

CHIRP MARITIME FEEDBACK

Issue No: 33

Autumn 2013

EDITORIAL

TEN YEARS OF MARITIME CHIRP

In 2003, the role of CHIRP, originally a reporting programme for the aviation industry, was expanded to include the maritime sector. The mission of the Maritime Confidential Hazardous Incident Reporting Programme is to enhance maritime safety by providing an independent confidential reporting system through which mariners can report hazardous incidents and safety issues. We receive reports from mariners of all nationalities on ships of any flag. CHIRP reviews each report, discusses with the mariner a proposed course of action, and then follows up the report. Selected reports may, with the mariner's permission, be included in CHIRP Maritime FEEDBACK so that safety lessons can be promulgated more widely in the maritime community.

The term "hazardous incident" means an occurrence which nearly resulted in injury or damage, i.e. an accident was narrowly avoided. It is often referred to as a "near-miss". By learning from such incidents, we can hopefully avoid future accidents. Hazardous incidents can occur in all aspects of vessel operation; including cargo handling, catering, engineering, navigation, shipboard services, ship/shore interface, etc.

There is no need to send us an anniversary card! Instead, please make a personal contribution to improving maritime safety by following this special anniversary version of the CHIRP acronym:

Comply with safety procedures.

Help others by looking out for their safety.

Intervene to correct unsafe situations.

Report hazardous incidents.

Personal commitment to safety.

The phrase "I must do something" is much more powerful than saying "Something must be done".

OPERATING AND TECHNICAL MANUALS

In Issue No 1 of this journal, we included a report about the quality of manuals provided on board. CHIRP subsequently produced a paper entitled "Marine Operating and Maintenance Manuals – Are They Good Enough?" This was reviewed by the Maritime Safety Committee of the International Maritime Organization. The IMO then issued a Circular advising that *"the attention of all relevant stakeholders needs to be drawn to the importance of ships' crews having access to up-to-date, accurate and user-friendly shipboard technical operating and maintenance manuals, particularly for safety-critical marine equipment."* CHIRP would be interested to hear whether the manuals on your vessel meet these criteria.

COLLISIONS

Despite the investment in sophisticated collision avoidance systems there is a continuing incidence of collisions, often due to basic failure to comply with the International Regulations for Preventing Collisions at Sea – the ColRegs. For every such collision there are many near-misses between vessels. When a give-way vessel fails to take early and substantial action to keep well clear, the margin of safety is eroded and anxiety is caused on the bridge of the other vessel. However, fuming in frustration does not achieve anything. Instead, report the incident to CHIRP. We typically alert the manager of the other vessel and invite him to investigate. As a good example of a positive outcome of this, we are repeating a previous report of an unpredictable encounter in the English Channel.

CHANGE OF WATCH

Peter Tait, Chief Executive of CHIRP, is retiring after a career that has included RAF Vulcan pilot, test pilot, display pilot, senior positions in commercial aviation and aerospace, and, since 1995 has guided the CHIRP organisation. We welcome his successor Ian Dugmore. Ian comes from the position of Head of UK Airprox Board, prior to which he was an Air Commodore in the Royal Air Force.

We also welcome Captain John Rose as Director (Maritime). John started his career at sea with a major oil company, subsequently qualifying as Extra Master Mariner and achieving a Master of Laws degree. Thereafter, his positions ashore included Harbour Master and later an assignment as General Manager with an oil company in Houston. Subsequently he set up his own consultancy company. This work included advising shipping companies on improving their safety management systems. In his leisure time, John has a narrow boat and has recently completed a 1050 mile trip around the canals of England and Wales. He is a Fellow of the Nautical Institute and a Younger Brother of Trinity House.

I am retiring after six fulfilling years as Director (Maritime). The success of CHIRP depends on those mariners who initiate action about hazardous incidents. Thank you to those who do so. Please support CHIRP and the new team by contributing reports.

Chris Rowsell

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CHIRP receives reports on a range of hazardous incidents that have occurred within the commercial, fishing and leisure sectors of the maritime community. Here are a number of reports which will be of wider interest, together with the "lessons learned" as described by the reporter. The CHIRP comments have been reviewed by the CHIRP Maritime Advisory Board which has members from a wide range of maritime organisations. Full details of the membership can be found on our website - www.chirp.co.uk.

