SAFETY ALERT – 01/2024

(Jan – June 2024)

Best Practices Initiatives Carried On board

1. Washing mooring lines with fresh water after every use.
2. Labelling dry store items with short expiry.
3. Using soap water to check leakage during line pressure test.
4. Using chaffing guards on mooring lines
5. Proper lockout-tagout used while working on electrical equipment.
6. Crew making sure of using three-point contact while on ladder or stairs.
7. Crew members have been following company procedures while carrying out various tasks.
8. Keeping mess rooms, tables, drawers clean, hygienic and clutter free.
9. Keeping drying machines filter free from lint by regularly cleaning the filters after use.
10. First in first out – practices in the galley. Consume first the older stock before the new one.
11. Always bring re-usable water bottle near the working area for regular water consumption.
12. Crew members working in consideration to safety, occupational health and to protection of environment identified in all assigned jobs.
13. Toolbox meeting carried out before starting daily jobs.
14. Post warning signs/ notices to be put up, use lock out/ tag out for various job.
15. Using take 5 card prior starting any job.
16. We always check and taking nothing for granted.
17. Crew is using proper PPE as per job and company requirement.
18. In Engine workshop, tools are properly stowed and secured immediately after work is completed.
19. Using additional rope to secure air hose to avoid whiplash.
20. Manhole properly secured with ropes around surroundings of opening and sign board posted.
21. Adding name of the vessel during walkie talkie communication to avoid interference from other vessel.
22. Printing documents only when necessary.
23. Mooring rope guard always in place.

Unsafe Act & Condition reported (Jan-June 2024)

1. **Unsafe Condition:** Chair in crew mess room found with broken leg.
2. **Unsafe Condition:** After Tank cleaning operations, oily rags found on deck.
3. **Unsafe Act:** Crew member was noticed using a fry pan without a handle.
4. **Unsafe Act:** After cargo operations, Cargo sample bottles were stored in CCR,
5. **Unsafe Act**: Self-closing mechanism for Bunker sounding Pipe was left in open condition.
6. **Unsafe Condition**: Terminal Watchman Was Found using mobile phone on deck. The Terminal Watchman Was Stopped Immediately and Escorted Inside Accommodation.
7. **Unsafe Condition:** Radar was found working while one crewmember was working on the monkey island.
8. **Unsafe Act**: One crewmember forgot to report that he was going to the monkey island so that the OOW can stop the radar.
9. **Unsafe Act**: One crewmember saw working on deck wearing only a hat without helmet.
10. **Unsafe Condition:** Some Scuppers Were Found in Open Position While at Anchorage At Gibraltar Port.
11. **Unsafe Condition**: One Crewmember Was Working on Deck Without Helmet.
12. **Unsafe Act**: One of the crew member after completion of his cleaning job, did not secure the bucket properly which was full of soap solution and rushed for tea break.
13. **Unsafe Act**: One Of Crew Member Working at Height without Safety Harness.
14. **Unsafe Condition**: When I Was Doing Rounds, I Found Some Oil on The Floor About Three 3m Of the Accommodation Entrance Door & so making the area vulnerable for slip/trip/fall hazards.
15. **Unsafe Act**: After opening manhole in thruster room while we were coming up one crew had spanner in his pocket which might fall in anytime and hit the person who was behind him.
16. **Unsafe Act**: While alongside at Sapele, crew members started preparing gangway, but port officials started to board the gangway without safety net rigged. He was stopped immediately once pointed out by duty AB.
17. **Unsafe Condition**: During greasing, the Rescue boat wires and sheeves the deck area became slippery due to drizzle and spot grease on deck. This gave rise to slip/trip/fall hazards.

18. **Unsafe Condition**: Due to passing shall, razor wire sharp pieces were found scattered along the ship side and on deck. These sharp pieces on deck could cause injuries to the people working in the vicinity.

19. **Unsafe Act**: While shifting lube oil drums, insufficient number of crew members were found performing the task. This is a clear sign of improper planning and might give rise to injuries to personnel.

20. **Unsafe Condition:** During daily routine was observed that around auxiliary engine no 1 floor was greasy/slippery. Involved person was advised to perform a good cleaning of the area, to avoid some slippery accidents or other events.

21. **Unsafe Condition**: During safety round in ER, it was observed that few rags wasn't removed from the VBU safety filters after maintenance was performed. All staffs were alerted to follow the COSWP and remove all the rags from machinery items & working areas to avoid having any further issues.

