



UNITEAM NEWS

Edition: December 2000

New vessels



M/V Anna Lehmann

We have recently taken over under our crew-management the sister vessels M/V Anna Lehmann and M/V Karin Lehmann, both built and delivered in Holland during the last quarter of 2000, of 4,111 DWAT and 261 TEU capacity. M/V Anna Lehmann is appearing above just before the arrival of our crew. We hope we will be able to publish soon a picture of her crew as well, in one of our forthcoming editions.

INDEX

Page 1

- New vessels
- The crew of M/V Cho Yang Ace

Page 2

- ISM Code and Quality Procedures. Why do we need them?
- Internal Audits

Page 3

- The way things are done.
- Emergency Drill
- P&I News – Lifeboat on-load release equipment

Page 4

- The Safety Triangle
- Suggestions Column
- Jokes
- Christmas wishes

During Capt. Rolf's visit to the M/V Cho Yang Ace, we have received positive feedback from all onboard about **UNITEAM NEWS**. A minor complaint however was expressed, to the effect that their photograph did not appear in the newspaper. Undoubtedly, this is a request we not only welcome but also cannot refuse, therefore we have the pleasure to insert a picture of the Cho Yang Ace crew who have been working hard to maintain their 4,800 TEU vessel on her world wide trade. The vessel trades between North Europe through the Suez Canal to the Far East and the West Coast of the USA. We are pleased to see our crew looking happy and healthy. Keep up the good work and stay safe.



The Crew of the M/V Cho Yang Ace

ISM Code and Quality Procedures. Why do we need them ?

This was a prominent question in the shipping industry 5 years ago, when fears over the implications of the ISM Code on the shipping Industry were running high. But the ISM Code has been around now for 3-4 years already in full operation on Bulk Carriers, Passenger vessels and Tanker vessels. It is now generally accepted as an essential part of the administration procedures on board and even on most of the container and general cargo vessels that do not require the mandatory ISM Certification until August 2002, Safety Management Systems have been established. So why is it that we are still asking the question as to why we need the ISM Code standard in our industry?

The answer is really quite simple. In too many cases the implementation of a Safety Management System only adds an additional burden of paperwork. Checklists are "created" to show to External Auditors that checks are being done, when in reality the checklists are either completed three days after the actual event or are completed in haste without proper consideration, just to get rid of the headache.

This is unfortunately sad, defeating the whole purpose of the ISM code and quality procedures. A Quality System is one that improves an organisation. Even if we think that we are the best we must always look at the reality. Can anyone honestly claim to make Zero mistakes in anything that he does?

The very realisation that we are humans and as humans we make mistakes every day in life, is reason enough to have a quality system that documents procedures to be followed, allowing us to refer to reminders ensuring that we carry out our duties with the least amount of errors. One effective way to do this is the use of checklists.

Although it is important to understand that as humans achieving 100% consistency is impossible, the important thing is not to rest on this belief but to take on the challenge to get it right, first time, every time and meet the challenges of life.

In this context the ISM

Code has not been fully successful in its implementation in the industry. Numerous checklists that have no meaningful result for the safe operation of the vessel end up in completing paper for paper's sake and a loss in reality of motivation for making significant improvements in the Safe Operation of vessels.

At Uniteam we strive to minimise the burden of paperwork on our crewmembers whilst increasing the standards of safety and efficiency onboard. This ambitious program was embarked upon more than a year ago. To assist in our continuous improvement process, Capt. H. Rolfs, who has served with Uniteam on our vessels since 1994, has come into the office to assist in collecting and implementing ideas for improvement. Capt. Rolfs has commenced visiting vessels to obtain the input of our crew, as it is only onboard that the real needs for improvement and training can be observed. Thus the contribution from our crew will be very much valued in order that we may continue to improve together.

Internal Audits

During the Month of October Internal Audits were conducted by Mr S. Fyfe both on the M/V Tete Rickmers and the M/V Sea Master. Both Audits were successful and our thanks go out to the crew involved in the Audits for their kind co-operation and assistance.

The information received during the Audits was very useful in ensuring the continued development and



Uniteam Yangon Staff at the end of the Internal Audit

improvement of the Quality System. Our aim with the Quality system is to ensure that it works for the benefit of the crew in safeguarding life and ensuring efficient working practices.

The M/V Sea Master has had its Certification for 4 years already and it is due for the renewal Audit in December 2001. The M/V Tete Rickmers has only been in service since 15/06/2000 and will most likely undergo the external audit some time in January 2001.

Further to the above ship Audits, the Internal Audit of the Office in Yangon was carried out as per the ISO 9002 regulations. The outcome of the Audit was very positive and it was evident from all the office staff and the documents analysed that the quality system was running as per ISO 9002 and company requirements.

The results of the External audit of the office will be published within the next edition of the [UNITEAM NEWS](#).

The way things are done

Start with a cage containing five apes. In the cage, hang a bunch of bananas on a string and put stairs under it. Before long, an ape will go to the stairs and start to climb towards the bananas. As soon as he touches the stairs, spray all of the apes with ice cold water. After a while, another ape makes an attempt with the same result - all the apes are sprayed with ice cold water. This continues through several more attempts. Pretty soon, when another ape tries to climb the stairs, the other apes all try to stop it. Now, turn off the ice cold water.

Remove one ape from the cage and replace it with a new one. The new ape sees the bananas and wants to climb the stairs. To his horror, all of the other apes attack him. After another attempt and attack, he knows that if he tries to climb the stairs, he will be attacked.