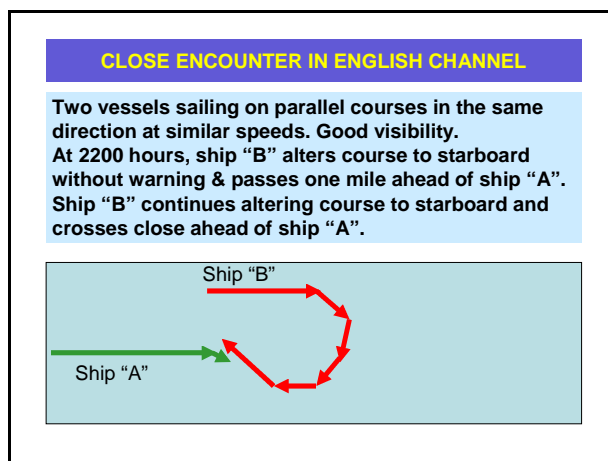
COMMERCIAL SECTOR REPORTS

COLREG COMPETENCY

Report Text: I was the officer on watch on my vessel "A". We were proceeding on course 110 deg at speed approx 13.6 knots in the Western Approaches to the English Channel in good visibility. Another vessel "B" was proceeding parallel on the same course and speed, about 6 nm ahead, approximately twenty-five degrees on my port bow. General traffic situation was clear without any potential collision risks for either vessel.

At 2200 hours vessel "B" started altering course to starboard. The green navigational light of vessel "B" became visible. It appeared that vessel "B" intended to cross about one mile ahead me. I made a VHF call identifying myself and my relative position to the vessel "B". I brought the attention of the OOW of "B" to the developing close quarter situation and requested him to take preventive action in accordance with Rule 15 of the ColRegs. At this moment the Captain of my ship arrived on bridge.

When the distance had decreased to 3 miles I made another VHF call. The OOW of "B" assured me that he would keep clear of me. Finally vessel "B" passed about 0.8 mile ahead of me.



From this moment everything happened very quickly. The situation had appeared to be safe as vessel "B" had crossed ahead of my bow and was approximately ten degrees on my starboard side, green to green, with a CPA of 0.5 mile. However she started altering course to starboard again, showing her red navigation light. We gave a signal of five short flashes on our lamp. Our Captain ordered rudder to starboard, so she crossed my bow for the second time at distance of approximately less than 0.5 nm ahead. The vessels passed port to

port at full speed and with a distance of 0.25 mile. After clearing my port side the other vessel altered course more to starboard and set her course towards Falmouth.

Thirty minutes later I received a VHF call from that vessel - asking if I have "cooled down".

CHIRP Comment: The OOW on ship A appears to have acted prudently in calling the Captain for what turned out to be a highly unpredictable situation. Although the report does not explicitly state this, we assume that the Captain advised the OOW that he was taking over the con. Ship A appears to have taken proper action under Rule 17 to avoid a collision. We would however add that sound signals should be made in accordance with Rule 34.

We sent a summary of the report to the manager of ship B. When we originally published this report in Issue 17 of CHIRP MARITIME FEEDBACK, we had not received the full response from him. He subsequently advised that he was so concerned at the report that he had visited the ship to investigate. It transpired that the Master had not previously been aware of the incident. The Officer of the Watch was a young officer, new to the company. The ship had "time to kill" to make a pre-arranged E.T.A. at her next port. The Captain had left a night order for the OOW to do a round turn at 2200 hours before proceeding to the port. The OOW interpreted this literally, without consideration to the traffic situation (or perhaps not appreciating the manoeuvring characteristics of his vessel.)

The manager recognised that the competency assurance procedure in its recruiting process needed improvement, and introduced the use of ColReg training and testing software across his fleet.