22. **Unsafe Act:** Painted area on deck not cordon-off, Advised all deck crew to tie a rope and cordon-off the area to prevent other crew members to step on fresh paint.

23. **Unsafe Condition**: It Was Observed Filters of Washing Machine Dryer Not Cleaned, Explained All Crew Importance of Cleaning This Filters To Prevent From Fire hazards.

24. **Unsafe Condition**: On Accommodation Deck Port Side Embarkation Ladder Not Secured Properly. Same was notified to Deck officer and lashing was taken Immediately.

25. **Unsafe Act:** After the boat drill, crew members have left his lifejacket in alleyway floor, rather putting them back in cabin/or in designated locations. All crew members were reminded to comply with safety norms & keep all Safety items at designated locations so that same could be used without wasting much time during emergency.

26. **Unsafe Act:** Crew Member Found Using Normal Slippers Without Back Stripes, Advised All Crew to Use Sandals or Slippers with Back Stripes in Accommodation.

27. **Unsafe Act**: Crew Member Found Without Rubber Gloves While Galley Cleaning, Advised All Crew to Use Proper Gloves for Various Jobs On-Board.

28. **Unsafe Condition**: Fire extinguisher was not properly secured after using for cargo operation, advised all crew properly to secure all LSA, FFE & SOPEP after use.

29. **Unsafe Act**: It was observed that one of crew member was wearing cotton gloves while buffing bolts, crew member was stopped immediately and advised him hazards of using cotton gloves while using fixed buffing machine. He was asked to use proper tools & PPE at work place to avoid having any incidents/personal injuries.

30. **Unsafe Act**: During departure it was observed that after securing the deck for sea passage, crew didn't close the door from deck to accommodation.

31. **Unsafe Act**: After the fire drill it was observed that one BA set has not been refilled which was used during drill.

32. **Unsafe Condition**: During round on deck, it was found that big steel plate was not secured properly.

33. **Unsafe Act**: Observed one crew member during bunker hose connection without proper PPE, He was stopped immediately and asked to wear proper PPE prior resuming the job.

34. **Unsafe Condition**: During safety rounds on deck at port. Observed more than 4 rounds of mooring rope on tension drum. Deck crew members were trained on MSMP requirements regarding 03 layers of mooring ropes to be maintained on tension drums.

35. **Unsafe Condition**: Observed oil in compressor room floor. Immediately cleaned.

36. **Unsafe Condition**: Before start of discharging sludge safety officer found out that the connection of sludge hose is not fully bolted & only 4 bolt were put in place instead of 8 as designed.

37. **Unsafe Act**: Vessel Arrival in Fort De France Crew are preparing pilot ladder without wearing life vest.

38. **Unsafe Condition**: Vessel at berth in Fort De France for taking bunker, after taking bunker crew did not remove the bunker reducer on the manifold and keep unblind and bunker oil dropped in the drip tray while vessel was out at sea after bunkering ops. C/E was asked to secure the bunker manifold blind flanges to avoid dripping of bunker oil in the drip tray & so to avoid pollution.

39. **Unsafe Condition**: During safety round and accommodation inspection. Found out that crew changing locker are dirty and some coverall are hanging in the shower curtain.

40. **Unsafe Condition**: FSS round has been done and observed lashing on liferaft was not properly tightened, Same was corrected immediately.

41. **Unsafe Condition**: When opened door on starting box for deepwell pump, door fell down due broken hinges, same was secured properly.

42. **Unsafe Act**: Crew member was noticed attempting to carry gas free fan alone. (more than 20 kgs), he was stopped and assistance was rendered to him to complete the shifting jobs safely. All crew members were reminded to follow COSWP.

43. **Unsafe Condition**: While deck safety rounds Master observed a chipping gun safety lock made fast with rope, it was removed immediately and hazards associated with such act has been discussed with crew members.

44. **Unsafe Condition**: While Performing Fire, Safety and Security Rounds at the End of the 00-04 watch, Duty AB found one accommodation door insecure, while vessel transiting through HRA. He immediately reported the same to duty officer and secured the Door with nut Bolt. This unsafe act/condition was discussed with the crew to make sure all accommodation doors to remain closed and secured all the time, especially while transiting HRA.

45. **Unsafe Act** : During bunkering operation, it was observed that the crane was being operated for hose handling purpose without rope tighten to the hook, causing the hook block to get uncontrolled swinging which might damage to any ship's structures.

