Title: V GROUP SAFETY DIGEST (#4)

Content:

This VSL Bulletin contains as attachments the following Group Circular Letter and Safety Bulletins:

1) Circular Letter VCIRC/RSQ/0458 "Prevention of Yellow Fever into China"
2) Safety Bulletins 01/2018 and 02/2018 issued to share lessons learnt respectively from:
   a) a lost time injury accident
   b) an overflow incident during bunkering

Note: The subject Group WI and Circular Letter are herewith attached with their original text

Actions required

Vessel:

1) Review the attached V Group Circular Letter and Safety Bulletins

Note: Reference is also invited to Case studies/ Lessons learnt # 6/2016 and #2/2017 recalling analogous pollution incidents with Leisure vessels

2) Implement actions required by the relevant paragraphs of each Group Circular Letter and Safety Bulletin, as applicable
3) Confirm implementation via the Shipsure Inspection Manager

Note: Record follow-up actions under HSEQ Circular Follow Up

Crew Managers:

1) Review the attached Circular Letter VCIRC/RSQ/0458 "Prevention of Yellow Fever into China"
2) Ensure any on-signing crew member from affected areas holds a valid yellow fever vaccination certificate

[redacted] Completed [redacted]

Circular Letter

Circular Letter No:	**VCIRC/RSQ/0458**	**Section:**	**HSEQ Department**
Issue Date:	**2nd February 2018**	**To:**	**All Masters**
		Cc:	**Fleet Managers**
			HSEQ Managers

Prevention of Yellow Fever into China

Yellow fever outbreaks have been declared by authorities in Nigeria, Peru and Brazil. In order to prevent the spread of yellow fever to China, the Administration of Quality Supervision, Inspection and Quarantine (AQSIQ) issued an announcement on 19th January 2018 which is valid for 3 months.

Announcement

The announcement states that any person aged 9 months or older, from the above mentioned areas shall present a valid yellow fever vaccination certificate to the entry inspection and quarantine institutions when entering China. For those without a valid vaccination certificate, a period of 6 days from leaving the following areas must have elapsed before entry is permitted.

- Nigeria
- Peru
- Brazil (except Ceará, Rio Grande do Norte, Paraíba, Pernambuco, Alagoas, Sergipe)

If any person from the above mentioned countries is experiencing symptoms of yellow fever, which include fever, chills, headache and muscle pain, they must declare this to the inspection and quarantine institutions.

Disinfection of vessels

Where vessels arrive in China from the aforementioned countries, authorities will conduct an examination and if the vessel does not possess a valid disinfection certificate, the vessel may be required to be disinfected at special locations away from land and other vessels.

Vessels that sail from ports within the affected areas to China are required to obtain a mosquito eradication certificate before departure.

Implementation by Local CIQ Offices

Please be aware that CIQ requirements may vary between Chinese ports, for example:

- At Xiamen, mosquito eradication measures will be conducted at berth regardless of proof of disinfection.
- At ports Hainan, Longkou, Laizhou, Yantai, Qingdao and Rizhao, mosquito eradication certificate shall be presented during port entry formalities; otherwise, local CIQ will require mosquito eradication measures to be conducted at anchorage before ship's berthing.

Note: The above requirements may change as the epidemic situation develops. The cost of disinfection may be different from port to port. Disinfection may be charged by vessel GT, ship type or other standard.

Recommendations

Note: Check with local agent regarding CIQ's requirements before arrival so as to avoid any possible delay.

HSEQ Department

Applicable to: All vessels

This Circular has been issued to share lessons learned from a lost time injury incident.

Event Summary

New mooring wires were being fitted to the aft mooring winches. The new wires were stored on wooden reels. During fitting, the crew lost control of the transfer rate of wire rope from the wooden reel to the winch storage drum. This resulted in the wire end breaking loose from the reel and striking the bosun who suffered injuries to his face and head from both the strike and subsequent collapse on the deck.

Photo 1/2 : (Above): Wire from reel through fairlead and back to winch drum. Note that photos show fitting of wires on foc's'le. Incident occurred on poop deck.

3. Above: Wooden reel post incident

4. Right : Injuries

5. Right: Wire eye secured to wooden reel pre-incident

Immediate Actions Taken

- First aid and medication administered as per CIRM advice
- Evacuated by air ambulance to shore hospital for further treatment

The Incident

The wooden reel was suspended just above the deck using a provision crane.

The wire was to be fed over the side, back onboard through a deck fairlead and then onto the winch storage drum. (Photo 1 & 2 above *show foc's'le arrangement*).

However, after 2 layers were successfully laid on the winch drum, the wire on the wooden reel began to run freely overboard under its own weight, increasing the erratic movement of the wooden reel. Seeing the wooden reel rapidly spinning and now swinging from side to side, the Bosun unwisely made an attempt to steady the reel by himself and in approaching, the light rope securing the wire eye to the reel parted, releasing the eye of the wire which hit the Bosun in the head /face.

Direct cause

- Bosun attempting to stop the wire running out
- Lack of control of wooden reel feed rate. A greater length of slack wire on deck leading from the wooden reel to the fairlead would have facilitated this control.

