

IMCA Safety Flash 17/16

June 2016

These flashes summarise key safety matters and incidents, allowing wider dissemination of lessons learnt from them. The information below has been provided in good faith by members and should be reviewed individually by recipients, who will determine its relevance to their own operations.

The effectiveness of the IMCA safety flash system depends on receiving reports from members in order to pass on information and avoid repeat incidents. Please consider adding the IMCA secretariat (imca@imca-int.com) to your internal distribution list for safety alerts and/or manually submitting information on specific incidents you consider may be relevant. All information will be anonymised or sanitised, as appropriate.

A number of other organisations issue safety flashes and similar documents which may be of interest to IMCA members. Where these are particularly relevant, these may be summarised or highlighted here. Links to known relevant websites are provided at www.imca-int.com/links. Additional links should be submitted to webmaster@imca-int.com

Any actions, lessons learnt, recommendations and suggestions in IMCA safety flashes are generated by the submitting organisation. IMCA safety flashes provide, in good faith, safety information for the benefit of members and do not necessarily constitute IMCA guidance, nor represent the official view of the Association or its members.

Summary

The incidents in this safety flash cover maritime safety and seamanship, whether movement of cargo in heavy seas, collision avoidance, or mooring.

The sixth incident is a product awareness alert relating to certain orange smoke signal flares.

1 Near Miss: Cargo Shifted in Heavy Seas Whilst Alongside Platform

A member has reported an incident in which there was an unplanned movement of freight containers on a platform supply vessel. The incident occurred during rough weather whilst the vessel was engaged in deck cargo and fuel transfer alongside a platform. The vessel, which was positioned down-wind and with starboard stern quarter to weather, was hit by a sudden and unexpected squall. The vessel was designed with a low bulwark.

The weather and sea conditions at the time of the incident were wind 25 knots, swell 3m. One larger squall wave hit the stern and flooded the back deck. The water shifted one container and overturned another. The back-loaded containers had not yet been secured due to on-going back-loading.

There were no injuries, no spills, and no external damage to the containers.



Our member noted that this near miss incident was potentially very serious, and the incident has been treated as a potential fatality. The following lessons were learnt:

- ◆ The risk of abnormal waves should be taken into consideration in risk assessment and tool box talks for work, particularly when the vessel is positioned stern to weather;
- ◆ Greater emphasis should be placed on the 'stop work policy' – anyone should be able to stop the job, any time, when in doubt;
- ◆ A new and higher bulwark will be fitted to this and similar vessels working in these waters.

Members may wish to refer to the following incident (search words: *cargo, shifted*):

- ♦ [IMCA SF 21/15](#) – Incident 3 – *Fatality during loading operations* – Members will note that this earlier incident is almost the same but unfortunately resulted in a fatality.

2 Mooring Rope Fouled the Propeller and Parted

A member has reported an incident in which mooring ropes were slacked more than required resulting in a fouled propeller. The incident occurred during berthing operations when the engines were being used. The fouled lines became taut and parted. Fortunately, the recoil was vertically up and down, as the angle was 90 degrees, straight down from the universal leads to the propeller. The men on stations were standing in the snapback zone, but the near vertical whiplash missed them.

The propeller was fouled – there were damaged rope guards and mooring ropes. The vessel had to come off-hire for repairs (fortunately the stern tube seal was not damaged).



Propeller is almost above the universal leads

Our member's findings included the following:

- ♦ Crew were using appropriate personal protective equipment (PPE) for the task;
- ♦ The immediate cause of the incident was excessive slackening of the ropes when the propeller was turning;
- ♦ Causal factors included:
 - lack of situational awareness and inadequate understanding of the physical constraints of the ship as the leads being almost directly above the propeller
 - ineffective communication between bridge and mooring station
 - bridge issuing orders to slack when the propeller was turning
 - mooring stations obeying the instructions without checking propeller clearance and/or warning the bridge
 - excessive line laid out on deck which ran out to foul the propeller
 - there was no risk assessment carried out for this mooring operation
 - there was no safety briefing and no tool box talk carried out
 - there was inadequate supervision;
- ♦ The root causes were found to be:
 - inadequate understanding of risks involved
 - lack of situational awareness of the surroundings.

Our member took the following preventative actions:

- ♦ Ensure proper risk assessment carried out for mooring operations;

- ◆ Ensure safety briefing and toolbox talk conducted by the person in charge, ensuring that all crew involved in the mooring operation know the risks and actions to prevent incidents;
- ◆ Vessel joiners should be properly briefed on ship-specific tasks and constraints;
- ◆ Ensure more effective communication between bridge and mooring stations to include warnings as to prevent such incidents;
- ◆ Person in charge to take extra precautions and ensure they supervise the area and task properly;
- ◆ Re-train crew on hazards and dangers involved in mooring operations;
- ◆ Entire mooring deck area should be considered a potential snap-back zone. All crew working on a mooring deck should be made aware of this with clear visible signage.

Members may wish to refer to the following:

- ◆ [IMCA SF 04/09](#) – Incident 3 – *Understanding mooring incidents* – from the UK P&I Club;
- ◆ [IMCA SEL 038](#) – *Mooring Incidents* – video;
- ◆ [IMCA SPP 12](#) – *Mooring safety* – safety poster;
- ◆ [IMCA SEL 029](#) – *Mooring practice safety guidance for offshore vessels when alongside in ports and harbours*.