NOT NOT-UNDER-COMMAND

Report Text: My vessel has been drifting off a Caribbean island waiting for berthing for over one week. Annoyingly, a large percentage of the vessels drifting in this area, especially at night display Not Under Command lights and change their AIS status to Not Under Command as soon as they stop and start to drift. This is commonly twice per day. Day signals have been much less obvious. Apart from the fact that this use of the signal and status is blatantly false and against the content of the ColRegs and the UK MCA MGN 152 'reminder', the few of us not using this signal are penalised by the idleness and intransigence of those that do. On occasions where my vessel and another have been drifting into a close quarters situation and the other vessel has been called, the response is invariably on the lines of "You move, I'm not under command" or "You move, I am not under command and it will take XX minutes to get my engines ready - you are under way and can move". Either response could, at best, be termed rank bad seamanship in the circumstances.

Can these vessels offer a satisfactory explanation for this obviously incorrect behaviour and misuse of the NUC Signal? Would any of the vessel's owners care to comment on the advisability of their crews allowing their vessels to repeatedly drift within a few miles (often less

than 3, sometimes 2 or less) of the coast if genuinely not under command? Possibly the local coastguard may also care to share an opinion on this subject.

CHIRP Comment: As the reporter states, this general issue is the subject of Marine Guidance Note MGN 152. This was published in 2000 by the UK Maritime and Coastguard Agency. It points out that the definition in ColReg Rule 3 of a vessel not under command is “a vessel which through some exceptional circumstance is unable to manoeuvre as required by these Rules and is therefore unable to keep out of the way of another vessel.” MGN 152 goes on to say that “In some cases, vessels erroneously or falsely display NUC signals when their main engines or auxiliary machinery are shut down for reasons other than breakdown or necessary maintenance. Such vessels must adhere to their collision avoidance responsibilities as power driven vessels underway (Rule 18 of the ColRegs).”

In case there is any argument on whether a vessel which is drifting with engine stopped could be construed as a vessel not under command, we emphasise that the definition in ColReg Rule 3 refers to “exceptional circumstance” i.e. something that is a rare instance or extraordinary. Routine stopping of the engine to allow the vessel to drift would not be an exceptional circumstance. Furthermore, although it may be inconvenient to restart the engine, this does not mean that the vessel is “unable to manoeuvre”.

Although not raised in this report, we have also heard that some vessels turn on their deck working lights as an indication that they are drifting. There is no provision for this in the ColRegs other than for a vessel at anchor (Rule 30).

In terms of the degree of risk associated with misuse of NUC lights and shapes, we cannot recall an accident report in which this has been identified as a contributory factor. Nevertheless, it is of concern when informal practices develop which are not in compliance with regulations. In particular, a “pick and choose” attitude to the ColRegs can lead to confusion, and sets a poor example to junior officers.

The reporter has also stated that some vessels are sometimes drifting to within two or three miles of the coast. The risk of this would be that if the engine failed to restart, the vessel may go ashore before tugs could arrive. We have alerted the national Maritime Administration to this.

REPORTS FROM SHIP MANAGERS

Ship managers with well established safety management systems typically have their own in-house reporting schemes. Often such reports would be of interest to the wider maritime community. CHIRP is pleased to receive and publish these. We respect the confidentiality of the reporters and do not disclose identities of ships or companies.

STEVEDORE'S STOVE

Report Text: An officer on one of our ships noticed that a foreman of the stevedores had brought on board a

small gas cylinder and was using that for making hot coffee on deck. It was close to an area where dangerous cargo was loaded. The officer informed him that it is strictly forbidden to use any open fire. We have shared our deep concern with the charterers and the stevedoring company.

One of the problems identified is as to how the gas burner (small pocket sized camping stove) was taken through the container terminal security and then brought onboard past our watchman. We have instigated improved security with the watchman now required to search all bags even though the vessel remains at security level 1. While this may cause delays with the stevedores before cargo operations it has to be done.

CHIRP Comment: It is fundamental to improving maritime safety that individual mariners must be prepared to intervene to correct an unsafe situation. We commend the ship's officer for his prompt action in this case. It is encouraging that the matter was reported to the ship's manager you via its incident reporting system.

CORRESPONDENCE

CHIRP welcomes correspondence about the reports we publish. We reserve the right to summarise letters received. We apply the same rules as for reports, i.e. although you must provide your name, we do not disclose it.

