Safety Alert

Number: 22-10 **Published:** 22/06/2022

Subject: CO2 System Left Non-operational After Servicing

What Happened / Narrative

An MSF members vessel had recently undergone a Firefighting equipment survey, all equipment was fully inspected, and any faults or discrepancies were rectified. The Fixed CO2 system flexible hoses were renewed as the system had reached it`s 10 years of service life.

To allow the survey to be conducted in a safe manner the safety pins had been put in place, while the outside contractors carried out their inspection. When finished these should have been removed, to make the system ready for activation.

On re-joining the vessel at the scheduled crew change almost 4 weeks after the survey, the C/E/O after a routine inspection, found that the safety pins inserted during the survey had not been removed and were still in place making the system inoperable. This unnoticed action had a high potential to develop into a serious incident if the CO2 system had been required for extinguishing an engine room fire.

A similar safety alert had been issued by the vessel owner to their fleet in August 2021.

Why Did it Happen / Cause

Details on causes and corrective actions specific to this incident were not provided by the submitting party / vessel owner but lessons learned, and actions below were reenforced from the previously mentioned fleet safety alert that had been issues in August 2021. This guidance was relevant to the incident described.

It should be noted that the below recommendations were specific to that vessel owner and each vessel should review against their own processes.

Corrective Actions Taken / Recommendations

1. Before any work, including contractual work commences on essential Fire Fighting equipment. A Permit to Work should be issued, this must include an entry in the isolation log, to the effect that the system has been isolated. This should be backed up by an entry recorded in the deck log. This helps to ensure that the system cannot be left in an inoperable condition.
2. Never assume and rely that all will be well and ok. Assumption is the pathway to undesired events. Always check and verify.
3. Always inspect 3rd party actions to ensure any systems they work on, is reinstated to original design intent after completion of the task.
4. Work is only complete when the isolations are removed, and the permit can be closed.

This is a perfect example of Safety Flashes / Lesson Learned, issued by the company, not being acted upon, distributed, or reviewed by all crew members. It is imperative that circulars issued by the shoreside office staff are fully discussed, disseminated to all crew members, and acted upon, as required to maintain the safety of all onboard the vessels.

Please ensure that all circulars, safety flashes, lesson learned, and outside bulletins are suitably posted, discussed and noted by all crews. It is very important that your back to backs are kept updated with all bulletins while they are on leave, do not just leave notices on the mess room board. Include them in your hand over notes so they can be acted upon and noted as required.

- Could a similar occurrence happen on your vessel?
- If not, why not?