

Title: V GROUP SAFETY DIGEST

Content:

This VSL Bulletin contains as attachments the following Group Bulletins:

- 1) Technical Bulletin 02/2017 "Administration Notifications"
- 2) Safety Bulletin 03/2017 "Lifeboat Winch Brake Failure"
- 3) Safety Bulletin 05/2017 "Bosun's Chair Rope Failure"

Note: The subject Group Bulletins are herewith attached with their original text, but references to procedures have been amended in line with the Leisure VMS

Actions required

Vessel:

- 1) Review the attached V Group Bulletins
- 2) Revisit the Leisure VMS sections referenced in the Bulletins
- 3) Implement corrective and preventive actions as required by the relevant paragraphs of each Group Bulletin
- 4) Confirm to your DPA

■ ■ Completed ■ ■

ADMINISTRATION NOTIFICATIONS

Applicable to: All Vessels

Event Summary

A managed vessel was recently detained in Italy. The vessel had sustained damage to one of the auxiliary engines which was under extended repair upon arrival in port. PSC considered the damage as an “accident” that **had not been declared** to them, as required by SOLAS Chapter 1 Regulation 11 paragraph (c) - outlined below.

Note: See also Leisure VMS sections:

[Operations](#) > [Ship Operations](#) > [Ship Technical Operations](#) > Maintenance and Repairs carried out by Ships Crew and Managing Technical Failures
[Operations](#) > [Safety Management](#) > Hazardous Occurrences & Reporting

Legislative Requirements

SOLAS Ch. 1 Reg. 11 para. (c) states:

Regulation 11

Maintenance of conditions after survey

- (c) **Whenever an accident occurs to a ship or a defect is discovered**, either of which affects the safety of the ship or the efficiency or completeness of its life-saving appliances or other equipment, **the master or owner of the ship shall report at the earliest opportunity to the Administration**, the nominated surveyor or recognized organisation responsible for issuing the relevant certificate, who shall cause investigation to be initiated to determine whether a survey, as required by regulation 7, 8, 9 or 10 is necessary. **If the ship is in a port of another contracting government, the master or owner shall also report immediately to the appropriate authorities of the Port State** and the nominated surveyor, or recognised organisation, shall ascertain that such a report has been made.

Actions To Take

1. For any vessel that sustains damage or a defect, or where equipment is under extended maintenance, any of which affects the safety of the ship or the efficiency or completeness of its life-saving appliances or other equipment, the correct notifications must be submitted to the management office, and the vessel's Administration and relevant authorities at the earliest opportunity.
2. When vessels are scheduled to arrive in a port, with a system not as per operational design, similar notifications must be advised to the management office, Flag State, Classification Society, and the local Port State Control authorities prior to arrival.

Marine Operations Technical Department

LIFEBOAT WINCH BRAKE FAILURE



Applicable to: All Vessels

Event Summary

Vessel Type	:	Chemical Tanker
Event	:	Lifeboat Winch Brake Failure
Consequence	:	Damage to lifeboat

Incident

The following incident occurred on board one of our managed vessel during a routine lifeboat drill. The port lifeboat was to be lowered to water level without any crewmembers embarking then returned to her stowage position.

On removal of the forward harbour safety pin, the boat started to run from its position and descend under its own weight at speed. This resulted in the aft part of the boat hitting the aft davit and the bottom part hitting the embarkation deck, damaging the boat.

What Went Wrong

Annual servicing of both lifeboats was conducted on 10th February 2017. After servicing, the starboard lifeboat was tested. The port lifeboat was not tested as the vessel was berthed port side alongside at the time.

The port lifeboat and davit winches had not been tested since the date of servicing until the date of incident, despite the fact that the SOLAS regulation 20 / 6.3 and the VMS* dictate the lifeboat is to be moved from its position on a weekly basis. While the moving of the boat was considered a critical requirement, given that the davit system had not been tested at the time of servicing, rough weather deemed that this operation could not be carried out.

***Note:** Leisure VMS section [Operations](#) > [Safety Management](#) > [Safety Equipment & Maintenance](#) > Lifesaving Appliances (LSA), Tenders & Zodiacs and related Planned Maintenance

Before the start of the lowering operation, the effectiveness of the brake was not verified, it was however noted that the harbor pin was difficult to remove, this suggested that there was some issue with the braking system.

Following the incident the Service Company re-attended to investigate the winch brake failure. A significant amount of grease was found contaminating the brake disks. The Service Company then reported that when they had conducted the annual servicing in February the brake disks were also found contaminated with grease. The grease contamination was neither reported verbally to the Master nor stated as a finding in the service report at the time of the annual servicing.

At the time of annual service there was no supervision by a responsible officer. The work was also carried out during the hours of darkness.