LIFEJACKET DONNING INSTRUCTIONS

Report Text: Regarding the article on lifejacket design in Issue 31 of CHIRP MARITIME FEEDBACK, the wearer of the lifejacket in the photograph has not placed his hands in the correct position for entering the water. It may give the wrong advice to other users. One hand should firmly grasp the lifejacket just below the chin, pulling down to avoid injury to the neck when entering from any height and the other hand should be placed over the nose as illustrated.

CHIRP Comment: The photo in Issue 31 shows the wearer with his arms across his chest, holding his nose with one hand and grasping his wrist with the other hand. This method is the same as that shown by a major supplier of lifesaving appliances in their donning instructions.

Nevertheless, we recognise the merit of the method described by our correspondent of holding the lifejacket just below the chin with one hand, and covering the mouth and nose with the other.

On carrying out a web-search of donning instructions for lifejackets, we note that there is little consistency between the various manufacturers. Some show both arms being across the chest, without covering the mouth or nose. Others show how to tie the lifejacket but give no guidance on holding the lifejacket or covering the mouth and nose. We invite comments from manufacturers of lifejackets.

LIFEJACKET DESIGN

Report Text: I am writing to you in regards to the Issue No.31 and specifically about the Lifejacket Design article. I am a mariner onboard a cruise ship. We have been supplied with additional lifejackets that compared to the old type are quite bulky and VERY tight around the neck. These are made by a major manufacturer.

I totally agree with the concerns raised by our fellow mariner: this kind of lifejacket is really tight around the neck to the point that during drills, crew members wearing it felt uncomfortable in them and experienced a feeling of suffocation. In addition to that it makes quite difficult to perform basic safety related jobs i.e. preparing the lifeboats at embarkation deck, climbing up and down ladders and descending an MES chute.

Clearly these lifejackets passed the latest stringent tests required by SOLAS and have far better life saving capabilities. However they were not designed keeping in mind ease of wearing which is essential for those who work at sea.



CHIRP Comment: We have drawn this to the attention of the manufacturer of this lifejacket.

PLEASE JOIN US ON FACEBOOK

Click on the link from our website www.CHIRP.co.uk to the CHIRP Maritime Facebook page.

<http://www.facebook.com/pages/Maritime-CHIRP/388066931253279>

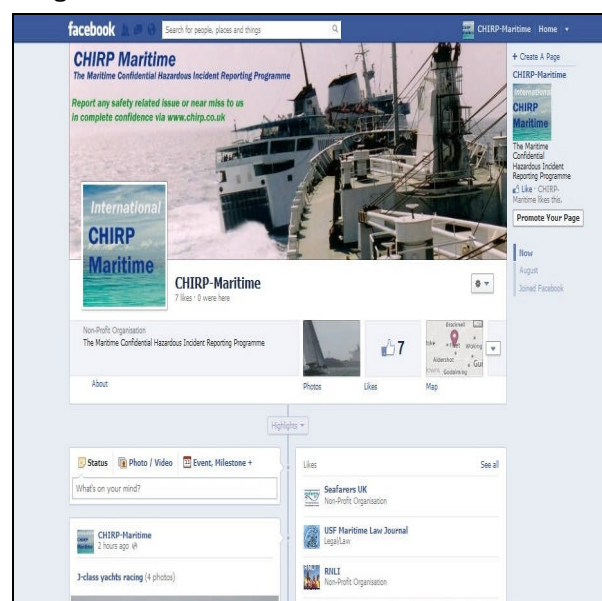
We use Facebook to comment on current maritime safety issues, particularly those in which confidential reporting of hazardous incidents could contribute to improvement.

For example, on 18th March 2013 we wrote about an announcement from the UK Maritime and Coastguard Agency that a shipping company and its Designated Person Ashore (DPA) had been fined for breaches of the International Safety Management (ISM) Code. During a Port State Control Inspection on a general cargo vessel it was noted that access was being made into the

vessel's ballast tanks without proper procedures being in place. Ice was issued. Three months later, the Inspector returned to the vessel. He identified that entries had been made into the ballast tanks without a valid gas free certificate being in place. It was also found that the DPA had been present onboard when these entries had been taking place.

