Information Sharing Bulletin

Premuda

Issue n° 23

August 2013

Lesson Learned

Summary:

Dear Premuda's fellows,

It's time for another Bulletin and for some general reflections.

Unfortunately, shipping market is still depressed and no specific signs of an increasing trend are still at the horizon.

But as a great person of the shipping said:

I"t's during our darkest moment that we must focus to see the light" (Aristotele Onassiss)

Despite the hard times, our Company is surviving and the help of everyone is appreciated, both on board and ashore.

Nevertheless to say, we need to row all together in the same direction, to bring the ship, our ship, out of the rough seas.

Briefly detailing this issue, the Academic lesson continues the excursus in the "world" of the Bills of ladings, which too often aren't receiving the necessary attention they require and need. The Bill of Lading is the most important document among all the cargo documents: its incorrectness might lead to serious implications and problems which cost time and enormous amounts.

The Vetting section is always well exhaustive and is highlighting the "Repsol Factor".

The Safety section deals this time with an important argument: the portable instruments and their calibration on board. Unfortunately we have to record several issues for this matter , causing on board problems and high costs for the transport and services. In this section there will be some information which we hope will be useful to the users on board and which can help for the use and the checks on board of these instruments.

Another important issue is that by this Edition, we will stop to print and send on board paper publications: Company's people will find the Information Sharing Bulleting available into the web page: this will save costs for printing and mailing publications, saving also the time spent for the latter and thus having the publication immediately available, upon its publication. In this sense we are aligning our Bulletin to the modern concept and system of working.

We hope this little change will improve our current system and our efforts for easier solutions will be appreciated.

Good reading to everyone!

G. Mortola

In this Issue:

The selected closed cases:

§ **Hazardous occurrence**

- **Lack of knowledge of ship's equipment**

§ **Incident**

- **Steam burnt**

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Selected closed cases

Premuda

COMPANY CLOSING OF ACCIDENT, INCIDENT, NEAR MISS, FAILURE REPORT

VESSEL	**FOUR BAY**	LOCATION	**AT SEA**
DATE	**20.06.13**		

Hazard occurence- Lack of knolwedge of ship's equipment

WHAT HAPPENED

During navigation with bad weather,the engine staff commence to transfer the exaust valves from diesel generator flat to engine room workshop using the fixed chain block. Chief engineer noted that the chain block MBL was below the weight of exaust valve,and He stop the operation.The operation resumed using engine crane.

COMPANY ANALYSIS/ROOT CAUSE ANALYSIS OF INCIDENT

Probably engine staff was not aware about mbl and swl of chain block available in engine room in use.

Probably not a correct breifing has been done to engine staff for this job identfyng all possible hazards and necessary tools to be use.

CORRECTIVE - PREVENTIVE ACTION TAKEN BY OPERATOR

§ Master should focus the matter during next safety meeting remind the importance to ensure all crew mwmbers are familiar with tools and equipment to be use for their jobs.

§ Safety Officers must carry on a briefing to ensure all crew involved in the job are aware about which are the correct tools to be use and all possible hazards.

§ Safety officer must check that all SWL are properly marked on equipment and maintenance is carried out on regularly basis and recorded on dedicated manual as per company procedure.

Selected closed cases

Premuda

COMPANY CLOSING OF ACCIDENT, INCIDENT, NEAR MISS, FAILURE REPORT

VESSEL	M/T FOUR SMILE	LOCATION	ADRIFT
DATE	03/07/2013		YANBU

INCIDENT - STEAM BURN

WHAT HAPPENED

Russian 3/E while overhauling a steam valve had his forearm burned. He did not report the case to anybody but just when the wound become worst on June 29th. Master immediately contacted CIRM for assistance and send him to shore Doctor on July 2nd. He was then declared fit for duty and sent back on board with additional medicines.

COMPANY ANALYSIS/ROOT CAUSE ANALYSIS OF INCIDENT

Feedback from ship-shore investigation stated he was not wearing heat protective gloves as assigned for the job.

CORRECTIVE - PREVENTIVE ACTION TAKEN BY OPERATOR

§ Master was instructed to held immediately a Crew/Safety meeting aimed to raise the bar of safety attention and promote widely use of Risk Assessment. This included the request of additional videotel CBTs for all engine crew to avoid recurrance.

Vetting Issues

Dear All,

Let us comment the second quarter period of 2013 on Vetting activity of the Fleet. As everyone knows Company sold out M/T Framura by 30/05/2013, and let me thank the Lady for the services rendered to the Company and all of us.

Title of this quarter may be the "REPSOL FACTOR".. as a matter of fact this Oil Major vetting approach is quite indigestive for our ships and Crew Staff, as by memory all Premuda vessels need at least to try one negative before to eventually succeed to get a positive one. Here we are claiming two negative, one with Four Bay (SIRE), and one with Four Island (Safety inspection). The two things are different as we well know that the SIRE inspections are going to OCIMF and so they are public for all Oil Majors performing screening on line. REPSOL standard is quite a strict one, and surely either Four Bay either Four Island are not youngest lady, but it is quite a pity see that in less of two months Four Bay is assessed positively by SHELL, while REPSOL is always penalizing any inspected vessel.

