

# Safety Clicks

Learning from  
others' mistakes

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## Why aren't we learning from our mistakes?

By Shannon Smith

If you review the audits and incidents that TDI has experienced over the last several years, you will see the same thing over and over. Failure to recognize risks and follow safety procedures could easily be the root cause of 90% of our non-conformities and incidents. So why aren't we learning from them?



In this newsletter, two articles are provided. The first is a case study of a triple fatality on a German flagged cargo ship that illustrates what can happen if procedures are ignored and STOP WORK authority is not used. In this case, the chief officer, who was supposed to have completed a Confined Space Entry checklist prior to approving entry into the compartment, tried to save his coworkers and wound up being one of the

victims. If he had followed procedures or if any of the workers had recognized the hazard and used STOP WORK authority, all three men would be alive today.

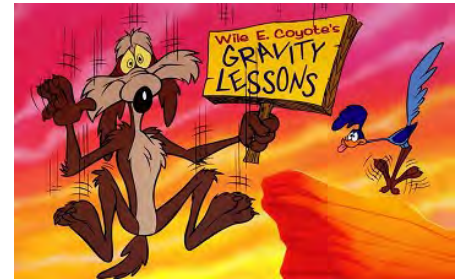
The second was written by a Chevron employee on his first cruise. The safety culture he came from was very different from the Chevron "Do it right or not at all" motto. He learned that the company expected everyone to stop work and work safely— not because it was written on a poster, but because no one wanted themselves or their colleagues to be injured.



Do you feel comfortable stopping work or writing a safety card for something you see that is wrong or out of place or in need of repair? Until you can answer confidently, "Yes!", then we have not reached our goal of a safety culture.



If you see someone at risk, use STOP WORK authority. Mitigate the hazard and then you can continue the work.



*"It's like déjà vu all over again."*

*Yogi Berra*

"... it seems unlikely that this incident was the first time anyone on the vessel had entered a confined space without following the rules and very likely that it was perceived a mere paper exercise that was unnecessary in the 'real world of seafarers'."

*Bob Couttie, Maritime Accident Casebook*

### Got a Story?

Share your experiences of when STOP WORK authority was used to stop unsafe work. Has anyone stopped you from hazardous conditions to keep you safe? Thank them! [HSE@tdi-bi.com](mailto:HSE@tdi-bi.com).

### TOP 3 Safety Card Hits

(Fleetwide last month)

**Communications 0**

**Safety Attitude 0**

**Tools & Equipment 0**

### **"Suntis Triple Death Mysteries" by Bob Couttie**

Is there anything remotely ambiguous about the signage on this hatch-cover? Why did three seafarers ignore them? Unfortunately the report from the [Federal Bureau of Maritime Casualty Investigation](#) on three confined space deaths aboard the German-flagged general cargo ship Suntis does not tell us. Key questions remain unanswered but the circumstances are all too familiar.



**“Suntis Triple Death Mysteries”** by Bob Couttie (cont'd)

According to the report, “MV Suntis left the port of Riga in Latvia on 19 May 2014 and reached the port of Goole in the United Kingdom on the evening of Saturday 24 May 2014. The discharge operation began with the unloading of deck cargo by a shore-based crane and stevedores at about 0545 on Monday 26 May.

Two OS were assigned to remove the tarpaulins that were attached to protect the deck cargo on board. One crew member (possibly both) climbed into the forward tween deck hatch during the discharge operation. The chief officer and a third seaman noted the absence of the two other crew members and proceeded to look for them. When they were not found in the aft superstructure, the AB and the chief officer proceeded forward (the AB via the wood loaded main cargo hatch cover and the chief officer on the starboard weather deck). On arriving at the end of the hatch, the AB saw the chief officer call and then climb into the forward hatch to the tween deck. When the AB arrived at and looked into the hatch, he saw the chief officer collapse.

