Safety Clicks

Learning from others' mistakes

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New Employees and Learning New Positions

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As the research business starts to pick up a bit, we are in the fortunate position of having more work than we can do with current resources. Using third party vessels is one way to approach this but it also means bringing in new people as well as cross training our existing employees to learn new or different positions.

Our **Short Service Employee** procedures are listed in Chapter 13 of the SMM. It defines a short term employee as one who has worked **less than six months with the company OR less than six months in a particular position.**

So moving someone from an ordinary seaman to an oiler position or from deck work to lab work—if they have never worked that position before or at least not in a long time —would mean they are an SSE to that position and the steps below should be followed.

- **SSEs will be easily visually identified** to the crew by a different colored hard hat, work vest, colored bandana or some other easy to see method to differentiate SSEs in work zones. (*Find what works on your vessel*)
- A current employee who is fully trained and qualified with respect to their job and HSE issues will be assigned as **a mentor to each SSE**. The mentor will ensure that the **SSE only performs tasks for which they have received proper training** and that they operate in a safe manner. (*On small jobs, a mentor may have more than one trainee. Take time to make sure each one can demonstrate proficiency and encourage them to tell you **why** each step is important to the process. If you are the one being mentored, ask questions to confirm what you think you understand and clarify what you don't. Take notes so you don't have to rely on your memory. It's the first thing to go...*)
- The **mentor and a supervisor will** evaluate the performance of the SSE and **decide when the SSE is fully qualified for the job**. (*Survey Crew qualifications cards are where the crew are rated for specific tasks as well as their behavior, safety management participation, safety attitude and demonstrated understanding of the process. Marine crew are rated in similar categories on their crew evaluation by the captain.*)

We do dangerous work in a challenging environment for a living. We work in small teams with very specific skills. Losing even one team member's expertise to a new or inexperienced employee can severely impact the team.

For most of us it has been quite a few years since we were new hires at TDI Brooks. It's worth taking a moment to remember what that was like.

The Mariners' Alerting and Reporting Scheme (MARS) is a confidential reporting system run by the Nautical Institute to allow reporting of accidents and near misses without fear of identification or litigation. The incident that follows does not contain names of persons or vessels, but is a real report that demonstrates how inexperience can lead to misunderstanding and poor decisions and can result in costly accidents.

Inexperience and Lack of Situational Awareness Lead To Collision

A general cargo vessel was making way in a busy commercial traffic lane. A bulk carrier was behind the vessel and slowly overtaking.

TOP Safety Card Hits

(Fleetwide last month)

Housekeeping 4

Safety Attitude 3

Inexperience and Lack of Situational Awareness Lead To Collision

The Officer of the Watch (OOW) of the general cargo saw another vessel ahead. He did not use ARPA or the AIS data to determine the vessel's name or status. He assumed that the vessel was crossing their bow from starboard to port so he thought his vessel was the give way vessel.

The vessel he saw was actually a fishing vessel engaged in fishing, not a crossing vessel. The fishing vessel began to move away from the commercial traffic lane but the general cargo vessel OOW did not immediately notice this. When he did notice the course change, he was confused as he was expecting the vessel to cross the traffic lane. His response was to continue steering starboard, putting the fishing vessel about 30 degrees off his port bow. By then he was becoming unsure of what to do – and in the following two minutes he made several alterations of course to both port and starboard. He was still unaware that this was a fishing vessel trying to move out of his way.

The coast guard became aware that an ambiguous situation was developing and called the general cargo vessel. The coast guard inquired if the general cargo vessel was executing a 360 degree turn. Although this was not the OOW's plan, he replied yes. Immediately after this conversation, the OOW selected hand steering and applied 35 degree starboard helm. He did not realize that he was turning directly toward a bulk carrier about 500m away.

Meanwhile, the bulk carrier's OOW had also been contacted by the coast guard and after a short conversation, ordered hard port helm. Although the bulk carrier's OOW was aware that the general cargo was to do a 360degree turn, **he assumed** that the general cargo would pass ahead before starting the 360 degree turn. But within seconds he noticed that the cargo vessel was turning quickly towards him so he immediately ordered hard starboard helm. Soon afterwards the two vessels collided.

Lessons learned

- Although the fishing vessel had altered course in order avoid impeding the safe passage of the two larger vessels, this alteration was not seen by the general cargo vessel's OOW for over five minutes. This implies that the general cargo vessel's OOW was neither keeping a proper visual lookout, nor effectively using the electronic aids available.
- The intervention on VHF radio by the coast watch officer was timely, appropriate and well-intended. However, it unintentionally influenced the general cargo vessel's OOW to improvise a 360 degree turn, unwittingly turning towards the bulk carrier.
- The general cargo vessel's OOW suffered a complete loss of situational awareness. He was unaware of the proximity of the bulk carrier until the vessels collided.
- The general cargo vessel's OOW was very inexperienced, as shown by his inability to make sense of the fishing vessel's actions and his total loss (or lack) of situational awareness. **He had not yet developed sufficient competency to keep a bridge watch in a busy traffic area at night by himself.**

The general cargo vessel's OOW had been in charge of only 10 bridge watches before the accident and the Master had only known him for about two weeks. It is not known why the Master was sufficiently confident of the OOW's abilities to entrust him with the bridge watch in such a congested area at night.

Things that are glaringly obvious to an experienced crewman may not be at all apparent to someone new in that position—even if he has been working for years in another role.