Root Causes

Lack of Knowledge:	<ul style="list-style-type: none"> Harbour pin was difficult to remove, which indicated compromised brake system. However, ship staff did not check the brake but continued to force harbour safety pin out by hammer. Excessive greasing of the brake lever shaft bush resulted in grease breaching the oil seals and entering the brake assembly. There was no appreciation of how little grease the bush required nor the small capacity of the annular grease chamber. The practice adopted was to pump grease until it escaped through the outboard oil seal not realizing that it had already possibly breached the inboard seal.
Inadequate Procedures:	<ul style="list-style-type: none"> Vendor Control/Certification checks – The Service Company and Technician had numerous Class and Makers approvals for performing service on lifeboats and davit systems. However, did not have approval for this Maker's Equipment. The risk assessment did take the possibility of the brake failure into account, but a procedure to check the brake functionality was not included as a control.
Improper Planning:	<ul style="list-style-type: none"> The davit servicing was conducted during the hours of darkness, which is an inappropriate time. A responsible Officer did not oversee the servicing work.
Failure to follow procedure:	<ul style="list-style-type: none"> VMS* SOLAS regulation 20 / 6.3 – Weekly Inspections – Boats should be moved

***Note:** Leisure VMS section “[Operations](#) > [Safety Management](#) > [Safety Equipment & Maintenance](#) > Lifesaving Appliances (LSA), Tenders & Zodiacs and related Planned Maintenance”, including reference to MSC Circular 1206 “Measures to Prevent Accidents with Lifeboats”, as amended, and its annex 1 “Guidelines for periodic servicing and maintenance of lifeboats, launching appliances and on-load release gear”

Lessons to be learned / Actions to be taken

Chronic uneasiness should be a way of life on board. When the harbor pin was observed to be tight the question “why?” should have been asked. The Master/Chief Engineer should have been called if there was a concern or lack of knowledge to assess the situation.

Verification of documents prior to finalizing any service is critical. Regulation mandates an authorized service technician to be engaged to carry out the services, who must have authorization by the Maker or Class.

Clear knowledge of the system/equipment/machinery is vital to ensure proper maintenance. The people involved in the maintenance/service did not have a clear understanding of davit brake mechanism and how it worked. This was the reason that when grease was found on the brake assembly during the servicing on the 10th Feb 2017, it was not properly investigated to ascertain source of ingress. Consequently, no corrective measures were taken to prevent recurrence.

Service providers for safety systems, such as lifeboats and davits, must provide copies of their certification verifying that they are authorized to carry out the intended maintenance prior to commencing the service.

Marine Operations Compliance Department

BOSUN'S CHAIR ROPE FAILURE



Applicable to: All Vessels

Event Summary

Vessel Type	:	Oil Tanker
Event	:	Bosun's Chair fell due to rope failure
Consequence	:	Bruises and cuts on the left arm and fracture of Patella of right knee.

What Went Wrong

- **Failure to follow procedures (Working at Height)**
- **Inadequate inspection standard and assessment / evaluation of risks.**
- **Inadequate work standard – excessive slack in the safety line.**

During the rigging of razor wire on the accommodation aft bulkhead scupper pipes, a Bosun's chair was used for working aloft. A standby person was posted on the bridge deck at the top of the job area.

It was reported by the standby person that the Bosun's chair rope parted whilst the Bosun lowered himself. His fall was arrested by the safety harness. He struck his right knee against the bulkhead and wounded his left hand against the razor wire during the fall. The Emergency alarm was sounded and the PA system announcement was made to initiate emergency medical assistance.



Lessons to be Learned

- 1) Never underestimate a task due to the perceived simplicity.
- 2) Complete a Permit to Work for working at height as required by the VMS*

***Note:** Leisure VMS section [Operations](#) > [Safety Management](#) > Permit to Work System > Mast Working Aloft, Overside, On Lifeboats

- 3) Never carry out a task without supervision. In this case, the Bosun was carrying out the task but was also supervising the job.
- 4) The person in the Bosun's Chair must never control the lowering of the chair or the slack in the life line.
- 5) Ensure the Bosun's Chair is in safe working condition prior to use. The Code of Safe

Working Practices for Merchant Seaman Chapter 17 states:

- *17.5.3 On each occasion that a Bosun's chair is rigged for use, the chair, gantlines and lizards must be thoroughly examined and renewed if there is any sign of damage. They should be load tested to at least four times the load they will be required to lift before a person is hoisted.*
- 6) Ensure Manila ropes used for access equipment (such as Bosun's chairs, Pilot Ladders and stages etc) are:
- a) Cleaned using fresh water only;
 - b) Allowed to dry before storage;
 - c) Stored on suitable grating (i.e. wooden pallets) ;
 - d) Stored in a cool, dry and well-ventilated space;
 - e) If stored outside, cover to protect from sunlight.

Marine Operations Compliance Department