“The AB immediately climbed into another hatch to forecastle’s access hatch and switched on the cargo hold’s ventilation fan from there. After that, he ran back to the superstructure and alerted the master at about 0645. At the same time, the stevedores were informed that something was reportedly not right on board the Suntis. The AB collected his EEBD, which was stored in the cabin, and a breathing apparatus (BA) set from the aft store. In the confusion, he forgot the full- face mask, however. On arrival back at the forecastle, lifting slings were passed around the three collapsed crew members with the assistance of the two stevedores and they were pulled on to the deck. This involved the two stevedores, one with and one without an EEBD, and the AB with the BA set climbing down the ladder alternately.

“Although the BA also worked to some degree without wearing a mask, the AB and the two stevedores suffered severe breathing difficulties. None of the three crew members who climbed into the hatch survived despite immediate attempts at resuscitation.”

**Baldly, the casualties died because they broke the rules.**

The situation is a familiar one – an initial victim enters a dangerous space and collapses. A second person attempts a rescue and also succumbs, followed by another. Two-thirds of confined space casualties are people who have attempted a rescue.

**If you don’t do it right it’s your friends who will die trying to save you.**

The investigation describes the rescue attempts as ‘reckless’ and it’s hard to disagree. Inability to use the BA equipment properly and the inappropriate use of an EEBD – a piece of kit that should never be used to enter a dangerous space – suggest strongly that the crew had



BSU says the crew were accustomed to handling timber cargo and the risks involved.

either not been drilled in confined space rescue or that any such drills were ineffective. The investigation seems not to have determined what training had been done.

Suntis’s SMS looked good on paper: Any compartment or tank that is isolated from the outside air for an extended period is, without exception, defined as an enclosed space and may be entered only with the approval of a ship’s officer. The ship’s officer must work through and complete a checklist (‘Entering a confined space’) prior to approving entry to any such compartment. That requires measurement of the ambient air and only then will the master or ship’s officer responsible approve entry into the compartment”. Yet it seems unlikely that this incident was the first time anyone on the vessel had entered a confined space without following the rules and very likely that it was perceived a mere paper exercise that was unnecessary in the ‘real world of seafarers.

“First Time at Sea” by Claudio De Sousa Santos of the Hydra Voyager (cont’d)



This is my first time at sea as a deck cadet. Whilst on land I never fully considered the consequences of my actions; the most important factor during my life before coming to sea was to get the result of the job regardless if you are correctly following procedure. At sea, working for Chevron this could not be farther from the case.

Thus far, **I have learnt that getting results should never mean taking shortcuts or putting yourself, others or the environment at risk...** I have been surprised because here safety is the most important key to accomplishing any job, and tools such as the safety working Meeting, the Tool Box Meeting, Stop Work Authority based on HIT wheel help us when the job does not comply with our tenets of operation.

For example, I was participating in a job carried out in the Engine Room (removing fresh water pipes to be washed) and this task required a ladder climb. The ladder was not well attached on the strong point, and tools carried in pockets could fall resulting in serious injuries. **The job was stopped by the Master** as soon as he noticed that the job was not being carried out accordingly. The abnormal condition was addressed so then the safe working practices and procedure followed. I feel very fortunate to now be working for Chevron where time is taken for jobs to be planned correctly and whenever the job cannot be carried out safely or it becomes dangerous in any way it is stopped until proper arrangements are made. That is our commitment as Chevron and I am very proud to be part of Chevron’s safety culture: “Do it safely or not at all. There is always time to do it right.”

*[This article was taken from the Chevron September 2015 Safety Bulletin.]*

G T A X E H W Y H B  
 O N L R F A O L I Y  
 A H J H N D J S S P  
 U X F U S O M Y P A  
 V Z J P I O C I S B  
 W J I B C G T I O S  
 A U E L O X V S P A  
 I Z M H T I G L E R  
 J B W Y P X S F P V  
 X N V D Q O R B E W

Safety Tips– Word Find

See if you can find these common TDI acronyms.

- ABS– American Bureau of Shipping
- ORB– Oil Record Book
- MOC– Management of Change
- MLC– Maritime Labor Convention
- SOPEP– Shipboard Oil Pollution Emergency Plan
- ISPS– International Ship and Port Security code
- OTP– Oil Transfer Procedures

- NOC– Notice of Change
- ILO– International Labor Convention
- ISM– International Safety Management code
- PIC– Person in Charge