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Mariners’ Alerting and Reporting Scheme

MARS Report No 325 November 2019

Readers will notice in MARS report 201974 another scaffold incident that has injured crew, the third for 2019. Erecting and using scaffolding on a vessel at sea seems questionable – what do you think? Have you ever experienced a scaffold accident or close call? Write to us with the details.

Fluorescent lights a fire

While at anchor the vessel’s fire alarm sounded on one of the lower decks. The OOW sent the duty seaman down to investigate. The crew member found a deck-head fluorescent light releasing smoke. The appropriate circuit breakers were closed and the light was smothered, extinguishing the nascent fire.

The company investigation found that a poor quality capacitor had overheated and caused the fire.

Turning manoeuvre goes wrong

The vessel was moored port side to the berth (figure 1 in image). It departed in darkness and under pilotage with the assistance of three tugs, two made fast and one on standby. The vessel came clear of the berth and started turning to starboard (figures 2 & 3) to enter the channel. A few minutes later the vessel’s rate of turn slowed and the bridge team realised that the vessel had moved further south than desired (figure 4), very close to shallow water. At the same time the echo sounder indicated almost zero.

With the assistance of the tugs the vessel was brought north and continued the transit of the channel without further incident. All tanks were sounded during and after the transit of the channel and engine and rudder movement tests were carried out. No water ingress or abnormality was observed so, with the accord of Class, the vessel continued to the next port where an underwater inspection was to take place.

The company investigation found, among others that:

- The Master/Pilot information exchange did not include an agreement for the manoeuvring/turning of the vessel after departure.
- The vessel’s position during the turning manoeuvre was not monitored by the bridge team.
- The pilot’s instructions to the tug boat skippers during the manoeuvre were conducted in the local language, which was not understood by the rest of the bridge team.

Lessons learned

- A common understanding of the manoeuvre between pilot and bridge team is a good defence against unintended consequences.
- Darkness changes everything. Proper and close monitoring of the vessel’s position during port manoeuvring and navigation in restricted waters is always important, but doubly so in darkness.
- If tug orders are conducted in a language not understood by the bridge team, ask the pilot to keep you informed.

Crew member swept overboard through pilot boarding access door

As edited from USCG (USA) Safety Alert 05-19

A large container vessel was arriving at port in heavy weather; approx 40 knot winds and almost four metre swells. The vessel manoeuvred at about 10 knots to make a lee in preparation to embark a pilot via the side shell access door, 3.9 metres above the water. Two crew members were in the process of opening the pilot access door when the vessel was hit by heavy seas that forced the door open and flooded the embarkation space. As the seawater swirled and splashed in the space it swept one crewman out of the door and into the sea. Another crew member was injured.

Extensive search and rescue operations failed to locate the lost crew member, who was not wearing a personal flotation device.
Lessons learned

- If the side shell door is close to the height of the seas, there can be significant risks to persons in the boarding area.
- This event brings to the fore the importance of crew members wearing personal protection devices and safety lines when working over the side of a vessel, when exposed to the elements or when there is no barrier to prevent an accidental water entry.
- Identify potential hazards and conduct a risk assessment prior to opening the side shell port hatches.

MARS 201971

Lifeboat davit arm imbalance

> While at anchor, the deck crew were testing the port and starboard lifeboat davits, lowering the boats to deck level without crew on board, and then raising them back to the stowed position. The starboard boat was lowered and raised without incident. When the same procedure was attempted with the port lifeboat, the aft davit arm lowered but the forward one did not. The brake was immediately reapplied and actions were taken to bring the boat back to its secured position.

An investigation found that the wire clamp on the davit’s wire rope, which is instrumental in keeping the load balance between the davit arms, had slipped. Further investigation revealed the threads of the clamp’s tightening nut were very worn.

Lessons learned

- A system is only as good as its weakest link. In this case the lifeboat launching was not possible because of one small nut.
- Practice lowering of lifeboats is best done, if possible, without crew on board.