To be then underlined following points:

Four Sky excellent performances, especially the 0 REMARKS in Rotterdam, in the strict path of inspections carried out after the anchor and chain incident and the clearing of all technical hold received by involved Oil Majors, plus the Exxon one, discovering about incident via OCIMF and so claiming for a direct information!!

Difficulty for some Vessels, Four Wind, Four Island, for different reasons, as for instance operation in difficult areas (not reachable), or not vessel readiness, to be submitted to SIRE inspection. For these difficulties the latest SIRE of the vessels is going to be over dated and vessels might be difficult to be chartered on spot. Maximum attention and professionalism should be applied for preparing the vessel to next crucial appointment that might determine an opening/closing step on commercial vessel's chance.

Regards to all M. Leveratto

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SIRE Inspections performed during May – August 2013

Four Bay

*Vessel performed SIRE inspection with **REPSOL, Cartagena 21.05.2013 (10 NO)** with negative result, to be re-inspected at convenient disport. Then vessel performed a SIRE Inspection with **SHELL, New Mangalore 13.07.2013 (7 NO)** with positive result. Chevron and ExxonMobil referring to last Shell SIRE Report if necessary. Next inspection to be performed either with BHPB-Rightship or with BP, which considered vessel as unsuitable due to last Repsol SIRE Report.*

Four Island

Inspection was requested on 17 June 2013 to Shell at Al Muajjiz, Yanbu with no result, as well as to BP with same result.
Next SIRE Inspection to be performed with Shell, then with BP.
*Vessel performed Safety Inspection (NOT SIRE) with **REPSOL, Cartagena 23/07/2013 (15 No),** with negative assessment.*

Framura

Due to vessel's age limit (20 years) approaching in July and age policy of Major Oil Companies no other inspection was performed until vessel was sold on 30 May 2013.

Four Moon

No SIRE Inspection performed during this period, but probably a SIRE inspection will be requested by PDVSA at first opportunity in order to verify vessel's condition after their inspection carried out last 10 July 2013 (no SIRE inspection).

***Four Wind**: After last Shell SIRE Inspection performed last February with positive result, unfortunately it was not possible to arrange any other inspection due to vessel's long stay at Lome, Togo (West Africa) and voyage to Ust-Luga, Russia, where no operation was allowed at terminal due to security problems.*
Vessel was screened negatively by Total referring to last Shell SIRE Report, therefore inspection was requested to Shell at Tramandai, Brazil, on 15 July 2013, with no result. Then inspection was requested to Total, Eni, Statoil, BHPB -Rightship and Lukoil with the same result due to non availability of Inspectors at Tramandai.
SIRE Inspection has been requested again to Shell at next discharging port, hoping to have a positive result also in order to obtain Total vessel's clearance.

***Four Sky**: Vessel performed SIRE Inspection with **BHPB-Rightship, Balongang 06.05.2013 (3 NO)** with very positive result, then with **BP, Daesan 06.07.2013 (7 NO)** with positive result. Then vessel performed SIRE Inspection with **Shell, Rotterdam 29.08.2013 (0 NO)**, with excellent result. Exxon and Chevron referring to last Shell SIRE Report if necessary.*

Bulk Carriers:

***Four Springs:** no inspection performed during this period. Next inspection to be performed with BHPB-RightShip.*

Enclosure Company analysis on M/T Four Bay REPSOL SIRE.

10.09.2013 VETTING DEPARTMENT

Vetting Issues

PREMUDA Spa. GENOVA - VETTING/SAFETY AND TECHNICAL OFFICE

Vetting/ML - 01/2013

Date 3rd June 2013

FROM: M. Leveratto - Tech & Vetting Manager

TO: F. Beltrami - Fleet Director

L. Benzi – Commercial Manager

G. Mortola - SQEMS and Ops. Manager

Danilo Chiaruttini – Crewing Manager

Angelo Patanè – Vessel Superintendent

Paolo Leonetti – Safety Superintendent

REF: ***Analysis of negative outcome of REPSOL vetting inspection carried out on M/T "Four Bay"– IMO n 9015060 on 21st May 2013 at Cartagena (Espana).***

SIRE # MSZT-1349-1724-3692 ***carried out by Capt. Rafael Castillo by REPSOL .***

Result of the REPSOL Vetting inspection carried out on the M/T "Four Bay", with vessel under discharging operation in Cartagena port, on 21st May 2013, has been assessed negatively.

We regret to inform you that as a result of the inspection carried out the above mentioned vessel she has been rated as NOT ACCEPTED for Repsol use, as she does not comply with the Minimum Safety and Operational Standards required by this Company.

The status of non acceptance of the vessel will remain until the attached observations have been reported dealt with and it has been confirmed by a new physical inspection.

The initial list of Observation raised were related to ten (10) issues.

But as a matter of fact the observations received on official SIRE report were ten (10), even with a repetition of same technical observation in 8.48 and 11.42.6.

