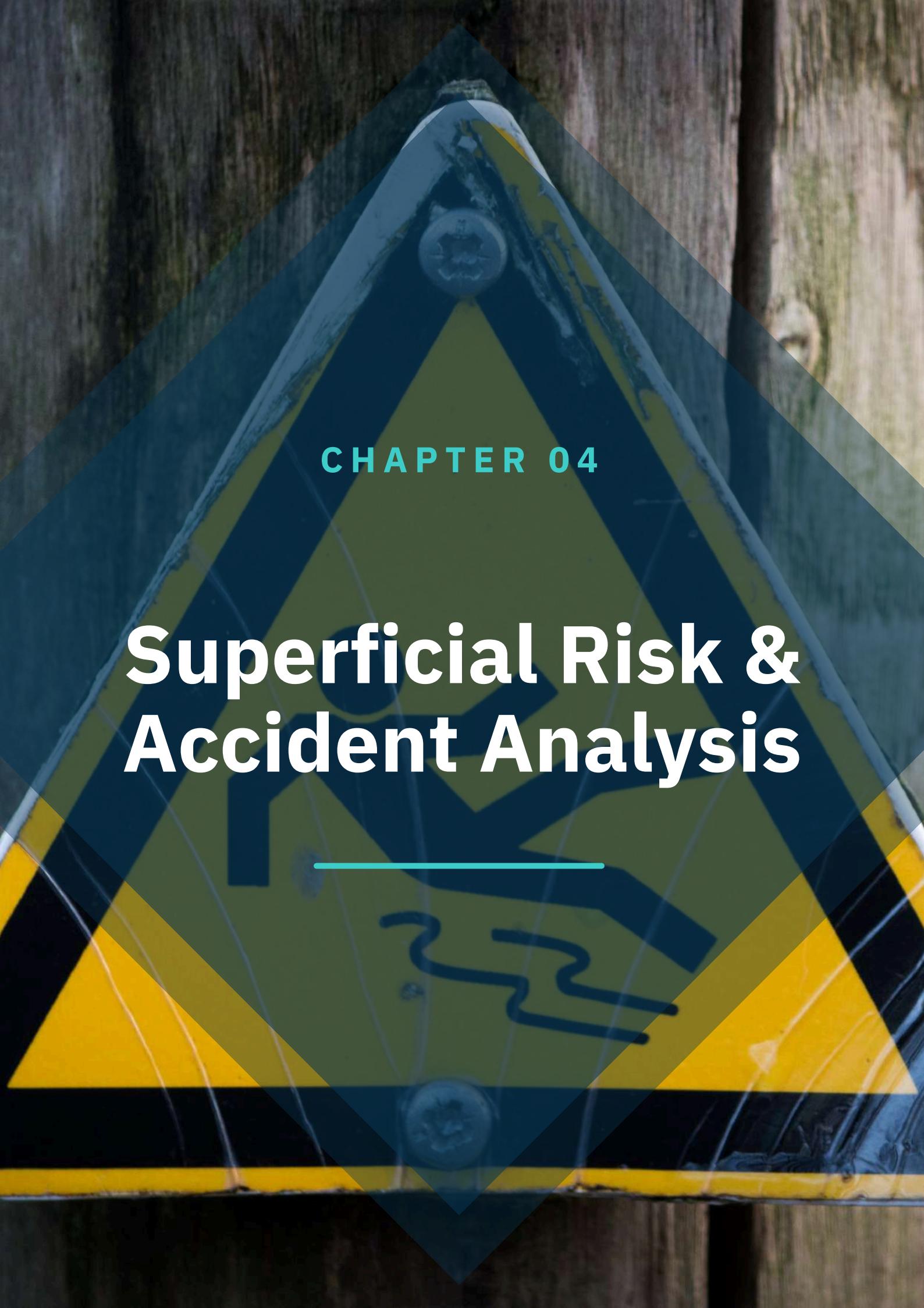
# Superficial Risk & Accident Analysis

# Superficial Risk & Accident Analysis

## STOPPING AT "*HUMAN ERROR*"

Many companies try to learn from mistakes, but their approach to risk assessment and accident investigation is shallow. Too often, the conclusion of an investigation is: "Cause: human error."

This answer feels quick and simple, but it is dangerously misleading. It closes the door to deeper questions: Why did the officer make that mistake? Was he fatigued? Was the procedure confusing? Was there commercial pressure? By blaming the individual, the company avoids responsibility for fixing systemic flaws — guaranteeing that the same error will happen again.

## SYMPTOMS OF SUPERFICIAL ANALYSIS

- **Generic risk assessments** – copied, outdated, and disconnected from real operations.
- **"Human error"** as the root cause – investigations end with blame, not understanding.
- **Template-driven reports** – repetitive, lacking depth, and with no corrective value.
- **Missed opportunities** – near misses ignored or filed away without systemic learning.