46. **Unsafe Act**: Observed One of Crew Member Handling Oil Buckets In Both Hand While Climbing Stairs Without Making "Three Point Contact".

47. **Unsafe Act**: While arranging the razor wire for fendering operation, one crewmember didn't wear proper gloves.

48. **Unsafe Condition**: Found In the Food Waste Bin Some Paper and Plastic Waste, Mixing of garbage is not allowed as per GMP.

49. **Unsafe Act:** One crewmember saw crossing the spring mooring lines while doing round when vessel was alongside Biskra.

50. **Unsafe Act:** While going to work in pumproom for cleaning the pumproom, the exhaust fan was started without first opening the natural vent or door. This creates vacuum and makes opening the door difficult and unsafe which might lead to injury.

51. **Unsafe Condition**: During cleaning, the sea water filters from I.G.G. cooling system the engine crewmember carried out the work observed that the air pressure hose has an air leak. The air pressure valve was closed from the air pressure hose and the air leak was rectified.

52. **Unsafe Condition**: After lunchtime while taking routine round the duty engineer observed a bucket with water left near an electrical motor. Our vessel could have rolled making the bucket capsize and throwing the water on the electrical motor. The bucket with water was removed.

53. **Unsafe Condition**: During Weekly Inspection Found Loose Washing Tap Support. Duty Engineers Was Informed. Washing Tap Was Tightened Up.

54. **Unsafe Act:** Crew member found without Boiler suit for helping in provision stores, Advised all crew Proper PPE should be worn even for small jobs.

55. **Unsafe Act:** During MGO filters cleaning, some MGO dripped down on the floor in Engine Room till Workshop. An engine crew member has observed the MGO leak and the stain was cleaned and all engine crew members were advised to pay more attention then doing this type of work.

56. **Unsafe Act:** Crew member found with untied shoe laces on Aft station, advised crew member to tie shoe laces, to avoid slip trip & Fall.

57. **Unsafe Act:** The duty engineer noticed that during the maintenance of HFO filter of HFO transfer pump is carried out some drops of fuel oil on the floor of the workshop and one engine crew member was about to slip.

58. **Unsafe Act**: During the storing one new spare electromotor in Engine Room Store Compartment, a personnel's glove caught under the wood support plate of the spare electromotor. The engine crew member could be injured because he did not check the condition of the items before moving it. The job was immediately stop to let the engine crew member safely take out the glove under the wood support of the spare electromotor.

59. **Unsafe Act:** During anchoring station, One of the crew member was not using safety goggles. He was asked to wear proper PPE.

60. **Unsafe Act:** It was noticed that one of the crew member was standing just below suspended heavy load during E/R blower maintenance work. Immediately informed crane operator to stop and advised crew members to keep safe distance from suspended load.

61. **Unsafe Condition**: During E/R maintenance work it was observed that one of the crew member using electrical buffing machine without guard, Immediately advised crew member to stop the work, educated crew member about hazards and advised to use safety guards prior putting them in use. Same was discussed with senior engineers during toolbox meeting.

62. **Unsafe Condition**: Stairs door are not marked with precaution of opening.

63. **Unsafe Condition**: Pilot ladder has been lowered in heist and so finally the lower steps hit the tug boat as Surveyor was on his way to embark onboard.

64. **Unsafe Act:** While mopping E/R ECR deck one of the crew members passed accidently from the wet floor.

65. **Unsafe Act:** It was observed that one of the crew member going down using ladder while carrying too many rags in both hands. Immediately, stopped crew member and educated him about three point contact while using ladder.

66. **Unsafe Condition**: After hectic work during Shapoli installation one of the crew member after completing his job left E/R without securing tools and oily rags.

67. **Unsafe Condition**: While leaving E/R one of the crew member found oily rag garbage bins was left in opened condition, this could cause spontaneous combustion and so could lead to a fire hazards.

68. **Unsafe Act:** During cleaning of ER bilge well aft. One of the crew left the floor open while preparing some cleaning materials required for cleaning.

69. **Unsafe Act**: In the smoke room it has been observed that the ash/Waste is being disposed along with the paper waste in the ash tray.

70. **Unsafe Condition**: During Safety Round We Found Water on ECR Platform And After Investigation, We Found Due To Heavy Rain Water Overflowing Through Funnel And Dropping On ECR Platform, With The Help Of Engine Crew, We Drained The Water from funnel deck and stopped water leaks in E/R.