3 Collision Whilst Drifting

A member has reported an incident in which their vessel collided with a fishing vessel. The vessel was waiting for pilots to arrive to take her into port, and was drifting in an area around 12 nautical miles away from the port. Her main engine was on standby for immediate use. Navigational watch was maintained with duty officer (second officer) and an additional lookout on the bridge. Weather conditions were reported as good. Duty lookout reported three times to the duty officer that a fishing vessel was coming closer to vessel. Each time the duty officer acknowledged the duty lookout. Nevertheless, the fishing vessel and our members' vessel collided. Around 18m of scratch damage was observed on the starboard side aft – no dents were found. There were no injuries to either crew.

Our member's findings were as follows:

- ◆ Their own vessel failed to act in accordance with COLREGS 1972, and Master's standing orders;
- ◆ The duty officer failed to take action when duty lookout sounded of the approaching fishing vessel;
- ◆ There was a failure to use main engine to avoid contact with the closing fishing vessel;
- ◆ The duty officer was engaged in handing over watch to his reliever;
- ◆ Work and rest hours were in compliance with company requirements.

Our member noted that as well as minor damage to the vessel there was significant reputational damage to the company.

The following causes were identified:

- ◆ The vessel was not acting in accordance with COLREGS;
- ◆ Poor seamanship;
- ◆ The duty officer acknowledged lookout's repeated warning of the closing in fishing vessel but no action was taken;
- ◆ Management Factors - Inadequate planning/communication
 - ineffective risk assessment of the drift position
 - Master's Standing Orders not followed
 - Master was not informed of the closing in fishing vessel.

Preventative measures:

- ◆ COLREGS should be followed;
- ◆ Drifting should be considered in the same way as being under way;
- ◆ Handing over watch should be deferred if safety of navigation is affected;
- ◆ Duty officer should not be engaged in any other work which could interfere with safe navigation;
- ◆ Approaching vessels should be monitored by all available means to ensure they pass at a safe distance.

Members may wish to refer to the following incidents (search word: *collision*):

- ◆ [IMCA SF 10/16](#) – Incident 1 – *Vessel in collision with floating dock*;
- ◆ [IMCA SF 12/15](#) – Incident 3 – *Collision between crew boat and anchored barge*.

4 Platform Supply Vessel Involved in a Near Miss Whilst On Location

The Marine Safety Forum has published the following safety alert regarding a near miss in the 500m zone. A PSV entered the 500m zone at an excessive speed. The excessive entry speed and direction of approach was observed by the other watch officer on the vessel and also by the crew of the installation who alerted the vessel accordingly.

Thorough investigation revealed the following:

- ◆ Senior Officer confirmed the vessel was moving at a speed in excess of normal approach speed;
- ◆ The 500m pre-entry checks were conducted further away from the installation than normal due to the vessel maintaining what was considered to be a safe distance while dodging infield traffic;
- ◆ The officer on watch had become overly fixated with course over ground and therefore failed to notice he had not yet reduced speed;
- ◆ The vessel pre-entry checklist and that of the installation had differing requirements with regard to when radars should be switched off.

Whilst within the 500m zone, Rule 6 of the Collision Avoidance Regulations (COLREGs) apply:

“Every vessel shall at all times proceed at a safe speed so that she can take proper and effective action to avoid collision and be stopped within a distance appropriate to the prevailing circumstances and conditions”.

Further information [here](#).

5 Near Miss: Bilge Cover Left Open

A member has reported an incident in which a bilge cover was left open. During a routine walk around the vessel, crew noticed in the engine room that a bilge cover had been left open. There was no barrier or signage in place. On investigation the bilge cover had been opened to permit brine pump maintenance work. This work had been interrupted and the employees had left the job, putting in place no safety precautions, but with the intent of returning later.

Our member noted that there had recently been two similar near misses in which covers have been left open in the engine



rooms on company vessels. The investigation and lessons learned has been included to the monthly fleet safety meeting presentations and distributed to all fleet for discussion, but the lessons were clearly not being learned.

Our member took the following actions:

- ◆ Stopped the job: the opened engine room bilge covers were closed and returned to a safe condition;
- ◆ A safety stand down was conducted with focus on maintaining and following the correct control of work procedures.

Key Lessons Learnt:

- ◆ Maintenance processes in the engine room should be planned, all risks assessed with further implementation of control measures where needed;
- ◆ Any openings or potential trip hazards should be controlled to ensure any risk is as low as reasonably practical;
- ◆ There should be effective supervision at all times;
- ◆ Vessel crews “not learning the lessons” – further effort required to address this.

Members may wish to refer to the following incidents (search words: *hatch, open*):

- ◆ [IMCA SF 08/08](#) – Incident 1 – *Fall through open hatch in walkway*;
- ◆ [IMCA SF 20/15](#) – Incident 2 – *Crewman falls down open hatchway during simultaneous operations*.

6 Product Awareness: Orange Smoke Hand Distress Signal

The United States Coast Guard (USCG) has published a safety alert regarding the withdrawal of the Certificate of Approval for certain orange smoke hand distress signals. This action has been taken because the chemical makeup of the signal was changed in October 2013 without Coast Guard approval, and the signal that was manufactured is at risk of spontaneous combustion when dropped.



These smoke signals may be labelled and marketed as “Polar MK 4” by NAMMO LIAB AB or as “IKAROS” by Hansson Pyrotech. “IKAROS” Hansson Pyrotech is the more current manufacturing name.

Datrex Inc., of Kinder, La., is the only distributor for these products in the United States. There are approximately 2790 such flares with this potential defect in circulation in the USA.

Further information can be found [here](#).