Vetting Issues

No any specific explanation, even if requested, was received by REPSOL for better addressing the SIRE failure reason. But to be noted that on initial "Summary of Observations", enclosed for prompt evidence, following notes were marked as "VERY HIGH" to be read as high risk, HR, as intended normally by other Oil Majors:

VIQ ITEMS 4.36 – 6.1 – 8.48 – 12.4 – 12.13

As a quick conclusion the failure is a direct consequence of the HR number of observation raised (5!!), penalizing the vessel in a direct way.

To be noted that the SIRE inspection has been prepared since long time, at least over one month, and following cautions and organizations have been settled for the task:

1. Philippine Chief Mate has been removed and changed with Russian one, Mr Kamzel, judged better in proficiency and Company system knowledge
2. Italian Chief Mate Mr Belviso has been embarked as additional for the voyage Malta to Cartagena for direct support
3. Safety Superintendent Mr Leonetti embarked in Malta to Cartagena for complete review of Safety/Navigation issues, plus over-viewing of Crew Staff/Vessel preparation.

On Board following Seniors:

- Captain → Enrique Vozmediano
- Chief Mate → Vadim Kamzel /Amedeo Belviso
- CE → Carlo Savalli
- Second Engineer → John Arnaiz

Reason of present communication is to analyze the grounds of present failure to be later discussed by the departments/Ship involved in the observations raised.

COMPANY ANALYSIS

We are here listing the observations given to the vessel :

2.7 Is the vessel free of conditions of class or significant recommendations, memoranda or notations?

Inspector Observations: The following class memoranda were note in the class status survey as follows: M.22.1.B: At the water ballast tanks surveys, the connections between sloping plates and shelf plates and lower athwart ship brackets at fwd corrugations are to be checked. M.27.1.8: SPS overlay reinforcement in cargo hold no. 7, the welding knuckle joint in way of SPS overlay reinforcement and SPS reinforcement in way of to be submitted for close up inspection from ballast tanks side and cargo hold side at each intermediate and special survey for the purpose of detecting its structural condition.
Company reply to REPSOL via OCIMF: As per enclosed abstract copy of Survey Status, the two memoranda (M.22.1.B raised on 29 Oct. 2003 and M.27.1.8 on 15 July 2005) were raised as consequence of a structural continuous monitoring and improvement carried out in vessel's life. These two WBTs are inspected according to Class requirements.

In addition of Class requirements twice a year during the scheduled ballast inspection of WBT Nr. 7 PT and Nr. 7 STB the welding knuckles are close up inspected and reported in the ballast monitoring form (see enclosure).

Vetting Issues

4.36 Is navigation equipment appropriate for the size of the vessel and in good order?

Inspector Observations: Course recorder was out of order.

Company reply to REPSOL via OCIMF: The course recorder was temporarily out of order due to loss of configuration. It was reset, but with negative result because it was losing the configuration after short time.

Service has been carried out at Algeciras anchorage on 28 May 2013 in order to replace the gyro signal converter Sperry 4891-AA Unit, the course recorder is now working properly (see enclosed Aage Hempel service report).

6.1 Are the Engine Room (Part I) and Cargo (Part II) Oil Record Books (ORBs) correctly completed?
Inspector Observations: The last bunker lines pressure test was done on 05 September 2012. Master stated that the test was an hydrostatic test using water and after the water was drained to the port slop tank. There was no record of diposal of this bunker oil contaminated water in the ORB Part II.
Company reply to REPSOL via OCIMF: The annual pressure test of bunker lines was done on 5 September 2012 but not properly recorded. Unfortunately during vetting inspection there was a misunderstanding, Master did not state that said hydrostatic test was done using water and that said water was drained to the pt slop tank, but he only said to your Inspector that the test could have been carried out either with water or with fuel oil using the F.O. transfer pump. There is no evidence of how the test was done and Senior Officers involved in that test are no more on board. In any case additional training to the Senior Officer presently on board has been conducted concerning the entries in ORB Part II (see enclosure). The schedule and procedure to carry out the pressure test on deck piping will be added in Amos PMS in order to follow the proper way and to have evidence of the test.

6.29 If the ODME has not been operational, was the fact recorded in the Oil Record Book?

Inspector Observations: The ODME was out of order on 08 May 2012 due to mechanical seal of the pump damage. The fact was recorded in the ORB Part II under code O instead of M. The equipment was repaired on 30 June 2012 but was not recorded under code M.71.
Company reply to REPSOL via OCIMF: This observation is referred to an ODME failure occurred last year and not properly recorded in ORB Part II, as well as the repair of said equipment. In order to avoid any reoccurrence a training was carried out to Senior Officer last year (see enclosure).

Additional training to the Senior Officers in charge will be conducted regarding the entries in ORB Part II.

8.9 Is the vessel free of inherent intact stability problems?

Inspector Observations: The vessel was not free of inherent intact stability. When all cargo tanks were 30% full and ballast tanks empty, as per loading computer, the stability was not OK.
Other Inspector Comments: This condition was well known by deck officers and a notice was clearly displayed in the CCR
Company reply to REPSOL via OCIMF: Vessel is in compliance with the intact stability requirements as per regulation 25A MARPOL 73 (78) as amended, and this was verified by Class (please see enclosed RINA declaration). All Officers are well aware of the stability conditions, and the notice is clearly displayed in the CCR.