## ROOT CAUSES

**Lack of knowledge and tools**
- Staff are not trained in structured root cause analysis methods like MSCAT, HFACS or the Swiss Cheese model.
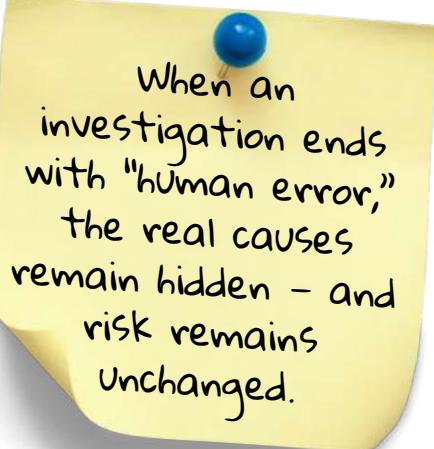
**Blame culture**
- It is easier to point at one person than to admit flaws in company policy, procedures, or leadership.

**Time and resource pressure**
- Investigations are rushed to "close the case" instead of digging deeper.

**Tick-box mentality**
- Risk assessments are created to satisfy auditors, not to guide safe operations.

When an investigation ends with "human error," the real causes remain hidden — and risk remains unchanged.

# How to Avoid
# **Superficial Analysis**

## ✓ TREAT HUMAN ERROR AS A SYMPTOM

- Involve seafarers in procedure design, testing, and improvement.
- Use workshops and onboard sessions to co-create workflows.

## ✓ MAKE RISK ASSESSMENT DYNAMIC

- Distinguish between mistakes and willful violations.
- Promote incident reporting as a learning opportunity, not as a blame exercise.

## ✓ TRAIN INVESTIGATORS

- Distinguish between mistakes and willful violations.
- Promote incident reporting as a learning opportunity, not as a blame exercise.

## ✓ APPLY THE SWISS CHEESE MODEL

- Provide simple channels: dedicated email, onboard forms, or digital apps.
- Most importantly: act on feedback. Show the crew that their input leads to real changes.

## ✓ USE HFACS (HUMAN FACTORS ANALYSIS AND CLASSIFICATION SYSTEM)

- Run risk workshops with officers and ratings.
- Capture the real hazards they face — far more valuable than templates written ashore.

> **!** *Human error is not the cause — it is the consequence of a weak system.*

A tanker operator investigated a grounding incident. The initial conclusion was "navigational error by officer of the watch." However, a deeper HFACS-based analysis revealed multiple contributing factors: fatigue after 6 hours on watch, unclear wording in the passage plan, and commercial pressure to maintain schedule. Corrective actions included rest management, clearer procedures, and adjusted schedules. The company prevented repeat incidents not by blaming one officer, but by fixing the system.
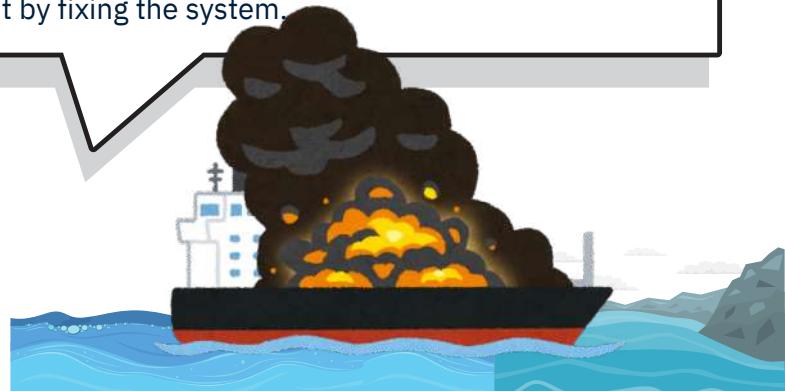
"Human error is not the cause. It is the symptom of a failing system."

# Ineffective Documentation & Maintenance Management

# Ineffective Documentation & Maintenance Management

## WHEN RECORDS FAIL, SAFETY FAILS

Documentation and maintenance records are the backbone of any SMS. They prove compliance, demonstrate readiness for audits, and guide crews in daily operations. Yet in many companies, documentation becomes outdated, inconsistent, or incomplete.

When drills, maintenance checks, or safety meetings are missing from records — or when multiple versions of the same procedure circulate — the system quickly loses credibility. Inspectors see this as a red flag, and crews lose trust in the SMS. Poor documentation is not just an administrative weakness; it is a warning signal of a deeper cultural and operational problem.

## SYMPTOMS OF SUPERFICIAL ANALYSIS

- **Version chaos –** outdated procedures still on board, multiple versions in use.
- **Incomplete records –** missing drill logs, training certificates, or PMS updates.
- **Outdated forms –** checklists that don't reflect current requirements.
- **Disconnection from risk –** maintenance plans treat all equipment equally, ignoring what is critical for safety.

