

CHIRP MARITIME FEEDBACK

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EDITORIAL

Shipping companies with a well-established safety culture should have their own near miss reporting programme. **CHIRP** encourages seafarers to maximise the number of reports of near misses, thereby increasing their learning from the reviews of such reports. For those seafarers who believe they are working within a Safety Management System that does not cover the hazardous occurrences they encounter, or where another company's SMS may have an adverse effect on their own activities, (such as port operations, or a vessel close quarter situation), then please use the reporting programme provided by **CHIRP**.

MISSING REPORTS

When taking into account the number of readers of this publication and their everyday exposure to maritime risk, we would expect to receive a greater number of near miss reports than that we currently experience. Reports are published only with the agreement of the reporter, having been edited only to remove identifying text. Each will represent the reporter's own perspective of the hazardous occurrence. **CHIRP** accepts reports from the commercial, fishing and leisure sectors. We are interested to see more reports on:

- Errors and error enforcing conditions
- Operating/Maintenance/Support procedures
- Regulatory aspects
- Unsafe practices or design

Readers of this publication are requested to take just a few minutes and submit a near miss report on any hazardous incident that they may have encountered. There are still too many people injured in maritime activities. I am sure some of these could have been prevented if individuals had learned from the lessons of others, who had encountered similar circumstances in the past.

The **CHIRP** comments have been reviewed by the 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

I hope you enjoy this edition of Maritime FEEDBACK.

John Rose Director (Maritime)

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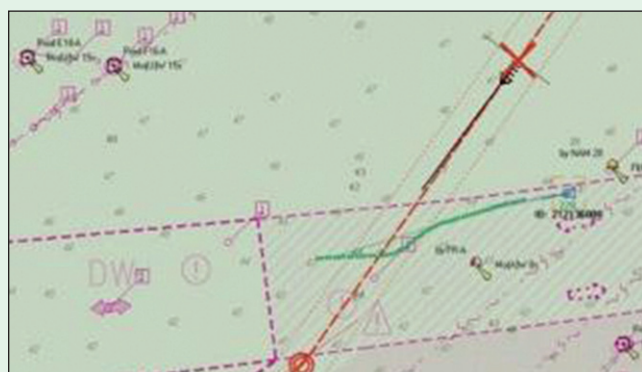
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REPORTS

NON-COMPLIANCE WITH THE COLLISION REGULATIONS IN NORTH SEA DEEP WATER ROUTE

Report text: We are loaded tanker Length 242m breadth 44m, draft 15m bound from Skagen to Rotterdam. Due to dense fog we proceed at 11.2 kts. From the East there is in traffic lane approaching vessel 'A' on a collision course. Our heading 220 and their heading is about 260. Collision is imminent and we called them ask to go astern of as per Collision Rules. They refuse and tell that it's too late for them! They tell us that they will go ahead of us, crossing our bow. We can easily see that it is not possible as they have only 8.7 kts speed. Our only possibility is stop engine and let the speed go down. Finally they changed their course more to port as observed from the radar track plotting pictures. If we had not stopped our engine, they never would have passed our bow. We had three radars plotting continuously their manoeuvres and situation was critical all the time and that's why we decided to ask what they are going to do. Our speed was only about 5kts when they finally passed our bow.



Lessons learned by the reporter: It has been clear to me for some time that professionalism on ships bridges is lower than ever. Since STCW came in force we have seen worse and worse quality people working on ship bridges. Many pilots see exhausted Masters who have been on bridges for days, as they can't let the Mates to be there alone. It's unbelievable how people vary with the same license from the same training requirements in schools. Almost every day we see and meet ships where people do not even know the 'Rules of the Road' or even basic seamanship skills. IMO with Government authorities should exercise controls on how these licenses are issued. What have we learnt from this? One must be extremely careful, as most probably there are people with a very poor knowledge of navigation on the other bridge and to keep well clear all of other vessels.

www.chirp.co.uk

FREEPOST RSKS-KSCA-SSAT, CHIRP, 26 Hercules Way, Farnborough GU14 6UU (UK only)
confidential@chirp.co.uk Freefone (UK only): 0808 100 3237 or +44 (0) 1252 378947

We see these things more and more every day and there is no end in this process unless somebody does something about it. Now in the ECDIS world, the game is going to get even worse. I don't feel good to see this. It would be nice to hear other colleague's comments.