8.48 Is the inert gas system including instrumentation, alarms, trips and pressure and oxygen recorders, in good order?
Inspector Observations: The fixed oxygen meter on the IG room was out of order.

Other Inspector Comments: One portable oxygen meter was placed and the oxygen content was checked by ship's personnel manually every 15 minutes. A new unit and the technician arrived on board before finish the inspection.
Company reply to REPSOL via OCIMF:

Suddenly before vessel's arrival at Cartagena the O2 analyzer was out of order. Immediate Failure Report was raised informing Company, Agent/Local PSC. According to Company instruction and failure process management carried out proper Risk Assessment, see enclosure. Continuous monitoring of O2 content in

Vetting Issues

COTs started immediately, and additional portable O2 meter was fitted on IG supplying line, recording data every 15 minutes.

Servomex (O2 analyzer Maker) Agents Service Engineer was requested to board the vessel as soon as arrived at Cartagena with spare analyzer unit. Repair completed during SIRE inspection as per enclosed service report. The unit is brand new and is working properly.

11.42.6 Inert gas plant, including the fans, scrubber, analyser and valves

Inspector Observations: See 8.48.

Company reply to REPSOL via OCIMF: See item 8.48.

12.4 Is the general condition, visual appearance and cleanliness of the weather decks satisfactory?
Inspector Observations: Aft weather decks and the central part of main deck were in very poor condition. Generalized rust spots and corrosion were observed.
Company reply to REPSOL via OCIMF: Main deck maintenance is/was in progress under continuous monitoring. Areas highlighted were the last ones to be carried out according to vessel's program.

The maintenance of these weather decks has been improved and properly carried out (see enclosed photos).

The maintenance is well programmed and will continue in the remaining decks.

12.7 Are pipe stands, clamps, supports and expansion arrangements satisfactory?

Inspector Observations: A number of clamps were found corroded.

Company reply to REPSOL via OCIMF: Pipe clamps maintenance and replacement is in progress according to Company Technical Inspection and reports. The maintenance/replacement of all clamps has been improved and properly done (see enclosed photos) for indicated areas. Check and maintenance of clamps will continue.

12.13 - Is the general condition of electrical equipment, including conduits and wiring, satisfactory?
Inspector Observations: One external light cover located in the poop deck, starboard side, was maintained closed using plastic ties.
Company reply to REPSOL via OCIMF: The plastic clamps were fitted as a temporary additional closing of the light cover, found not perfectly closed at last control/neon change).To be noted that the light under question was not in a dangerous area (poop deck). Full light has been replaced after completion of cargo operations (see enclosed photos).

All external light covers have been inspected in order to confirm the proper closing.

Company focused the matter and all aspects have been analyzed.

Certification and Documentation → 1 OBS (VIQ 2.1)

Navigation → 2 OBS (VIQ 4.4 then NOT reported in SIRE ; VIQ 4.36 – VERY HIGH)

Pollution Prevention → 2 OBS (VIQ 6.1 – VERY HIGH ; VIQ 6.29)

Cargo and Ballast Systems - Petroleum → 2 OBS (VIQ 8.9 ; VIQ 8.48 VERY HIGH)

Engine and Steering compartments → 1 OBS (VIQ 11.42.6 as repetition of 8.48)

General Appearance → 3 OBS (VIQ 12.4 VERY HIGH; VIQ 12.7; VIQ 12.13 VERY HIGH)

Vetting Issues

Vessel arrived to Cartagena with two important equipment out of order:

1. IGS O2 analyzer (official failure report n 04/2013 dated 16/05/2013) →VIQ 8.48/11.42.6

   As easily understand this failure is an important one. The matter has been requested by Technical Office to Master and Staff for a prompt risk assessment and effective evaluation of all actions intended to perform the discharging operation under Safe Control and monitoring. Immediate information has been given to Agent/Local PSC for eventual specific instruction to be followed. IGS quality has been duly checked, by additional O2 portable equipment fitted in same position on MD supplying line and recorded officially on a constant monitoring. Alternative manual operation has been implemented by Master under Safety Superintendent direct control, and explained to all Staff.

   Maker Service Engineer attended the vessel at Cartagena and completed the repair before completion of SIRE inspection.

2. Course recorder (no any official Failure has been raised as the Course Recorder was randomly working but Service attendance has been duly organized at discharging port) → VIQ 4.36

   As explained in Company reply the workability of the course recorder has been restored with Service attendance in Algeciras, after completion of the unloading operation. This in order to allow the proper attempts to repair/check for identification of correct remedial action.

Both of the Observations have been considered as HIGH RISK, but as a matter of fact both failures, affecting the automated workability of the vessel for systems involved, have been managed on manual mode under safe and evaluated approach.