## ROOT CAUSES

**Administrative overload**
- too much paperwork generated by bloated systems.
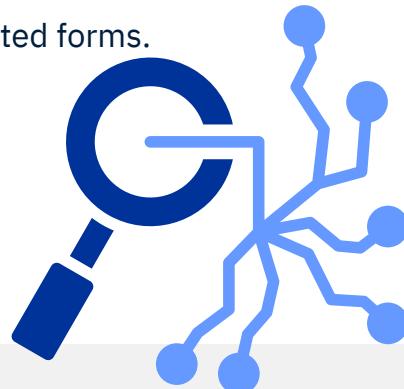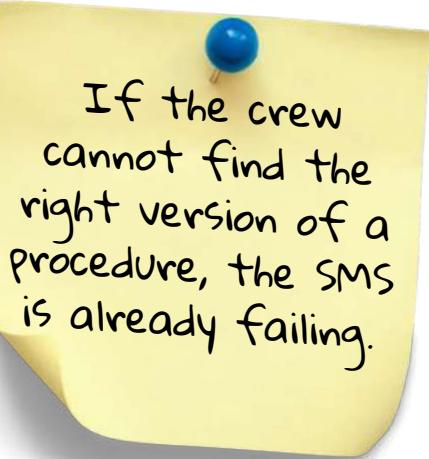
**Unclear responsibility**
- no one clearly accountable for updates and distribution.

**Compliance-only mentality**
- records created "for the audit" rather than as real tools.

**Weak feedback culture**
- crews don't report impractical or outdated forms.

*If the crew cannot find the right version of a procedure, the SMS is already failing.*

# How to Avoid Documentation & Maintenance Failures

## ✓ USE INTERNAL AUDITS AS HEALTH CHECKS

- Treat documentation consistency as a key indicator of overall SMS health.
- Go beyond compliance: ask whether the documents help the crew or only serve inspectors.

## ✓ INTEGRATE PMS WITH RISK ASSESSMENT

- Prioritize maintenance of critical equipment: steering gear, main engine, firefighting systems.
- Link maintenance schedules to risk impact, not just manufacturer intervals.

## ✓ CLARIFY RESPONSIBILITIES

- Assign clear owners for each document and system (e.g., Chief Engineer for PMS, Master for SMS checklists).
- Regularly audit not only if documents exist, but whether they are current and usable

## ✓ DIGITIZE DOCUMENT MANAGEMENT

- Implement a Document Management System (DMS).
- Ensure only the latest version is accessible on board.
- Track crew acknowledgements of updated procedures.

A shipping company experienced repeated PSC detentions for outdated manuals on board. Instead of adding more paperwork, they introduced a digital DMS and linked it to their PMS. Now, every crew member receives updates automatically, and maintenance priorities are tied directly to risk assessment. Within one year, detentions dropped to zero, and crews reported higher trust in the system.

*Weak documentation is a symptom of deeper SMS issues. By digitizing systems, linking maintenance to risk, and assigning clear responsibility, companies can transform documentation from a burden into a tool for safety and efficiency.*
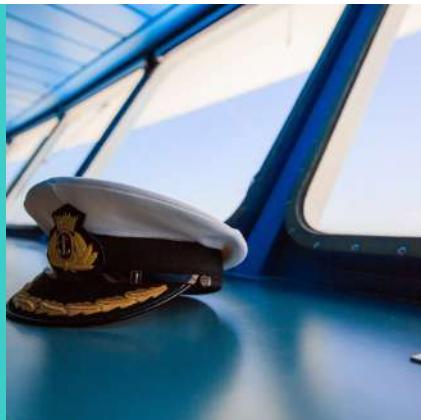
"Outdated documents are more dangerous than no documents at all."

# 5 Keys to an
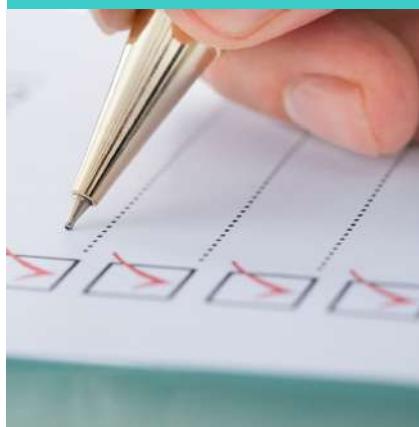# Effective and Simplified SMS

**IMPORTANT**

## Leadership Commitment

*Safety must start at the top.*

## Crew Engagement

*Without crew voices, SMS is meaningless.*

## Simplicity & Clarity

*Procedures must be short, clear, and practical.*

## Learning Culture

*Human error is a signal, not a cause.*

## Living Documentation

*Documents must be current, digital, and linked to risk.*

*An effective SMS is not about more paperwork — it's about clarity, engagement, and continuous improvement*

# Get In Touch

At **Deep Bridge Maritime Consulting**, we help shipowners and operators strengthen their safety culture and compliance.

**Our services include:**

⚓ Onboard Audits – navigation, mooring, cargo, ballast, bunkering, and vetting pre-inspections.

📝 SMS Development & Simplification – building systems that are clear, practical, and compliant.

🧭 Training & Support – workshops for crews and management to embed a safety culture.

Let's discuss how we can support your fleet.

**Captain Patryk Solarski**

📞 **+34 672 94 68 04**

✉️ **office@db-maritime.com**

🌐 **www.db-maritime.com**