71. **Unsafe Condition:** 26 May 2024 08:15 hrs. vessel at berth at Degrade De Cannes for discharging, safety officer taking safety round and found out that port side drip try plug is not secured.

72. **Unsafe Act:** On 30 May 2024 10 am carried out monthly inspection on accommodation and found out that garbage are not segregated properly which is plastic and paper are in same bin.

73. **Unsafe Condition**: In During wind observed ISPS box not properly lashed.

74. **Unsafe Condition**: Pin on Ventilation Handle was observed fully painted and so having difficulty in removing during emergency situation..

75. **Unsafe Condition**: On Bridge Deck, drain scupper was clogged by means of rag and so water was not flowing freely during rain and found water was overflowing from deck coaming.

76. **Unsafe Act:** While overhauling a Pump, checker plates were not in place as work was going on but no barricading was made, explained Engine team and others about the risk involved and need of barricading. As we don't have proper barricading items need to manage with ropes.

77. **Unsafe Condition**: Laminating machine left ON after use soon it was observed by OOW and turned off immediately

78. **Unsafe Condition**: In Rescue boat crane, chain guard railing for crane platform area found unsecured..

79. **Unsafe Act:** In During Departure While Securing Gangway Ladder After Removed All Securing Ropes And Nets From Ladder, One Crew Member Climb On Ladder Without Safety Harness /Life Vest.

80. **Unsafe Condition**: During inspection of forecastle noticed that 55 gallons open drum full of water found in bosun store.

Near Miss Reports (Jan - June 2024)

1. **Description:** Crew member reported fumbled at Manifold grating due to longer length of bolts used for securing gratings**.**
   Immediately excessive length shortened to avoid trips and falls.
- **Root Cause Analysis:** Improper size of bolts used for the job which gave rise to tripping hazards.
- **Corrective Action:** Suitable bolt was used to avoid tripping hazards.
- **Preventive measures :** All the securing arrangements for gratings were rechecked and ensured suitable size of bolts are used at all locations.

2. **Description:** Deck officer instructed the crew to get the sounding tape from the midship store. Crew open the weather tight door and keep it in open position without securing the hook. Vessel was underway with moderate to long swell from the beam. All of a sudden the weather tight door start banging and luckily did not hit the leg of the crew who was coming out of the store.
- **Root Cause Analysis:** Door left in open position & not secured properly.
- **Corrective Action:** Secure the weather tight door in open position before entering any compartment.
- **Preventive Action:** All crew members were advised to follow the COSWP and ensure weathertight doors are never left in open position without securing the hook.

3. **Description:** While carrying out maintenance and inspection of manifold valves, one section of manifold chain guards were found not in place. When crossing over the cargo hose, one crew member lost balance but held on to the adjacent chain guards/ stanchion and fell on manifold gratings however didn't sustain any injury.
- **Root Cause Analysis:** Wrong practice was followed by duty AB.
- **Corrective Action:** The chain guards put back in place. Same discussed during toolbox meeting & safety meeting.

4. **Description:** Jubilee Clip of Air Hose Found Deteriorated, Thus Oozing Out Air Slowly, Immediately Stopped Work, Required repair was carried out.
- **Root Cause Analysis:** Wear & Tear, Improper supervision
- **Corrective Action:** Stopped work and repaired the connection to avoid leaks.

5. **Description:** During weekly inspection of laundry, filters for drying machine was found clogged.
- **Root Cause Analysis:** Unsafe work practices was followed.
- **Corrective Action:** Filter was immediately cleaned & a notice was posted on dryer " Clean filter prior using dryer".

6. **Description:** During tank cleaning operation in starboard side manifold area, Some cleaning agents were left on deck and so making area slippery, one of the crew member was passing over it and almost tripped however was lucky as nothing happened to him.
- **Root Cause Analysis:** Improper house keeping, Lack of skill
- **Corrective Action:** Chief officer announced and isolated the area and cleaned immediately. Crew members were advised to follow the procedure for proper housekeeping.

7. **Description:** During picking up stores in Chaguaramas /TT bosun on the crane didn't attach a guiding rope from hook to control the balance. Outside wind force was BF 4-5.
- **Root Cause Analysis:** Lack of knowledge and unsafe work standards.
- **Corrective Action:** Was immediately stopped by duty officer on bridge and one rope for controlling the balance of hook was attached in order to avoid uncontrolled swinging of hook.