Analyzing the remaining items raised the next HIGH RISK items were related to VIQ chapter 12 - "General Appearance", and specifically to Main Deck condition on Aft and CN position (12.4), and to one external light cover, not in hazardous area, found secured closed by plastic strap (12.13). These two items, although underlining, with the additional observation (12.7) related to pipe clamps condition, a general maintenance condition not so good as expected, but for sure with due maintenance in progress according to Vessel Superintendent instructions, don't seem to be correctly marked as HIGH RISK. The evaluation is naturally a personal judgment and nobody can weight differently by inspecting body, but on vessels over 15 years age the maintenance is running on constant basis, according to vessel possibility under operation. By Vessel Master reporting under vessel preparation to SIRE inspection, correct continuous maintenance performance during Master La Pira embarkation period (14/10/2012 to 15/03/2013) could be questionable and will be firstly analyzed on vessel reports and then eventually discussed in pre joining briefing. But for sure vessel was not performing any SIRE since 11/12/2013 SHELL

Remaining items, two of which are related to a design issue (so no any chance to correct them, 2.7 and 8.9), VIQ 6.1 VERY HIGH and 6.29, are related to Pollution Prevention issues.

Both issues are related to Oil Record Book, ORB part II, and due recording to be performed on the same. Independently by the HIGH RISK one referred to Main Deck line pressure test, and supposed reply given by Master for an hydro-test performed with water then not reported in slop discharge, it is for sure to be recorded that this is a quite repetitive item raised by SIRE inspector, and that as Company we still have to address the issue on AMOS PMS with detailed job description that should have for sure supported the Master in the case, even recording what done along the time.

As final statement we identify the cause of the SIRE failure the n 5 HR observation received by REPSOL.

As a side note to be considered the actions already organized for the expected SIRE inspection and that unfortunately didn't turn out in a positive result:

Vetting Issues

- Safety Superintendent on board from Malta to Cartagena for carrying out Safety inspection and preparation (to be anyway noted that vessel obtained no remarks on Safety, good result, and only one on Navigation on course recorder issue)
- Change of Chief Mate from Philipino to Russian, with additional Italian Chief Mate from Malta to Cartagena.
-

We want here to underline all commercial consequences penalizing the vessel trading and Company business following a negative SIRE, and all the activity, including overcost and loss, it is necessary to activate to recover the failure especially in a market moment as the one we are leaving nowadays.

The commitment of Anyone, at any position, should be extremely more detailed and proactive allowing to the Team to reach the appointment fixed.

Requested action deemed necessary to interrupt and prevent fault like that:

1. Company will spread this analysis to all departments and Vessels and matter will be focused in any technical meeting and Master briefing in Office before embarkation.
2. Company meeting by Technical/Safety/Manning/SQE for deep analysis of Safety inspection and SIRE outcome.
3. Immediate Technical inspection scheduled to be carried out by Vessel Superintendent to verify correct closing of all notes raised and to confirm the actual maintenance program.
4. Vessel to be strictly monitored by all Office departments in order to clear any observation in the shortest time allowing the vessel to be presented to SIRE at soonest.

Buongiorno Marco,

mi sono permesso di telefonare all'ispettore ultima vetting REPSOL Rafael Castillo al riguardo il risultato della ispezione.

Sono rimasto molto male e anche se la decisione è stata pressa a Madrid, volevo capire il perché. Pare che siamo stati bocciati per:
Pressatura delle linee in coperta.
Servomex in macchina.
Course recorder.

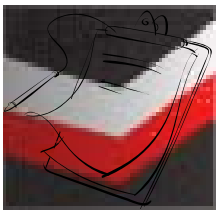
Come sempre, mi ha detto che si dovrebbe chiedere un'altra ispezione tra un mese per controllare che le osservazione sono state chiuse veramente.
Pare che non basta la nostra risposta anche se le prove delle chiusure sono evidenti.

Niente altro. Qui si continua lavorando come sempre. Altro non posso dire.

Saluti

Master M/T "Four Bay"

Remarks to be shared



Dear All,

WELCOME INTO THE SAFETY PAGE!

Dears readers, in this bulletin I would like treat the argument of "Use of electronic portable instrument for gas detection".

Since we noted several problems on use of portable gas analyzer instruments "Drager", has been decided to issue a guideline that can be used as reference from all ship's officers, to reduce instruments replacing for lack of familiarization with these gas analyzers.

.GUIDELINES FOR THE CORRECT USE OF ELECTRONIC PORTABLE INSTRUMENTS FOR GAS DETECTION

PRELIMINARY REMARKS

Please always consider that Dräger Portable Instruments are to be intended as **lifesaving devices**, for **personal use**, in ventilated confined spaces where high concentrations of corrosive volatile gases are not expected.
The use of these instruments as tanks, processes, lines 'analyzers' can be performed **for a limited time**, and **only if** the absence of chemical contaminants, gases from the cargo, process gases etc., in high concentrations, was ascertained. **If in doubt, check the atmosphere** using Dräger Tubes.
Measures of a different nature (e.g. continuous monitoring of % volume of O2 in a tank) must be performed with an appropriate instrument (typically, a paramagnetic-cell based Analyzer).