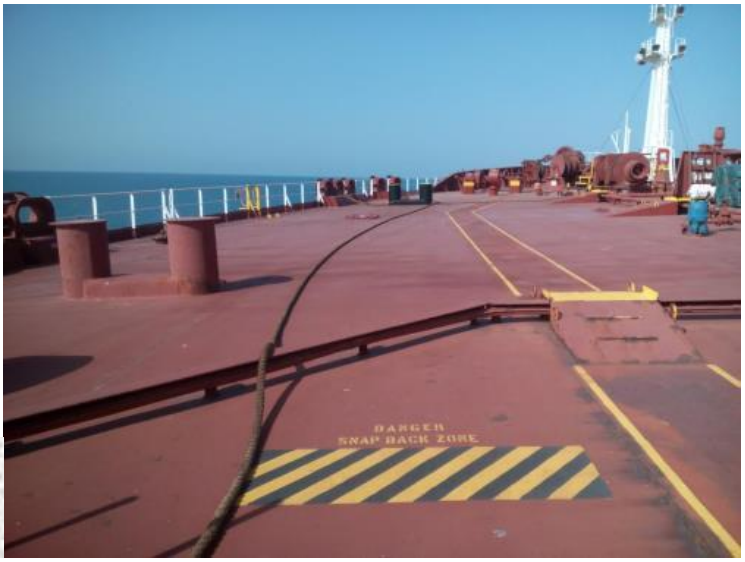


Photo to right shows fitting of wire in foc's'le area with sufficient slack on deck preventing wire running freely overboard

Root Causes

- Lack of planning job with relation to:
  - Control measures to prevent uncontrolled rotational speed of the wooden reel.
  - Effective Risk assessment of the task.

Preventive Measures/Corrective Actions

Following the incident, all work was stopped. The risk assessment was reviewed by ship and shore before resuming operations. The following further actions were put in place to mitigate risk.

- Distance from the wooden reel to the fairlead extended (at least 20 meters) on deck to prevent free running of the wire under its own weight.

Note: **Alternative solution**: A snatch block could have been used in lieu of taking the wire outboard.

Lessons Learned/Experience Sharing

A risk assessment and toolbox talk should be carried out prior to undertaking a critical task. Everyone is responsible for personal safety and the safety of those around you.

Please STOP the JOB if you think an unsafe situation exists!
That's a key step to accident prevention!

HSEQ Department

Applicable to: All vessels

This Circular has been issued to share lessons learned from an overflow incident during bunkering operations

Event

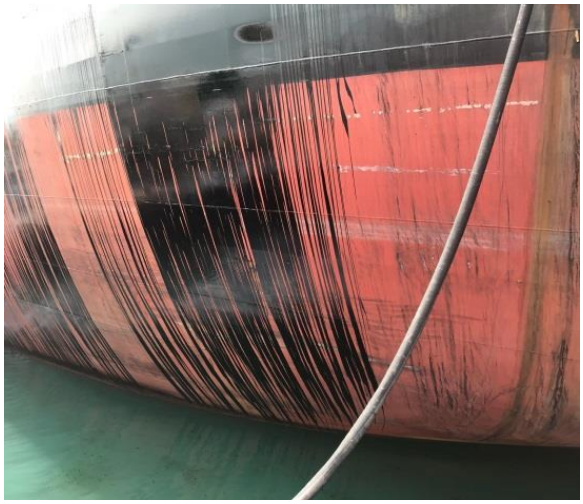
Whilst taking heavy fuel oil bunkers from a barge secured on the starboard side and discharging sludge to a barge made fast on port side, a bunker spill occurred.

Fuel oil overflowed from vent pipes onto the vessels main deck and overboard into the sea.

The bunkering operation were stopped immediately and the emergency response team activated to clean up the fuel oil remnants on the deck by means of chemical oil dispersant, saw dust and rags.

It was estimated that 100Ltrs of oil had escaped overboard.

Contractors were deployed for the clean-up operation on the ships hull and in the water.



What Went Wrong

- Dual operations were carried out without proper planning or risk assessment
- Insufficient crew was available to properly carry out the operations
- Operations resulted in crew fatigue
- No evidence was found that pre-operations meeting with bunker barge was carried out and that bunkering operations plan was discussed and limitations agreed
- Remote level gauges located in ships office were not working properly. Crew aware but no further control measures were put in place
- Tanks soundings were not taken regularly
- Bunkering rate was not verified or reduced as the tank reached its capacity level
- High-level alarm was NOT activated during overflow incident

Lessons Learned

- Pre-operation meetings and information exchange are critically important for good planning, performance of bunkering operations and incident avoidance
- Malfunction of monitoring systems such as remote tanks level gauges shall be considered as serious risk factor and additional control measures need to be considered
- Malfunction of safety devices such as bunker tanks high-level alarms shall be considered as high-risk factors and dealt with urgently
- Simultaneous critical operations such as bunkering, de-sloping or luboil supply shall be properly planned to ensure full control by responsible crew and availability of sufficient crew for the planned operation must be in place