We commented that it appears quite possible that the breaches of procedure were occurring before the Authorities became involved. In a company with an effective near-miss reporting system, such breaches would be reported as near-misses and corrective action taken, thus improving safety and avoiding penalties.

If seafarers do not feel that their concerns on near misses or safety issues are being properly addressed, they can report them to CHIRP. We follow up each report on an individual basis. Details of how to report are given on our website.



LEISURE SECTOR REPORTS

CAN YOU BE SEEN???

Report Text: We were in our yacht under power approaching a narrow channel from seaward making our first night passage of this area. We have neither a chart plotter nor radar, so I and my other crew member were very alert. With about 1 mile to go, I noticed another vessel following astern. I could only see its port and masthead lights, the lateral displacement of our tracks were very small.

I was satisfied that our stern light was working as it was reflecting off the inflatable that was in tow but not obscuring our light. When the vessel had closed to about 200 yards, I was concerned that it had taken no avoiding action as its track appeared to be closing.

I asked my crew to bring a torch to hand. When the following vessel was about 100 yards astern I believe a risk of collision existed so I turned 15-20 degrees to port which was towards the closing shore line. At the same time I shone the torch (8+LEDS) towards the vessel and

could see it was a fishing boat of about 40 feet. It maintained its heading and speed and passed about 10 yards down our starboard side. I am sure that had I not taken avoiding action a collision would have occurred. Our boat is fitted with an octahedral radar reflector correctly orientated.

CHIRP Comment: This clearly was a hazardous situation. It is useful in such cases to envisage the situation as it is being seen, or not seen, from the wheelhouse of the other vessel. They should of course be keeping a good lookout but nevertheless the stern light of a yacht may not be easily visible from the wheelhouse of a fishing vessel. Furthermore the stern light could possibly be mistaken for a light on the shore or as a vessel that is further away. It is also possible that, as the general visibility was good, the watch-keeper on the fishing vessel may not have been keeping a continuous watch on the radar and may not have spotted the echo from the yacht in the sea-clutter, even though she was fitted with a radar reflector. The octahedral type of radar reflector does have limitations; these are described in the Marine Accident Investigation Branch report into the loss of the yacht Ouzo. This report was published in 2007 and is available on the MAIB website.

With the foregoing in mind, it is worth considering whether there is anything yachtsmen can do to improve the probability of his yacht being sighted on future occasions. Rule 36 of the ColRegs regarding signals to attract attention provides that "If necessary to attract attention of another vessel any vessel may make light or sound signals that cannot be mistaken for any signal authorized in these Rules, or may direct the beam of her searchlight in the direction of the danger, in such a way as not to embarrass any vessel." It would appear prudent to equip a yacht with a powerful hand-held spotlight. Consideration may also be given to purchasing anti-collision flares, although great care must be taken in using these.

It is also worth considering what would happen if a collision is about to happen. Can the VHF be used from the cockpit? If it appears that a collision is about to happen, it is legitimate to alert the Coastguard by sending an urgency signal. Ability to send an urgency signal or a distress signal may be hampered by having to go down below to use the VHF.

As the Royal National Lifeboat Institution and the Maritime and Coastguard Agency point out "Lifejackets are useless unless worn." If a collision does occur, there may not be enough time to go down below to fetch them.

COLLISION BETWEEN SHIP AND YACHT

Report Text: I was in my yacht under sail in coastal waters in daylight. A commercial vessel was on my port bow. As I was in clear water, with no other shipping in the vicinity, I maintained my course as the stand-on vessel, expecting the ship to pass astern. In the event, the ship adopted a course to pass close ahead. At the last minute, I put the helm hard to port but at 3 to 4 knots, the response was slow with the result that my anchor struck the extreme starboard quarter of the ship. The ship's paint on my bow-mounted anchor is evidence

of this. If the ship took any avoiding action it appeared to consist of an increase in speed, thus aggravating an already dangerous situation. At no time did they use their whistle to alert me to the fact that they had no intention of changing course.

CHIRP Comment: We alerted the manager of the ship who investigated and advised as follows.

