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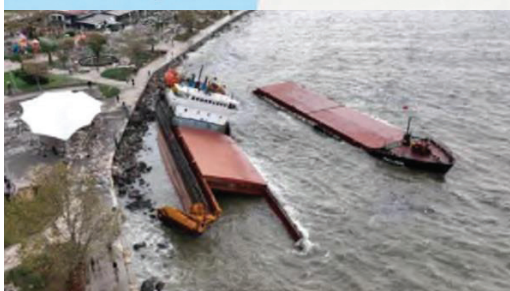
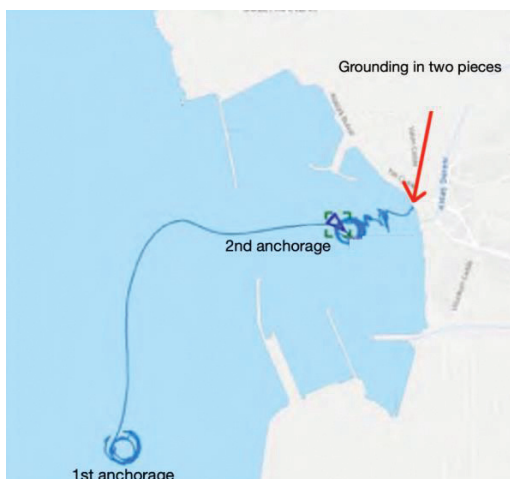
Vessel breaks in two at anchor

A small general cargo vessel with a crew of 13 arrived in ballast at its loading port and was sent to anchor outside the breakwater to await an available berth. Five days later, and still at anchor outside the breakwater, weather conditions were deteriorating. Strong onshore winds were expected, accompanied by high waves.

Because of its construction and freeboard, the vessel was limited by its Load Line and Class Certificate to '20 nautical miles offshore in the Black Sea,' and to maximum wave heights of 3.5

metres. The vessel's Master requested permission to seek more protected anchorage inside the harbour breakwater, and this was granted by the port authorities. Days later, with the vessel now at anchor inside the breakwater, the weather deteriorated yet again with winds at over 50 knots. Although the anchorage site inside the breakwater protected the vessel at first, the storm shifted to the southwest, which caused waves to come through the breakwater entrance. The vessel was now exposed to heavy weather and sea conditions. Even with the assistance of the main engine, the vessel could not hold at anchor, and began to drag.

The Master called for tug assistance but due to the dangerous weather the tugs could not leave their berths. It was now too late for a plan B. With the shifting winds and waves, the vessel was exposed to gales and very large waves. Suddenly, with the hull stressed beyond its limits, the vessel broke in two and drifted ashore. Thankfully, all 13 crew were rescued.



Lessons learned

- Even within the confines of port, weather-related wind and waves can affect your anchorage or berth.
- Keep one step ahead of events by having your Plan B ready. In this case, and in retrospect, the only option was to have berthed before the storm.



As edited from UEIM (Türkiye)
Investigation Board Decision
Number 17/D-05/2024ited from
USCG Safety Alert 14-25

MARS 202620

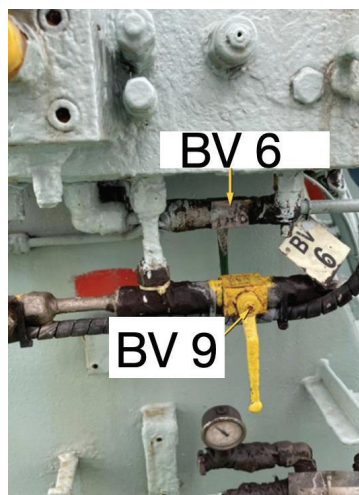
Check your ball valves

A ferry was on a scheduled run between two ports. The crew planned to carry out a routine test of the stored power launching system with the Fast Rescue Craft (FRC) during the transit. A toolbox talk was conducted before the test and the procedure for the stored power launch procedure was discussed. The vessel was stopped for the drill to take place.

The vessel-specific procedure for the stored power launch of the FRC consisted of 20 steps, including the operation of seven different ball valves in the davit's hydraulic system, located on two decks. The crew worked under instruction of a senior officer. When all the valves were thought to be in the correct positions and the boat was slewed out into the launching position, the order was given to operate the launch cable. When the launch cable was pulled, the FRC immediately fell about 9m to the water. Thankfully the FRC was uncrewed, so no injuries were incurred. However, the FRC was damaged beyond repair and had to be replaced.

The FRC was recovered and the launch system inspected. It was found that a valve for draining pressure from the hydraulic system was mistakenly left in the open position. The preliminary investigation found, among other things, that ball valve 9 (BV9) had been mistaken for BV6. The operation of BV9 was not included in the procedure for launching the FRC using stored power. Once BV9 was put in the open position, there was no hydraulic oil pressure available in the system to arrest the fall of the FRC once the launch cable was pulled.

The stored power launch system was subsequently tested using the documented procedure with the correct valve sequence and proven to work without incident.