CHIRP contacted the ship owner of ship 'A'. They replied with a report from their ship's officer of the watch (OOW) who confirmed the time and position as per the reporter's statement. The OOW observed the reporter's ship to be making a speed of 9.6 knots with ARPA plot showing an opening bearing to his starboard side with CPA 1.0 miles. The OOW claims his course was 263 and speed 8.7–8.9 knots and saw the ship abeam at 3–4 Miles distance, not in thick fog as claimed by the reporter. The OOW also did not hear any fog signals. He called the reporter's ship and told him of his intentions to alter course to port to increase the CPA to 1.5 miles. The reporter asked that he pass astern but the OOW replied it was too late to undertake that manoeuvre. The reporter's claim to have stopped his ship was not observed. The OOW on ship 'A' concludes he believes in such situations, altering course and good cooperation is more effective to avoid risk of collision, especially in good visibility and not dense fog. Also there was sufficient sea room with no closer vessel at that time.

CHIRP Comment: At a previous Maritime Advisory Board (MAB) meeting, a comment was made that exercises on the ship simulator, show that navigators are sometimes reluctant to make a large alteration to starboard to keep clear of a vessel on or near to their starboard beam. This appears to be such a case. It might also be that, as Vessel 'A' was close to the Northern edge of the Deepwater Route, the OOW may have been reluctant, perhaps unnecessarily, to go outside it.

The MAB reviewed the statements from both ships and they noted a number of inconsistencies between the reports from each ship, most notably one ship claims to be in dense fog and the other having clear visibility. However the statement from the OOW on the Ship 'A' reveals he saw red lights on his starboard side and therefore he was the crossing vessel and should have taken early avoiding action.

The reporter's list of lessons learned was not supported, as these appear to be opinionated and not directly related to the actual event. The Board expressed concern over the level of competence in the officer's understanding and application of the Collision Regulations.

CHIRP has replied to the operators of the Ship 'A' and advised them that based on the evidence they provided; the Board is of the opinion:

- The Officer of the watch (OOW) should have complied with the Collision Regulations and taken early and decisive action;
- OOW should have called the Master when the close quarter's situation appeared to be imminent;
- The company should undertake OOW training in order to improve the level of understanding of the Collision Regulations, and
- The company should consider the adequacy of their auditing of Bridge operations.

CHIRP also replied to the Reporter and advised him of the Board's appreciation of his report and relayed the opinion they have given to the cargo ship's operators. In addition, the Board reminded the reporter of the need for early and decisive action, as the other ship may not have easily noticed the reduction in speed of the tanker. The Board has questioned whether the original speed of 11 knots in dense fog was appropriate.

SAFETY OF PASSENGERS CROSSING EXPOSED DECK IN GALE

Report text: Loading of private cars was on the wet, exposed extreme rear outside upper deck of this Ro-Ro ferry leaving very young children and infirm passengers to cross a wet, slippery obstacle strewn deck in driving rain and very high winds. There was ample sheltered, dry vehicle accommodation that remained unused throughout the passage. The loading supervising crewman could only explain the loading plan as being due to the crew having no idea how many vehicles were to be loaded – even though vehicles had been checked in for about an hour before loading – and told me I needed to ask the loading officer if I wasn't happy with this explanation. I requested, via the Customer Service Officer if I might meet with the loading Officer once underway – but the Loading officer refused to meet with me to explain the reasons for this hazardous choice, and instructed the CS Officer to issue a complaint form.

I am not aware of any actual injury caused, but the increased risk of injury, accident or damage appears to have no explanation, other than that the Company did not appear to know what it was doing.

Lessons Learned: Loading of vessel must take into account passenger health and safety – as well as other loading considerations. A wet, windy, outside freight deck is a very hazardous and unfriendly place for children and infirm people.