8. **Description:** During accommodation weekly checks bridge freezer was found full of ice.
- **Root Cause Analysis:** Poor housekeeping.
- **Corrective Action:** Freezer was stopped and defrosted to remove ice accumulation from fridge.

9. **Description:** During painting on foremast forward one paint drum was left unattended without cover & all crew members were proceeded for a coffee break.
- **Root Cause Analysis:** Inadequate work standards, Inadequate Leadership and / or Supervision,
- **Corrective Action:** OOW observed this & called AB on radio and he was asked to cover the drum with lead to avoid spilling of paint.
- **Preventive Action:** This NM was discussed during safety meeting and all hands were advised to follow COSWP.

10. **Description:** During preparation for cargo operation in GEO/GUY the fire hose was rigged improperly as one of the security guard was tripped over this hose and almost fell down on deck but luckily nothing happened to him.

- **Root Cause Analysis:** Improper laying out of fire hoses and passage was impeded inappropriately.
- **Corrective Action:** Fire hose was properly arranged and also security guard was informed to take usual precautions while walking on deck.

11. **Description:** It was observed, during engine room UMS rounds E/R overhead crane chain was oscillating due to rough weather & loose securing. Immediately informed duty engineers & secured E/R crane properly. Also discussed same incident in toolbox meeting.
- **Root Cause Analysis:** Improper securing of crane hook,
- **Corrective Action:** Used proper sling & D-shackle for securing crane at fixed location in E/R. All engine were advised to follow the same practice while using the crane and parking them back in position.

12. **Description:** During mooring operations in DDC, mooring boat after taking 3 headlines (2 ropes from winch & 1 loose rope) was heading towards mooring pier with more speed than required. While slacking rope one of the winch rope got entangled and started to become tight. Duty Officer noticed and before he could alert the boat personnel the rope got tight and the person handling the boat was hit by the rope and also causing the mooring boat to loss the balance.
- **Root Cause Analysis:** Split drums are not provided**,** Due to design of winches while slacking ropes it gets stuck and start moving in opposite direction and so making the mooring rope tight.
- **Corrective Action:** Immediately stopped winchman and shore mooring boat personnel. Rope was cleared quickly and slackened as required by the mooring boat.

13. **Description:** While using cargo hose handling crane (Port side) for hose disconnection. Duty officer observed that one wire strands was broken. This could have lead to hand injury while handling the rope. Immediately after operation, the crane wire was renewed with the new set of wire.
- **Root Cause Analysis:** Normal wear & tier, Excessive use of crane due to frequent cargo operations.
- **Corrective Action:** Crane wire was renewed immediately after the completion of operation.

14. **Description:** During Mooring Stations, it was noticed that one of the crew members standing very close to the mooring rope under tension. He was immediately instructed to stay well clear. The crew member could have fatally injured himself if the mooring rope parted at that instance.
- **Root Cause Analysis:** Lack of training & Situational awareness (Human factor)
- **Corrective Action:** Every crew member is advised to be aware of the snap back zones and work safely during mooring stations. Mooring safety was discussed during safety meetings.

15. **Description:** During the Oil Spill drill, one of the crew member was on his way to get the oil spill equipment's from the fire store (Aft Port side). But instead of walking fast the crew member was spotted running, The crew member could have slipped and

injured himself. The crew member was immediately told to stop and proceed safely and carry out his duties.

- **Root Cause Analysis:** Under panic state, Under the influence of Performance Pressure.
- **Corrective Action:** The crew member was immediately told to stop and proceed safely and carry out his duties. All crew members were advised during debriefing to follow the COSWP during drills.

16. **Description:** During routine LSA/FFA checks, it was noticed that newly received stores was secured near firefighting equipment's in fire store, thus restricting access to the same. It would obscure the way to reach the firefighting equipment's when it might be required in case of an emergency.
- **Root Cause Analysis:** Improper stowage, and Housekeeping.
- **Corrective Action:** Immediately removed from there and were stowed in designated place. All crew members were advised to maintain the access to LSA/FFA in the uninterrupted state all the time so that time could be saved during real emergency.

17. **Description:** While preparing paint during routine maintenance job a crew member was found mixing paints without using gloves or safety goggles. Another vigilant crew member stopped him immediately and prohibited him from continuing until proper PPE for the work was donned.
- **Root Cause Analysis:** Lack of training.
- **Corrective Action:** Use of proper PPE for jobs which involve paints and chemicals.