Lessons learned

- Ideally, a procedure should fit on one page and be as simple as possible.
- In this case, the two valves were close together and the identification label for BV6 was sideways, so that it was not clear which valve it referred to (see photo - labels added to image). 9 and 6 can be confused when the orientation of the sign is not made clear.
- The BV9 valve was in the foreground and painted yellow, thus attracting more attention than the BV6 valve, which was in the background and more restrained in colour.



As edited from MAIB (UK) PA summary 1/25

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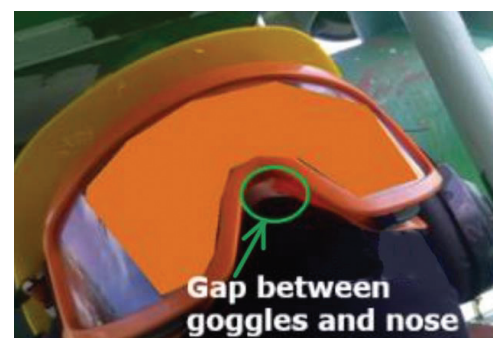
Mind the gap

A crewmember was assigned to perform chipping on deck near the cargo manifolds crossover area. While chipping, a particle of rust passed through a gap near the nose in his goggles and into the eye. He did not go directly to flush the eye, hoping that the particle would come out by itself.

After work the crewmember noticed that the particle was still inside his eye and tried to flush it with water. This did not work, so he reported the incident and received on-board medical attention. Following the incident, an ad-hoc meeting was carried out on board highlighting the importance of proper tightness and fit of safety goggles.

Lessons learned

- Any incident involving an eye should be immediately reported and attended to.
- As a general good practice, always check your PPE before each use.
- When wearing safety goggles for chipping, there should be absolutely no gap between the skin and the glasses.



MARS 202622

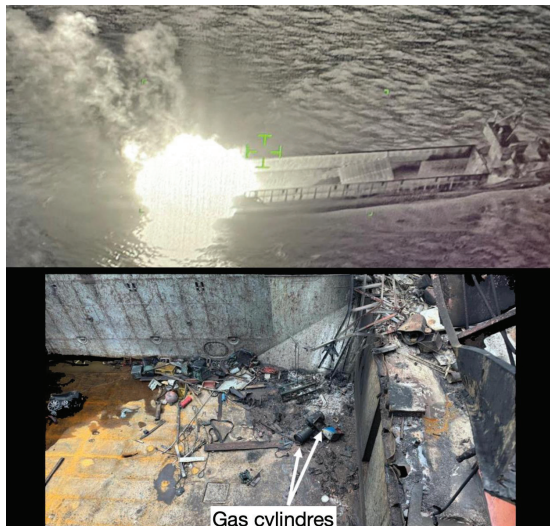
Inappropriate gas storage destroys a vessel

A dry cargo vessel in ballast was underway in strong winds and rough seas. At around 2100, when the vessel was approximately 35 nautical miles from shore, there was an explosion in a forward compartment.

The explosion tore open parts of the forward mooring deck. All five cargo hatch covers were dislodged; two hatch covers fell into the sea, while the remaining three collapsed into the empty cargo hold. Simultaneously, the vessel suffered an electrical power outage, but the main engine continued to function.

The crew quickly broadcast a distress call over VHF radio, which was received by a coast station, and a rescue operation involving several ships and two rescue helicopters was initiated. The entire crew were hoisted to safety by one of the rescue helicopters approximately 1 hour and 45 minutes after the incident. The vessel then drifted, abandoned, for two days, before being towed to a port of refuge. No one was physically injured in the incident, but the damage was so extensive that the vessel was declared a total constructive loss and scrapped.

The investigation revealed that the explosion was caused by propane gas leaking and igniting in a forward compartment. The general lack of space on the vessel meant that any available space was used on an ad hoc basis, and this compartment had been gradually converted into a workshop and paint storeroom. Several different products ended up in the same forward space, including two cylinders of propane with a total of 22 kg of gas.



The investigation found, among other things, that neither the crew nor the shipping company had identified that the space was unsuitable for these purposes, since it lacked proper ventilation and appropriate access routes. The space was also connected to the cargo hold, which meant that if oxygen depleting cargo was carried, the space could have been rendered oxygen deficient and so become a lethal trap for crew.

Lessons learned

- Propane and other flammable gases must never be stored in makeshift workshops or paint lockers. Hazardous materials require dedicated, certified storage areas that are physically isolated from potential ignition sources.
- Ventilation is non-negotiable. Any compartment used for chemical or gas storage must have adequate, independent ventilation to prevent the buildup of explosive atmospheres or oxygen-depleted air.
- Changing the use of a compartment (eg, converting a void space into a workshop) requires a formal management-of-change process to identify new risks, such as lack of access routes or connection to cargo holds.
- The crew's rapid distress call and successful evacuation highlight the importance of functional emergency procedures and communication equipment during a 'total loss' event.
- The investigation noted that the shipping company failed to identify the risks. Safety Management Systems should include regular audits specifically looking for unauthorised or unsafe storage practices in non-standard spaces.



As edited from SHK (Sweden) report SHK 2026:01

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