ON's Bell

NEWS ON THE WAY!

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# MARCH MESSAGE

**As we enter March, safety must move beyond discipline and become anticipation.**

The first months of the year have established our routines. Now, the challenge is not only to follow procedures—but to think ahead.

Operations are becoming more demanding:

- Increased port rotations
- Changing weather conditions
- Higher operational tempo

These factors require not just compliance—but awareness.

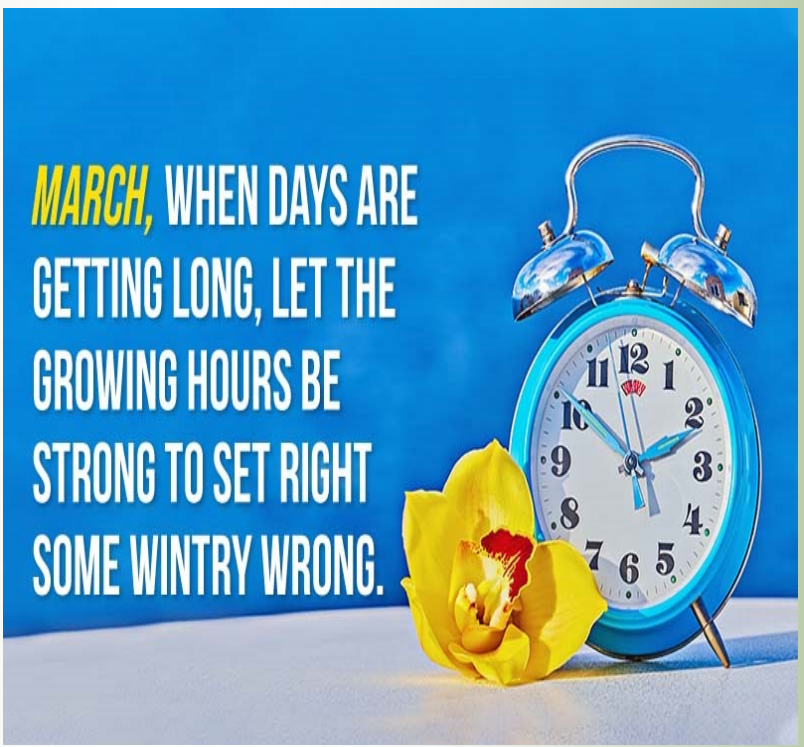
**Safety is not only about reacting correctly.**

**It is about anticipating what could go wrong—before it happens.**

Let March be the month where:

- We question assumptions
- We identify risks early
- We act before conditions deteriorate

By strengthening our foresight, we protect our people, our vessels, and our performance..



# SAFETY FOCUS

## SITUATIONAL AWARENESS & RISK ANTICIPATION

In dynamic operations, risks rarely appear suddenly—they develop.

Key reminders for March:

- Always reassess the situation before starting a task
- Identify “what has changed” since the last similar operation
- Avoid relying only on past experience
- Monitor surroundings continuously during operations
- Challenge unsafe conditions early

**Think ahead:**
“What could go wrong in the next 5 minutes?”

Professional awareness means staying mentally engaged—not just physically present.

# PRE-AUDIT & PRE-INSPECTION MINDSET

As we approach the end of the first quarter, vessels should focus on:

- Accuracy of records and logbooks
- Verification of critical equipment readiness
- Closure of outstanding PMS jobs
- Valid certification and documentation
- Drill performance and crew familiarity

**Reminder:**

Good preparation eliminates last-minute pressure.

Consistency now prevents findings later.

# CREW WELLBEING

## STRESS MANAGEMENT & WORKLOAD BALANCE

March often brings operational intensity and tighter schedules.

Supervisors and officers should:

- Monitor workload distribution
- Encourage short recovery breaks where possible
- Promote clear communication within teams
- Watch for signs of stress or reduced focus

Stress, like fatigue, affects:

- Judgment
- Communication
- Reaction time

A focused crew is a safe crew.

# SAFETY CORNER – KEY REMINDER

Recent observations indicate:

- Tasks started without full briefing
- Overconfidence during routine operations
- Reduced communication between departments

## MINOR DEVIATIONS ACCEPTED AS "NORMAL"

## KEY TAKEAWAY:

**"Normalizing small deviations leads to major incidents."**

Do not accept "almost correct."

Do it right — every time.

## SAFETY CORNER – NEAR MISS
## SLIP DURING MOORING OPERATION

**Event Description**
During vessel mooring operations for bunkering, a crew member working at the aft station slipped on a wet deck surface.
The crew member managed to quickly grab onto nearby equipment, preventing a fall in close proximity to the mooring winch.
No injury was sustained.

**Actions Taken**
Operation continued with increased caution
Deck condition was highlighted to the team
Crew reminded of slip hazards during wet operations.

**Lessons Learned**
Wet deck surfaces significantly increase the risk of slipping, especially during critical operations such as mooring.
Maintaining awareness of footing and environmental conditions is essential.