18. **Description:** When vessel passing in rough sea one of crew member entered to Paint Store and didn't secure watertight door by hook. Immediately informed him before entering inside should properly secure watertight door.
- **Root Cause Analysis:** Negligence, Lack of knowledge
- **Corrective Action:** Door hook was put back in place to avoid banging of doors.

19. **Description:** When vessel approach to berth FWD & AFT Team Stand-by For Mooring, suddenly heavy rain started pouring and none of the crew members had bought rain coat or gumboots and so started getting drenched,
- **Root Cause Analysis**: Improper work planning.
- **Corrective Action:** Crew members were advised to carry proper PPE whenever heading for mooring stations especially whenever there's likelihood of getting rain during stations.

20. **Description:** While getting off the accommodation Stairs, Handrail was uprooted and nearly caused 3rd Officer to fall on staircases. Luckily he didn't sustain any injury due following the principles of 3 point contact while using ladder.
- **Root Cause Analysis**: Heavy weather, All ship's structure/hand rails to be maintained in order.
- **Corrective Action:** Engineers Notified, immediately got the railing fixed.

21. **Description:** During Receiving Provision from Aliaga 1 Crew Member Was Found Walking Towards Suspended Provision Pallet.

Immediately All Crew Members Were Re-Briefed to Keep Well Clear And Not To Stand Underneath any suspended load to avoid injury.

- **Root Cause Analysis**: Negligence, Improper positioning of task.
- **Corrective Action:** Respective crew members was immediately asked to stay clear from hanging object.

22. **Description:** Galley personnel boiling water for cooking moong dhal. Vessel alter her course to proceed with her new course. As the vessel changed her course so began to roll heavily due to high swell from the port beam. The pot with boiling water suddenly slipped from the hot plate and fallen on the floor and spilled hot water on deck. The guard rail on the hot plate was not fitted during that time as it was removed during the last evening cleaning. The galley staff was luckily away from the place as he was cutting / chopping some vegetables.
    - **Root Cause Analysis**: Hot plate guard rail removed / Heavy sudden rolling of the vessel due change in course.
    - **Corrective Action:** Put back hot plate guard rail in place & instructed all galley staff to follow the galley safety and never take any short cuts at workplace.

23. **Description:** On 03.06.2024 after loading operation with Bitu Express in Lome Offshore, the crew and surveyor took final ullage by opening the ullage port, and on this time the mother vessel was light and was rolling heavily, so while we opened ullage plug the cargo spilled out from ullage pipe but luckily didn't fall on ship's staff or on surveyor.
    - **Root Cause Analysis**: Bad weather caused vessel to roll suddenly, Open gauging practice was followed for COTs.
    - **Corrective Action:** During bad weather, try to check the reading directly from SAAB remote gauging arrangements

24. **Description:** During loading Point a Pierre TT 2nd engineer and Chief engineer go on deck to check and prepare reducer for bunker but 2nd engineer was not wearing proper PPE and he was in witj T-shirt. Immediately informed to use proper PPE before going on deck.
    - **Root Cause Analysis**: Lack Of Discipline and Improper PPE was worn by 2E.
    - **Corrective Action:** Immediately Stopped and Informed to use PPE provided by the company, Use of proper PPE was insisted during safety meetings.

25. **Description:** During round on deck found inflatable lifejackets in use are checked by vessel personnel and allready more than 1 year not serviced by shore.
    They are in good condition but nevertheless should be serviced by shore.
    - **Root Cause Analysis**: Because they are used often they should be serviced every 12 months by shore but due to lack of knowledge, safety officer create certificate and said is still ok to be used even if service was not carried out as per timeline.
    - **Corrective Action:** Shore servicing was immediately arranged from office.

26. **Description:** During fire drill in engine room fire extinguisher was used for drill purpose and explanation but after drill completed was not restored in initial position.CO found

this after drill debriefing -checking with 3/O .immediately was restored and all crew informed that after each drill the equipment should be restored to their initial position.

- **Root Cause Analysis**: Procedure not followed correctly, Communication gap between PIC and crew member.
- **Corrective Action:** Extinguisher was placed back in position immediately and all crew members were advised to follow the same practice after each drill.