SAMPLING AND MEASURING

- Prior to sampling, check and test the atmosphere of the volume you're attaching the sampling tube to.

- If a **Cargo Tank** is to be sampled, refer to the Cargo Safety Sheet that the charging facility is supposed to have issued. Can the Cargo release corrosive volatile substances? Is the Sculpture content substantial? **If in doubt, check** at least the H2S content using Dräger Accuro Pump and Tubes.

- **Always use the line filter** when sampling from remote.

- If you really have to sample from a remote potentially harmful space, perform brief, spaced samplings, leaving the instrument pump fresh air for several minutes in between.

- If you're not sure how to handle a potentially damaging application, don't hesitate to **contact the SafetySupt and ANCB's technical staff** to get advice on how to rig up a reliable and safe measure.

MAINTENANCE

- Routinely check the line filter and all the internal filters of each instrument. Filters must be **clean and dry**.

- Don't let the instrument's batteries discharge completely. If the batteries get totally empty, the instrument will need a long warm-up time when switched on again. Instruments can rest on the charging cradle all the time when not in use. The electronic charger unit will prevent overcharging and/or overheating.

PERIODIC CHECK-UPS

- Use **only** Calibration Standards for Portable Gas Instruments, certified and current.
- **Never use gases from other sources**, fire detector test bottles, lighter gas etc.
- If in doubt, refer to the latest Calibration Certificates issued by the Calibration Company to identify the correct standards.
- In case of **LEL test**, consider that different norms can be followed. 100% LEL can correspond to 5% Vol, or to 4,4% Vol (International Standard, followed by ANCB and Premuda). Check the latest Calibration Certificates to identify the correct ratio.

TROUBLESHOOTING

- Should an instrument sound continuously and give sensor alarms after a measuring cycle, do as follows:

  Switch the instrument **off**.
  Take it to a **clean** air area.
  Switch it on and **start the pump**

Remarks to be shared

Leave it breathe in fresh, clean air for **10 minutes**.
Perform a **Fresh Air Calibration** (refer to Instrument's Instruction Manual)
If the alarms don't go off, **check the internal filters**.

- Don't overlook **cross-sensitivity**. In the sampled mixture can be found gases to which the sensor are cross-sensitive. This can result even in negative (below-zero) readings. If in doubt, refer to the Cargo Data Sheets issued by the producer.
Cross-sensitivity can in some cases explain temporary drifts, alarms and faults.

Read and understand all the Sensors' Data Sheets. These, if not present on board, are available on demand in digital format from ANCB.

CONCLUSIONS

Once again it must be stressed that in order to obtain safe and accurate results from portable electronic instrumentation, they must be operated **only by trained staff**, with a good understanding of the instruments' operation, **familiar with the User's Manual**, and having all the written **documentation**, data tables and charts of sensors and gases at hand.
It is moreover crucial that the person in charge, before performing a measure, makes an **'assessment'** of the criticalities that might emerge from the measure procedure and/or from the subject of the measure. If in doubt, ask a superior or contact Dräger for advice.

Collision between vessel at pilot station

PREAMBLE - The case we are going to analyze is a real occurrence selected among those proposed by IMO, to be considered and analyzed by shipping Companies. This is the 1st case we're going to analyze: it involves two vessels engaged in manoeuvring situation. The aim of the analysis is to put the focus on the chain of errors that led to the incident and to try to learn a lesson on "how it could be avoided".

What happened?

A tanker collided with a dry cargo vessel at a river entrance. The tanker was outbound and approaching the pilot station to disembark the pilot, while the dry cargo ship had just picked up a pilot a few minutes before the collision. It was daylight but dense fog reduced the visibility to about 120 meters. Both vessels were preoccupied with pilot embarkation/disembarkation preparations. There were only the pilot and the master on the bridge of the tanker. The master was distracted with manual steering and the pilot was occupied with disembarkation arrangements. Due to circumstances of traffic and tidal current, the dry cargo ship was about 0.4 miles in the way of the outgoing channel. The vessels were aware of each other's presence 6-7 minutes prior to the accident. The pilot of the tanker tried to contact the dry cargo ship for several minutes in vain. Later, the pilots had communicated their intentions and agreed that the tanker would head southerly and pass from the port side of the cargo ship. But the pilot of the tanker was again distracted with disembarkation arrangements and did not make the agreed manoeuvre. The last attempts of communication were unsuccessful due to radio interference. Shortly afterwards, both ships came in sight of each other and it was realized that a collision was imminent. The pilots advised to put the helm midship and to go full astern, however, the two vessels collided. There was a VTS in operation in the region but VTS operators were passive during the development of dangerous situations.

The tanker suffered damage to her bow. The dry cargo ship suffered damage on the port side under the forecastle area in way of the forepeak store, forepeak tank, anchor hawsepipe, and indentation under the water line in way of forepeak tank and bulbous bow. There were no injuries or pollution.

Lesson's Bearing

Why did it happen?