Next, remove another of the original five apes and replace it with a new one. The newcomer goes to the stairs and is attacked. The previous newcomer takes part in the punishment with enthusiasm. Again, replace a third original ape with a new one. The new one makes it to the stairs and is attacked as well. Two of the four apes that beat him have no idea why they were not permitted to climb the stairs, or why they are participating in the beating of the newest ape.

After replacing the fourth and fifth original apes, all the apes, which have been sprayed with ice cold water, have been replaced. Nevertheless, no ape ever again approaches the stairs.

Why not?

Because that's the way they've always done it and that's the way it's always been around here. And that's how the company policy begins....

Therefore, in order for us NOT to be like Apes we have a Quality Management System with reporting procedures

which allow ideas to be heard from all parts of the company from the Trainee Cook to the Chairman, to help us reach our objectives, "which of course are not only the bananas."

Emergency Drill

An Emergency Situation at the port of San Vicente was simulated by the Chilean Emergency Responses services.

In order to make the drill more realistic the M/V CSAV Atlanta and her crew were requested if they could participate in the situation.

The organisations involved in the drill were the Governmental Maritime Organisation, the Harbour Master, the fire brigade department, the HAZMAT team fire department, Regional Contamination Control Centre, Naval Airforces, Emergency room of local hospital, and the National Safety Labour Organisation.

The scenario was for the vessel to initiate the drill with the announcement of a fire on board, water pollution from the vessel and a number of crewmembers and stevedores injured or intoxicated. The fire was to be of the extent that the crew needed to be evacuated.

The crew acted quickly and correctly at short notice to provide first aid and evacuate the ship safely. All materials and documentation that would be useful for later collecting evidence were secured and carried ashore.

The drill was carried out successfully and smoothly in the presence of Government officials and the National Press. The crew were praised for demonstrating a high degree of co-operation and Safety awareness in conducting the drill.

Based on the reports that we received from the Government Officials praising the crew's professionalism, we wish to congratulate the crew of the M/V CSAV Atlanta for demonstrating with pride the standard of our Uniteam Crew and thank Capt. Durzynski for keeping us informed regarding this interesting event.

P&I news — Lifeboat on-load release equipment

In an incident, the boat had been lowered into the water. Two men were inside the boat and two men were by the davit. The boat had been lowered by using the remote lowering control from inside the boat. When the boat touched the water, the fall wire continued to pay out, forming loose coils of wire on the winch drum. With the boat still attached to the fall wires, it was decided to wind, by manual means, the loose wire back on to the drum. However, during

this operation the crank handle suddenly spun out of control as the wire began to pay off the drum again and struck the crewmember who was turning it, breaking his arm.

The winch brake and on-load release equipment were found to be in good working order when they were examined. The crewmembers, including the injured man, were certain that the correct procedures had been followed and that the winch brake had not accidentally been released.

Therefore, the only plausible explanation for the sudden release of wire has to be that the winch brake did not engage when the remote lowering control was reset. The continued release of wire, after the boat had entered the water, is an indication of the brake being off. It is likely that the remote lowering control wire had jammed temporarily and was still holding the brake off.

How can this type of accident be avoided?

First, it is important to remember that the weight of fall wire is sufficient to pull more wire off the winch drum. When wire pays out after the boat has settled in the water it is necessary to check that the winch brake is properly engaged. Secondly, when winding in loose turns, it is preferable to use a winch motor rather than the crank handle. If manual winding is unavoidable, it is safer to use a crank wheel rather than a crank handle. Thirdly, if there is any doubt about whether the winch break has engaged, the boat should be disconnected from the falls and the defect reported to the chief engineer. Whenever a lifeboat is lowered it is advisable to examine closely all sheaves and moving parts for indications of a sticking wire or for other defects that could result in a malfunction.

(Source : "Signals" (North of England)).

Suggestions column

"UNITEAM NEWS" is designed for the interest of our crew and to keep all Uniteam employees informed of the developments within our company. We would appreciate and welcome with pleasure your feedback and any articles of interest, or humour that you would like us to include within our next editions.

The Safety Triangle

1 DEATH from every 30 Major Accidents
1 Major Accident
30 Minor accidents
330 Unsafe Acts or actions

Research has shown that from approximately every 330 Unsafe Acts 30 are likely to result in a Minor injury. Of these 30 Minor Injuries one is likely to be a Major Accident. And from 30 Major Accidents 1 normally results in death.

This may not be particularly pleasing for our crew to hear but this is a reality in which we live and the only way that this situation can be changed is for all crewmembers to recognise the importance of their safety and the safety of their fellow crewmembers.

It is essential that on board every ship a Safety Culture exists. A Safety Culture is a working environment where Safety comes first and one in which each crewmember takes care for his own safety and promotes ideas for the improvement of Safety.

Safety is continually improving, requiring personal commitment and responsibility from everyone involved in the operation of the vessel.

Jokes

A wealthy man lay critically ill in the hospital. "There is only one thing that can save you," his doctor said. "A brain transplant. It is experimental and very expensive."

"Money is no object", the man said. "Can you get a brain?"

"There are three available. The first was from a college professor, but it will cost you 10,000 USD."

"Don't worry, I can pay. What about the second?"

"It was from a rocket scientist. It will cost you 100,000 USD."

"I have money. And I'd be a lot smarter too. But what about the third?"

"The third was from a government bureaucrat. It will set you back half a million dollars."

"Why so much for the bureaucrat's brain?" the patient asked.

"Never been used."

*Season's Greetings and our best wishes for a happy and prosperous
New Year 2001*



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