27. **Description:** After departure Guyana /Georgetown BT flap forward was not closed while vessel was prepared for sea.
- **Root Cause Analysis**: Improper work supervision - Bosun requested OS to close BT flap but OS missed out and got carried away with other jobs.
- **Corrective Action:** BT flap was immediately closed once pointed out by senior hand, All crew members were advised to follow the “preparation for sea” checklist properly.

28. **Description:** During Shapoli torque ring installation by mistake one of the crew members unknowingly put his foot on the fire bilge suction valve and accidently crack opened hence water starts back flowing and bilge high level alarms triggered two times.
- **Root Cause Analysis**: Improper Position for Task and lack of Situational Awareness.
- **Corrective Action:** Immediately informed duty engineer , assisted engineer for rectifying the issue by tracing the line and finally cracked open valve was closed out immediately.

29. **Description:** During routine checks it was observed that in ECR many charges for UHF & charges for portable power tools were left connected to the extension and were left unattended, immediately informed to duty engineer and disconnected all equipments to avoid overheating of switch board and so to avoid fire hazards.
- **Root Cause Analysis**: Incorrect Use of Equipment and lack of knowledge.
- **Corrective Action:** Disconnected all chargers from the extension also advised before UMS all chargers and extensions to be disconnected and connect chargers only during manned E/R.

30. **Description:** During unmooring operation, new on-signers didn't wear proper PPE & also observed 2 person without gloves. They were immediately informed to wear proper PPE during Mooring/Unmooring Operations.
- **Root Cause Analysis**: Negligence, Lack of supervision by Station PIC.
- **Corrective Action:** Crew member was asked to wear proper PPE, Mooring safety was discussed with all crew members.

31. **Description:** After receiving spare parts, wooden pallets were left in alleyway with naked securing nails on wood boxes pointing in upward direction, This could have seriously injured to someone passing by the area in case came in contact with this naked nails.
- **Root Cause Analysis**: Improper securing, Items kept loosely inside accommodation.
- **Corrective Action:** Items were stored back inside the garbage drum and made the area clear from all obstructions.

Incident Report (Jan-June 2024)

1. **Description**: Vessel was at Freetown port berth No 1 awaiting pilot for departure. At 1100 hrs LT Tugboat named 'GOLF' was approaching from Our Port quarter and with a sudden movement hit our fish plate and ship side under the fish plate. Minor scratches found on fish plate and on ship side plate.
   Root Cause Analysis: Tugboat approached at unsafe/inadequate speed.
   Corrective Action: Reporting was made, Tug boat was issued protest letter from Master.
   Preventive Action: Planned appropriate repairs at next opportunity. Bridge team & Station PIC must keep an eye on the Tug's movement and ensure she is moving with safe speed and avoid banging the vessel.

2. **Description**: After starting the heating of the cargo lines, during the routine rounds, cargo leaks were discovered on the column of pipes in the pump. Estimated Quantity @ 200LTRS,
   Root Cause Analysis: Expansion of cargo in column due low flash point during cargo heating, During final loading, cargo lines were flushed with Gas oil as per terminal requirements so vessel had to use ship's pump. After line flushing, cargo line column in pumproom was not drained off properly so prior discharge when line and pumps were heated up this trapped cargo in pumprrom line column got heated up and due low flash point vapour pressure in the cargo line increased and as valves were closed so gave rise to leakages from flanges.
   Corrective Action: Cargo line pressure was dropped by opening line master valve and line was emptied out to avoid having excessive vapour pressure in cargo line. All nuts and bolts of cargo line flanges were retightened at the location from where leak occurred.
   Preventive Action : All Bitumen vessels were advised to drain all lines completely after each cargo operation to avoid similar issues in future. COF has instructed notice in CCR reg draining of lines after cargo operation.

3. **Description**: On arrival in Aliaga port during preparation for the Pilot to disembark from Stbd. Gangway, the wire of the Stbd. Gangway was parted, and the ladder fell into the water. The Gangway was recovered and secured in position. No crew members were injuries.
   Root Cause Analysis: Excessive wear & tire of gangway wires, Improper supervision.
   Corrective Action: Gangway was secured in position, wire replaced with new one.
   Preventive Action: PMS routines for greasing and lubrication of gangway wire and associated gears must be carried out regularly and same must be verified by Tech. Supt. in office. Gangway wire renewal period has been reduced from 48 months to 36 months in SMS.