MARS 201972

Unacceptable practices lead to grounding

Edited from official SHK (Sweden) report RS 2019:04e

> A car carrier was underway in good visibility. The OOW had taken his watch at 0400 in the morning. A lookout was also on duty on the bridge but from time to time he left to conduct fire rounds. At one point the OOW altered course to port to close the coast and continued to do administrative tasks, glancing at the ECDIS from time to time.

Occupied with his administrative tasks (or possibly sleeping), the OOW allowed the vessel to continue into shallow water where, some two hours and 40 minutes after having altered course to port, it grounded. At the time, the lookout was away on fire rounds. Upon grounding the OOW put the propulsion to stop. The Master was soon on the bridge and the grounding checklist was activated.

The salvage operation was long and complicated. Once refloated, the vessel was declared a total constructive loss and was sent to scrap.

Lessons learned

- This was a preventable accident: a perfect storm of how not to run a ship.
- Lookouts should perform lookout duty to the exclusion of all other work. If lookouts are performing other tasks either your ship is undermanned or it is badly managed, or both.
- The BNWAS is there for your safety – keep it turned on.
- It goes without saying that an OOW should be sober and occupied solely with navigating the ship.
Stairs slip-up injures crewman

- Some deck crew were engaged in casting off a bunker barge. As they were letting go the lines on the upper deck, they heard a noise at the port side break of the accommodation. On going there, they found an injured crew member lying on the deck.

  Apparently, he had been descending the steep steps rather hurriedly, facing forward and possibly not holding the handrail. Additionally, he had not noticed the stairs were wet due to a slight drizzle. All of these factors allowed him to slip and then slide down the stairs, injuring the back of his head, shoulder and ankle.

  The victim was given first aid and taken to hospital.

Lessons learned

- The best way to descend steep stairs is facing the stairs with at least one hand on the railing.
- Rushing down stairs is not necessarily the fastest way down.
- Anti-slip strips on stair edges can help prevent slips, especially in wet conditions.

Scaffolding comes crashing down

- Scaffolding had been erected on top of hatch cover four of a general cargo vessel to allow two crew members to paint the crane jib while the vessel was underway. Seas were slight with no swell. A permit to work had been issued and the generic risk assessment was considered. Both crew members were wearing personal protective equipment (PPE) and safety harnesses.

  After they had completed painting the accessible parts of the jib, the two crew loosened the top securing rope, removed their safety harnesses and started descending the scaffolding from opposite sides. As they were climbing down the ship suddenly began rolling and the scaffolding tipped over, collapsing on the hatch cover and taking the two crew members with it.

  The two victims were badly injured, and the vessel had to urgently deviate to evacuate them. One of them had to undergo surgery and both were subsequently repatriated under medical escort for further treatment in their home country.

Mooring line pays out too fast

- A tanker was berthing at a terminal. At the aft mooring station, a crew member saw that the slack mooring rope was not feeding out the fairlead and he tried to expedite the feed to the mooring tug. While he was handling the rope slacks on deck, the rope started to pay out and then accelerated outboard through the fairlead.

  The officer in charge (OIC) of the aft mooring station did not notice the developing hazard of the fast moving mooring line as his attention was on the attending mooring tug. The rope caught the crew member’s arm as it slid out, causing a fracture to his left forearm. First aid was provided and the crew member was sent for shore examination, where it was recommended that he be repatriated.

Lessons learned

- Crew should be advised not to take any actions while handling mooring lines unless the OIC has been advised and the action has been approved.
- OICs of mooring operations need to closely monitor crew members to ensure they do not become complacent or otherwise inadvertently undertake a dangerous act, putting themselves and others in a dangerous situation.
- A fast moving, heavy mooring rope presents a clear hazard. If a mooring line is too heavy to control, take one or two turns around a warping drum and then pay it out using an extra crewman to ease off turns around the drum.
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