**Key Takeaway**
Always be aware of deck conditions during operations.
Use appropriate footwear and maintain stable positioning, especially near machinery.

## SAFETY CORNER – NEAR MISS
## OPEN OVEN DOOR IN GALLEY AREA

**Event Description**

**During routine meal preparation in the galley, the oven door was left open after removing food trays.**

**At the same time, another crew member entered the galley carrying a tray of food. Due to limited space and vessel movement, the crew member nearly walked into the open oven door.**

**The situation was noticed just in time, and contact was avoided. No injury or damage occurred.**

**Actions Taken**

**Oven door was immediately closed**

**Situation discussed with galley personnel**

**Awareness raised regarding housekeeping in confined working areas**

**Lessons Learned**

**Galley spaces are often confined and subject to vessel movement, increasing the risk of contact with equipment.**

**Leaving equipment open or unattended can create unexpected hazards for others working nearby.**

**Key Takeaway**

**Always close and secure equipment after use.**

**Maintain awareness and clear working space, especially in confined areas.**

## SAFETY CORNER – NEAR MISS
## BUNKER VAPOUR ENTERING ACCOMMODATION

**Event Description**

On 13 March 2026 at approximately 1000 LT, a strong smell of bunker vapour was detected inside the accommodation.

Crew members promptly reported the unusual odour to the Officer on Watch and the Master. It was later identified that a bunker pipe had broken in the Engine Room, resulting in a spill. Vapours from the spill entered the accommodation through the internal ventilation system due to air circulation.

The ventilation system was not shut down immediately, allowing the vapours to spread.

**Actions Taken**

Incident reported immediately to bridge and engine department

Source of leak identified in Engine Room

Ventilation system reviewed and corrective actions taken

Area monitored until conditions returned to normal.

**Lessons Learned**

Failures in fuel systems can quickly lead to hazardous vapour release.

Ventilation systems can unintentionally distribute harmful vapours throughout accommodation if not promptly controlled.

Timely isolation of ventilation is critical in such situations.

**Key Takeaway**

Immediately stop or isolate ventilation in case of vapour release.

Rapid response limits exposure and prevents spread to accommodation areas.

## SAFETY CORNER – NEAR MISS
## PROTRUSION HAZARD ON WALKING PATH

**Event Description**
**During a routine deck inspection, a ballast tank entrance handle was found in the upright position.**
**This created a protrusion hazard along a walking path. If a crew member had passed through the area—especially at night or while carrying equipment—there was a significant risk of tripping and falling, potentially resulting in injury.**

**Actions Taken**
**Handle repositioned to its safe (closed) position**
**Area checked for similar hazards**
**Crew reminded to secure all fittings after use.**

**Lessons Learned**
**Even small protrusions can create serious tripping hazards, particularly in operational areas and low-visibility conditions.**
**Maintaining safe and clear walkways is essential to prevent avoidable injuries.**

**Key Takeaway**
**Always secure and properly position equipment after use.**
**Keep walkways clear and free from obstruction at all times.**

## SAFETY CORNER – NEAR MISS
## UNSECURED PAINT CONTAINER IN ENGINE ROOM

**Event Description**
**A crew member from the engine department was engaged in painting activities in the Engine Room.**
**Prior to leaving the work area for a break, the paint container was left unsecured and uncovered. Due to vessel movement (rolling), the container could have overturned, creating a potential fire hazard as well as a spill risk.**
**No incident occurred.**

**Actions Taken**
**Work area checked and paint container secured**
**Container properly closed to prevent vapour release**
**Crew reminded of housekeeping and securing requirements.**

**Lessons Learned**
**Unsecured materials in machinery spaces can quickly become hazardous due to vessel movement.**
**Flammable substances such as paint must always be properly stored and secured, even during short breaks.**

**Key Takeaway**
**Always secure and close containers before leaving the work area.**
**Good housekeeping prevents fire risks and spills.**

## SAFETY CORNER – UNSAFE ACT
## FAILURE TO WEAR REQUIRED PPE

**Event Description**
**A deck crew member was observed performing work duties on deck without wearing the required Personal Protective Equipment (PPE). The task required appropriate protection, including safety helmet, safety boots, gloves, and eye protection. The absence of essential PPE exposed the crew member to potential injury hazards.**
**PPE Not Worn**
**Safety Helmet**
**Safety Boots**

**Potential Hazards / Risks**
**Head injury from falling objects or impact**
**Foot injury from dropped tools or equipment**
**Reduced protection in case of slips, trips, or contact hazards**

**Actions Taken**
**Work stopped immediately**
**Crew member instructed to wear proper PPE**
**Safety requirements reinforced by supervisor.**

**Lessons Learned**
**Failure to wear PPE significantly increases exposure to avoidable injuries.**
**Even routine tasks can present hazards that require full protection.**

