Bridge Memorandum #14: Fleet Incident Reports

Captains:

For a long time we have been collecting information about incidents, accidents, equipment losses and near misses. In reviewing those events for 2014, certain trends have become evident. Hand injuries were one of the top injury types. To reduce hand injuries, we required every vessel to review the entire 5 part Hand Safety Series from the Toolbox Talks with their crews. More recently, we became aware that there is a general lack of understanding of our safety system across the fleet. In response, we have developed a core safety curriculum and will be formalizing this training in 2015.

As part of the efforts to improve our safety performance, we have designed the Fleet Incident Report. If there is a lesson learned from an incident that can be beneficial to the fleet, this is the format we will use to share it. The report may just raise general awareness and/or there may be specific actions for each vessel to take in order to prevent a similar incident from occurring on that vessel. These will be posted on the Crewing Module under the Memos/ Incs tab, along with the fleet memos, bridge memos and notices of change. They are intended for public view, so you can post them in a central area, just as you do with the fleet memos.

TDI-Brooks is committed to the safe operations of our ships and technical operations. Meeting this objective requires a constant focus on good safety performance and continual efforts at improvement. This doesn't happen without you. We appreciate those who consistently follow TDI procedures and hold others to a higher standard. We also welcome any suggestions or ideas you may have to improve our safety culture and practices.

Pete Tatro

Director of Operations/DPA

	Fleet Incident Report and Lesson Learned	FIR # 1 Distribution Date: 12 Jan 2015 Action Item Due: YES

Incident Report

What Went Wrong

On October 21, 2014, the medic suffered minor abrasions and lacerations while showering when the curved tempered glass shower surround shattered. The medic slipped and fell on the glass fragments. Drainage was inadequate despite to previous attempts to repair the drain. There was no non-skid surface to prevent the slip and no grab bar or safety rail to prevent the fall.

What was done to correct it at the time

The glass shower was removed and replaced with a vinyl shower curtain. A hand rail and non-skid floor cover were installed in the shower.

Actions you need to take to prevent a similar incident on your vessel:

Department	Responsible Person	Action to take	To be Completed by Date
Engineering	Chief Engineer	Inspect all showers for non-skid surface on the floor and grab bars or safety rails on the walls. Order and install these items in any shower that does not have them. **Report completion** only **after** both non-skid and a grab bar or safety rail have been installed in every shower.	**31 Jan 2015** Report completion to HSE@tdi-bi.com

Approvals

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