'The watch keeper at the time of the reported incident recalls the yacht involved and was not aware of any contact being made between the two vessels and did not consider the incident a near miss as in his opinion there was no risk of collision and the passing distance acceptable for the area and vessels involved. No formal report was therefore made on board the vessel. As stated, a course was set to pass ahead of the yacht and the opening aspect was duly monitored. The ship's speed was set at 'full' and remained constant throughout. The yacht eventually passed a point approximately 100 metres away from the ship's starboard beam progressing clear astern and was observed to clear away on the port quarter. If during this passing stage a last minute adjustment by the yacht resulted in some unfortunate loss of control, this would have been regrettable and beyond the ship's control. Any anxiety caused to the yachtsman was not intended.'

There is obviously a major difference in the accounts of the encounter between the two vessels. It is not the role of CHIRP to attribute blame but rather to identify the lessons from reports. It is clear that, as the yacht was under sail and not under power, and the encounter did not take place in a narrow channel, the ship was the give-way vessel.

With reports of encounters between a yacht and a ship, it is useful to look back and consider whether, in the absence of appropriate action by the give-way vessel, there is anything that the yacht as stand-on vessel could have done to avoid a collision and to increase the margin of safety. Rule 17 (Action by stand-on vessel) of the ColRegs applies:

i) Where one of two vessels is to keep out of the way the other shall keep her course and speed.

ii) The latter vessel may however take action by her manoeuvre alone, as soon as it becomes apparent to her that the vessel required to keep out of the way is not taking appropriate action in compliance with these Rules.

When, from any cause, the vessel required to keep her course and speed finds herself so close that collision cannot be avoided by the action of the give-way vessel alone, she shall take such action as will best aid to avoid collision.

In summary, the ColRegs put obligations on both the give-way and stand-on vessel to avoid a collision

ACCIDENT AT SAILING CLUB

Report Text: An accident happened whilst attempting to recover the safety boat up the ramp using a combination of rope and towing webbing. The safety boat was mounted on a launch trolley. The ramp was very slippery due to a significant build up of pebbles and small stones from recent high tides. At the foot of the

ramp lay significant “steep lip” of stones and pebbles presenting an obstacle to be overcome. At the time of the accident the tide height was close to the base of the ramp. Since it was unsafe to operate the tractor on the sloping section and due to the tide, impossible to drive the tractor on the beach, the tractor had been positioned on the horizontal section of the ramp approximately 15m from the safety boat. This distance between tractor and launch trolley was such that an extension of the webbing permanently attached to the tractor was needed. This procedure has been common practice at the club in these tide conditions.

A snap shackle had been used to connect the rope to the webbing. This snap shackle failed and was catapulted towards the two members who were attempting to clear a path for the launch trolley, the wheels of which had become bogged down in the loose pebbles. The snap shackle struck one of the members on his back very close to the left shoulder and bounced into his face just above his left eye. The blow to the shoulder was of sufficient force to cause him to collapse. The injury to the other member occurred when the broken end of the webbing struck him on the left side of his head just above his ear.

CHIRP Comment: In slightly different circumstances, the injuries could have been more severe so the club was absolutely correct in recording and following up the incident. We make the following observations:

- **STRENGTH AND INTEGRITY OF THE WEBBING.**
 - We assume that the safe working load of the snap shackle might have been considerably less than that of the webbing. Could the snap shackle be replaced by a bow-shape shackle?
 - If the snap shackle had not failed, might the webbing have snapped with the high load? Consideration should be given to the adequacy of webbing
 - The webbing and associated gear should be inspected regularly.
- **WORKING IN THE SNAP-BACK ZONE.**
 - It is generally hazardous to have people working in the snap-back zone of a rope or strop under high tension. In this case, the two people were in the zone assisting in getting the trolley over the lip. Can this be avoided in future? Would it be feasible to consider larger or wider wheels, more frequent shovelling of the pebbles to remove the lip, etc?
- **SUPERVISION OF THE OPERATION.**

Is there generally a person supervising the operation who can give signals and warnings to the tractor driver and to all those involved?

We were pleased to hear subsequently that the club had addressed the issues and implemented improvements. This is a good example of the value of investigating accidents so that the lessons can be applied. It highlights the importance of assessing the risks of operations and applying safeguards.