4. **Description**: Voyage 18 - discharging at Port Harcourt, Nigeria - 04.04.2024
   12:00 LT - Cargo discharging completed. 12:30 LT - Commenced cargo hose air blow. Cargo tank no. 5P drop valve opened to drain any remaining bitumen on vessel cargo deck line into 5P COT. Air was supplied from the vessel for air blow. Terminal controlling the air blow by opening and closing their shore valve. (Shore valve 50 meters from

shore pipeline end) After a series of 4 times air blow vessel crew secured the manifold to fully closed position and same informed to foreman as agreed prior starting disconnection.
13:18 LT – Completed cargo hose air blow.
After completion of air blow, terminal foreman instructed his personnel to disconnect the cargo hose to return to the vessel. Three cargo hoses was used during this operation due to distance from vessel to shore pipeline. Shore team started disconnecting the flange between the 2nd and 3rd cargo hose with empty drum below the connection to enable to drain the hoses content by gravity onto the empty drum on barge, to transfer back the first two hoses to the ship after draining and the third hose connected to the shore at last. During the disconnection of the cargo hose, some amount of bitumen sprayed on deck of the barge used for vessel to come alongside. Vessel manifold was about 5 meters high and shore pipeline was about 2 meters high from the barge which make the loop on the cargo hose and terminal personnel disconnected from the lowest part of the loop (In between no.2 and no. 3 hose flanges). Hose bitumen contents drained over the empty drum. Sprayed bitumen cleaned up by shore personnel. After cleaning, disconnection of cargo hoses resumed and completed at 15:00 LT.
Root Cause Analysis: Wrong disconnection procedure was followed, cargo hoses were disconnected from lowest part of hoses however should have been other way rounds.
Corrective Action: Drained the remaining bitumen cargo form the cargo hose to the empty half drums and cleaned the spilled oil on barge.
Preventive Action: Hose connection/disconnection process must be supervised by Responsible officer/Senior deck hands.

5. **Description**: While vessel is drifting off coast of Guadeloupe & awaiting for berthing instruction, at 18:15 Fire alarm sounded, and duty officer announce that there is a fire alarm indicated in CCR. Crew are immediately proceed to CCR and investigated the cause of alarm and they found out that the wire plug of portable radios in CCR is burning.
   18:15 Fire alarm active on the Bridge – location CCR
   18:16 Duty Officer announce fire in CCR.
   18:18 All crew assembled at secondary Muster station (Poop deck Stbd. side)
   18:20 Reported all are accounted. Ventilation and power supply switch off.
   18:22 Fire Fighting team 1 proceeded for fire extinguishing in CCR.
   18:25 Fire is extinguished by using dry powder and reported there is no sign of re-ignition.
   18:30 Completed action by crew.
   Root Cause Analysis: Overloading of charging plug & switch board,
   Corrective Action: Fire was extinguished by the Fire party, power supply to the electric supply board was immediately disconnected.
   Preventive Action: Instructions posted at all locations near switch board to avoid overloading of switchboard and only authorized charging cables and distribution boards to be used onboard. All hands were advised to recheck the connection at all locations carefully and ensure no make shift arrangements are in use near switch boards.

6. **Description**: On arrival to Owendo berth 3 after all fast at 1524hrs - 15/06/2024, it was observed that the vessel was listed by about 3deg to Starboard. Investigation by sounding all the vessel was carried out and it was discovered that the vessel is aground and sitting by her port-midship to port forward, while starboard side and all round aft are floating freely.
   Further investigation of all internal tanks were made at 1800hrs-15/06/2024 and ensured watertight integrity is maintained on ship.
   Immediately, plan was made to quickly commence discharge from center tanks to bring the vessel bodily up and so floating state could be reinstated.
   This was done and the vessel was safe at the next low tide.
   Root Cause Analysis: Unsafe berth, information reg depth at berth was not shared by the pilot or agent prior arrival of the vessel.
   Corrective Action: Commenced discharge operation immediately from center tanks and tried to bring the vessel bodily up, once vessel was lighten up then vessel was brought to alongside with the help of mooring lines, she was safely moored alongside.
   Preventive Action : Master has been advised to obtain the depth information at berth well in advance to avoid touching the bottom while coming alongside. Ship's staff must remain vigilant at such ports where depth information are doubtful and so ensure a proper RA is prepared prior calling these ports in future.

Thank you for your kind attention.

Maritec Tanker Management Pvt. Ltd.

QHSE Team.

25/07/2024