**Key Takeaway**
**No PPE = No Work.**
**Always wear the required protective equipment before starting any task.**

## SAFETY CORNER – UNSAFE CONDITION
## UNSECURED GALLEY EQUIPMENT DURING HEAVY WEATHER

**Event Description**
**During heavy weather conditions, several pieces of galley equipment were observed not being properly secured.**
**Due to vessel movement caused by rough seas, unsecured or inadequately secured items created a significant risk of shifting or falling within the galley area.**

**Potential Hazards / Risks**
**Injury to galley personnel from moving or falling equipment**
**Damage to galley appliances and surrounding infrastructure**
**Increased risk of spills, burns, or cuts during vessel movement.**

**Actions Taken**
**Equipment secured immediately**
**Galley area checked for additional unsecured items**
**Crew reminded of securing procedures during heavy weather**

**Lessons Learned**
**Heavy weather significantly increases movement onboard, making proper securing of equipment essential.**
**Even small items can become hazardous if not properly fastened.**

**Key Takeaway**
**Always secure all equipment before and during heavy weather.**
**Proper preparation prevents injuries and damage.**

## SAFETY CORNER – UNSAFE ACT
## FAILURE TO WEAR PPE – CARGO INSPECTOR

**Event Description**
**From the Cargo Control Room, the Chief Officer observed a cargo inspector on deck without wearing the required Personal Protective Equipment (PPE).**
**The situation was immediately addressed by alerting the duty seaman, and the inspector was instructed to return and properly equip himself before continuing activities.**

**Actions Taken**
**Inspector stopped from continuing work**
**Instruction given to wear full PPE**
**Situation corrected immediately**
**Awareness reinforced among personnel**

**Lessons Learned**
**All personnel onboard, including visitors and third parties, must comply with vessel safety requirements.**
**Failure to wear PPE exposes individuals to unnecessary risk and sets a poor safety standard.**

**Key Takeaway**
**PPE requirements apply to everyone onboard — no exceptions.**
**Always ensure proper protective equipment is worn before accessing operational areas.**

## SAFETY CORNER – UNSAFE ACT
## WATERTIGHT DOOR LEFT OPEN WITHOUT AUTHORIZATION

**Event Description**
**A watertight door on the main deck was opened by crew members to dispose of garbage overboard and was left propped open and unattended for several minutes.**
**The bridge was not informed of the door being opened.**
**Potential Hazards / Risks**
**Compromised watertight integrity of the vessel**
**Increased risk in case of emergency or water ingress**
**Violation of safety and operational procedures**

**Actions Taken**
**Door closed and secured immediately**
**Crew reminded of procedures for opening watertight doors**
**Importance of informing the bridge reinforced**

**Lessons Learned**
**Watertight doors are critical safety barriers and must remain closed at all times unless strictly required.**
**Opening such doors without proper communication and control can significantly increase risk.**

**Key Takeaway**
**Never leave watertight doors open unattended.**
**Always inform the bridge and follow procedures when opening them.**

## SAFETY CORNER – UNSAFE ACT
## SHARP EDGES IN GARBAGE BIN

**Event Description**
Two empty fruit syrup cans were found in a garbage bin with their sharp top covers exposed and not properly disposed of.
The sharp edges were protruding, creating a potential hazard for crew members handling waste.

**Potential Hazards / Risks**
Cuts or lacerations during garbage handling
Risk of infection from open wounds
Unsafe waste management practices

**Actions Taken**
Hazardous waste removed and disposed of correctly
Garbage bin checked for additional unsafe items
Crew reminded of proper waste disposal procedures.

**Lessons Learned**
Improper disposal of sharp objects can easily lead to preventable injuries.
Waste handling must be carried out with the same level of care as any other onboard task.

**Key Takeaway**
Dispose of sharp objects safely and correctly.
Always ensure edges are secured to prevent injury during handling.

# Welcome aboard!

**We're happy to have you onboard! You're now officially part of the team—which means two things:**

1. **You're here to work safely and professionally**
2. **You're now also responsible for not breaking anything (including yourself)**

**As you start your assignment, remember: safety isn't just a priority—it's the rule. Even if you've done a task a hundred times, this ship has a special talent for surprising people when they least expect it.**

**A Few (Very Important) Reminders:**

- **Learn the vessel layout early—wandering around looking lost is not a recognized safety procedure.**
- **Know your muster station—this is not something you want to figure out last minute.**
- **Wear your PPE—yes, even when "it will only take 2 minutes." (That's when things usually happen.)**
- **If you're unsure, ask—guessing is great for quizzes, not for safety.**
- **See something unsafe? Report it—before it becomes tomorrow's near miss report.**
- **Respect procedures and your teammates—we all want to go home with the same number of fingers we arrived with.**

**We're here to work as a team, keep things running smoothly, and make sure everyone has a safe and successful voyage.**

**Once again, welcome onboard—and remember:**
**the safest crew is the one that thinks before acting… and keeps doors closed, tools secured, and coffee cups upright.**

D/C VALENTE Aldo
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