- The visibility was very poor due to dense fog and several inbound vessels and an outbound tanker were in the same area nearly at the same time, many of which were converging on the pilot boarding area.
- The vessels were distracted and preoccupied with embarkation/ disembarkation arrangements. The vessels did not monitor, track or communicate with each other and did not learn each other's intentions well in advance of the accident.
- The dry cargo ship drifted too much southward, well in way of the outbound traffic due to strong tidal current. Her speed was reduced considerably as she was getting ready to pick up the pilot, and this increased her drift and she landed in way of the outbound traffic lane. The bridge team of the dry cargo ship and the pilot were late to realize the developing danger caused by the ship's position.
- The tanker did not execute the agreed avoidance action due to distraction of the pilot.
- VTS took a passive approach. It only acknowledged messages but did not warn either vessel of the other's intention, despite the very poor visibility and the position of the dry cargo ship which had drifted southwards in way of the outbound traffic lane.
- The pilots and bridge teams on both vessels did not make a full assessment of the risk of collision.
- ARPA was not used effectively on either vessel to assess the risk of collision. By the time the ARPA was used on the dry cargo ship, it was too late for it to provide reliable information.
- Effectively, no one held the con on the bridge of the tanker because both the master and pilot had deferred to the other, there was no discussion or questioning of the intentions of the dry cargo ship, and at a critical time they involved themselves with tasks that were inappropriate given the impending close quarters situation.
- The bridge on the tanker was insufficiently manned in the circumstances and conditions. It did not comply with company requirements or port authority instructions to pilots, however, no additional resources were requested by the pilot.
- The communication between all parties involved was unclear and prone to misunderstanding, and use of standard marine phrases was not practiced.

What can we learn?

- The availability of VTS, having a pilot on board or approaching to pick up a pilot must not be a reason to relax or defer taking timely and efficient collision avoidance action. It shall be recalled that with the exception of Panama Canal, responsibility always burden on Master' shoulder. The collision avoidance action should have been taken in ample time as per Rule 8 and 19 of the Collision Avoidance Rules.
- The navigator must have a good knowledge of the manoeuvring capabilities of the vessel.
- A detailed risk assessment should be carried out before entering areas of restricted sea room and plans for contingencies must be in place. Above is a clear example of the usefulness of Risk Assessment in evaluating all possible circumstances/hazards. Close monitoring of external factors such as currents, windage, shallow water effects on the vessel's manoeuvrability must be carried out. Human factors are to be considered too as clearly highlighted by the case study.

Selected and commented by Andrea Pittaluga

The Academic Lesson

BILLS OF LADINGS— cont.

Strictly linked to the **Bills of Lading** (B/L) is the **Letter of Credit (L/C).**

The Letter of Credit is issued by a bank: some trading banks that issue the L/C like to be listed as **the consignee on the "order"** BL instead of the actual buyer which is listed as the "**Notify Party".**

In this way the bank has title to the goods and is afforded extra protection in case the buyer does not come up with the money. However, very few banks like to get stuck with a load of goods.

The term "ACCOMPLISHED"

In most cases BLs are signed in sets of **three originals.**

They usually have the notation ORIGINAL printed or stamped on the face. Sometimes a BL states FIRST ORIGINAL, SECOND ORIGINAL and THIRD ORIGINAL.

In addition, duplicate copies may be distributed with the word COPY or NON—NEGOTIABLE stamped on them. The Master only signs BLs. At the bottom of the original BL is a clause with the following (or similar) wording:

In witness whereof the Master or his agent has signed 3 ORIGINAL Bills of lading all of this tenor and date; one of which being ***accomplished****, the others will be void.*

This means that as soon as a BL holder present one of the three original (not necessarily the first one), the master will deliver the cargo. Remember that as soon as a BL has been accomplished, the others are void.

The Master can cancel an original order BL by putting a wording on the back or by simply stamping ACCOMPLISHED or CANCELLED plus the ship's stamp and the Master's signature on its face or on the back.

A BL holder should never just sign the back of a BL that has not been voided yet, because without any specific "accomplished" phrase, it would turn into a bearer BL (with which we will deal at a later stage).

The term "APPARENT GOOD ORDER AN CONDITION"

The Hague Visby rules states that *"after receiving the goods into his charge, the carrier shall issue to the shipper a bill of lading showing among other things the apparent order and condition of the good".* This means that if a carrier receives damaged or off specs cargo, but issues a BL without any adverse remarks about the condition of the cargo (a clean BL), the BL holder is fully entitled to receive undamaged, on spec cargo. After the carrier has issued a clean BL, they cannot later on claim that the cargo actually had been received in a damaged or off spec condition.

Of course it is not easy to determine if the cargo is in apparent good order and condition.

Condition pertains to the external condition of the cargo: this is something visible and the master is able to ascertain. In this case, the BL should be claused accordingly.

On the other hand it is usually not easy for the Master to determine quality of the cargo because it refers to the internal condition of the goods and he is not expected to make an assessment. If in doubt about the condition or quality of the cargo, loading should be stopped and the local P&I Club representative be consulted.

In addition, shipper and carrier should appoint an independent cargo inspector to perform a detailed inspection.

Weight is another nebulous term. The weight for dry and wet bulk cargoes on the BL is usually based on shore figures. Invariably the ship's figures will be different. If the difference is small in percentage (for that particular trade), the master should accept shore figures and sign the BL.

However, if the difference is large, the master should issue a **Notice of Protest** and possibly leave the BL unsigned.

There is a lot of pressure on masters to issue clean Bills of lading, because it enables the seller of the goods to get paid under a L/C. In the absence of specific wording in the L/C, banks will only accept clean transport documents.

On the other hand, owners like to please their customer by issuing clean BL.

Sometimes a shipper will offer a **Letter Of Indemnity** in which the shipper promises to indemnify the carrier against cargo claims and related expenses, in exchange for the carrier to issue a clean B/L.

Unless the LOI has been backed by a bank guarantee, it is a pretty worthless piece of paper.

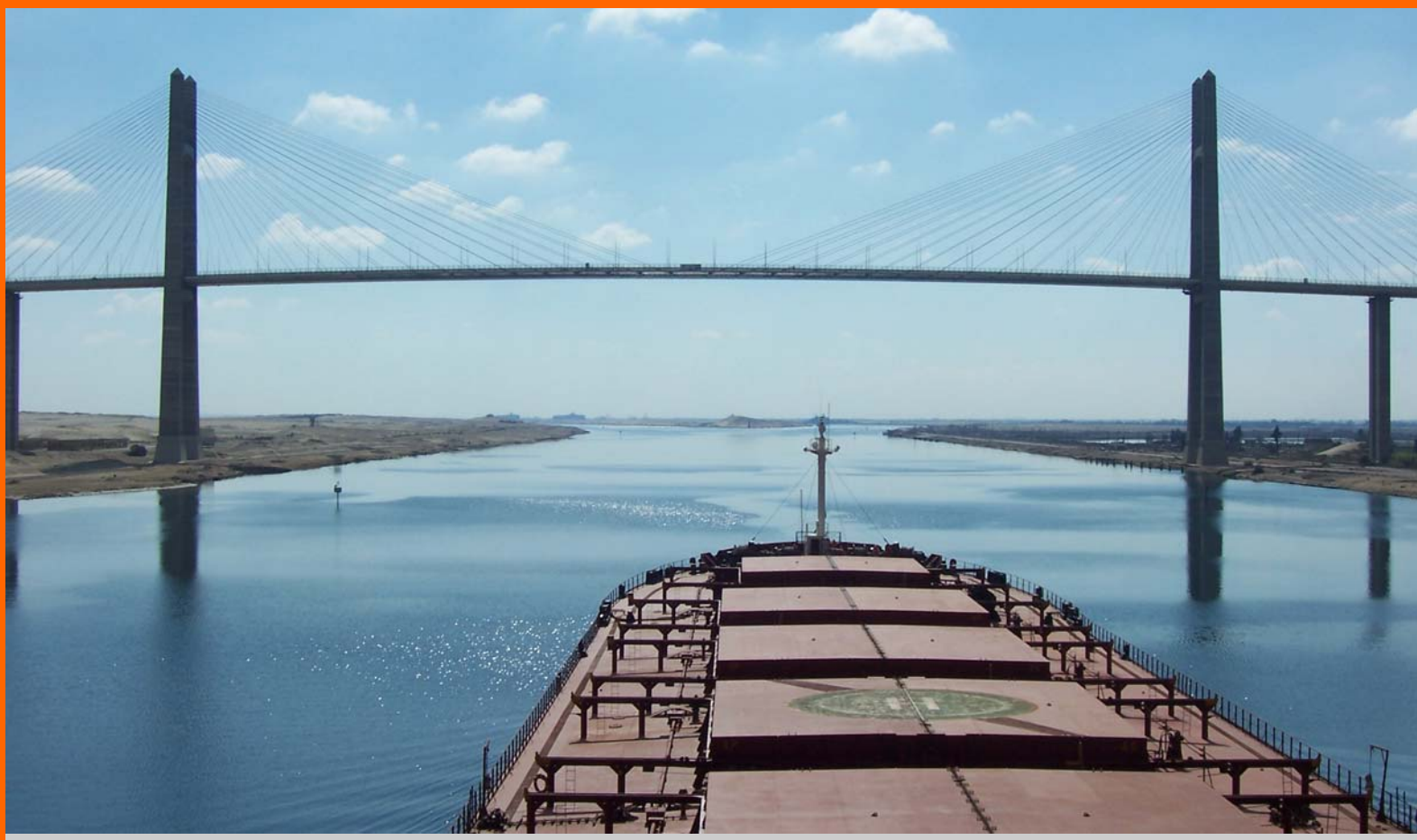
Generally speaking, it is to remind that P&I Clubs do not cover claims on Bills of lading that have been issued improperly.

Therefore a carrier should never issue a clean Bill of lading in exchange for a Letter of Indemnity.

*****

There are some more common terms associated with Bill of Lading and we will deal with the most common ones with the next edition.

Selected by P. Linari



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