CHIRP forwarded the report to the manager of the ferry. He responded, in summary as follows:

- The open deck in question is a certified passenger vehicle deck under Class and Flag rule.
- The deck surface is specially coated with anti-skid layer, deck fixtures are limited to elephant foot fixtures which are half circular shape painted with high visibility paint.
- For the day in question, the vessel was fully booked with passenger vehicles and trailers. The space referred to was likely to be a space left intentionally for a booked trailer that was still to be loaded, but stowed to ensure the passenger vehicles are able to leave at the port of arrival before the trailers.
- Vehicle decks are manned by a number of deck crew who are obliged to assist those who appear to need help



or ask for it. Those who need assistance can ask at the check-in, they will arrange a cabin staff member to meet them at the vehicle deck and/or placing their vehicle near the lift for easy access can accommodate this. There is also information on our Web site for those who require assistance, to declare this prior to boarding.

CHIRP thanked the reporter for sharing his concerns and compliments the Ferry operator for advising us on their standard practices for loading vehicles, along with the information available to passengers requiring assistance when boarding.

SEISMIC VESSEL AND YACHT

Report text: Seismic Survey vessel 'A' was conducting a marine seismic survey on a North Sea field. Vessel was towing ten seismic streamers at a speed of 4.5kts, each 6000m in length, separated by 100m, at a depth of 8 metres. Each streamer had tail buoy attached (bright yellow in colour and marked with yellow flashing light) to the end of the streamer. Vessel 'A' was accompanied by chase and guard vessels 'B' and 'C', the latter positioned behind the tail buoys, 'C' proceeding ahead of the seismic vessel). Seismic vessel is restricted in ability to manoeuvre due to towed equipment. All correct lights and shapes displayed by all vessels on the seismic survey.

During morning of the incident at sunrise, a leisure yacht under sail, approximately 30–40' in length flying Dutch flag was observed to be on a course which would result in her crossing behind the seismic vessel from starboard to port at a range of 4–5 kilometres astern of the seismic vessel (thereby directly over the towed marine equipment and at high risk of being hit by the tail buoys). Multiple attempts were made to contact the vessel using VHF by all three vessels, however no persons were visible on deck, vessel appeared to be sailing with no lookout. No navigation lights were visible. Chase Vessel 'C' was dispatched to intercept the yacht – they attempted to make contact using VHF, searchlight, ships whistle and then ultimately bullhorn. Contact was finally made when the yacht was approximately 150 metres away from the line of ten tallboys, having sailed over 5 of the ten towed streamers. Yacht then motored out of the danger area under direction of the chase vessel. Contact was established by shouting from vessel to vessel whereby the yacht indicated that they were bound for UK but had neither lookout nor functional VHF. Yacht crew (2 persons) had limited command of English, and vessel was not marked with name, hence it was not possible to establish the identity of the yacht.

Had the chase vessel been unable to reach and safely escort the yacht clear of the towed equipment, then the yacht had very high risk of being struck or entangled by tail buoy, which may have resulted in serious damage to the yacht.

Lessons Learned: Causes

- Until becoming dangerously close, the seismic vessel did not spot the sailing yacht early enough, either visually or by radar, nor did the chase vessels assigned to the same. Radar settings not optimised for prevailing weather conditions.

- Sailing vessel visually obscured by wave height and sun low on horizon behind – *Position of chase vessels could have been improved so as to assist with early detection and intervention.*
- Yacht was not compliant with IRPCS or conducting any form of lookout. – *Yacht did not carry operational VHF radio or any other auxiliary means of detection (AIS, radar reflector or similar).*
- Project was not correctly notified on Navtex/NTM. – *Lack of understanding of the potential hazards of offshore operations by leisure users.*

CHIRP Comment: We are pleased to publish reports that demonstrate the value of using root cause analysis after receiving a report of a hazardous occurrence.

We were advised the operator conducted a full incident investigation in cooperation with their client. Recommendations were issued to all vessels in their fleet, both in terms of positioning of guard vessels and the need for additional means of attracting the attention of uncooperative vessels (white parachute signal flares). They conducted a full review of their procedures along with those of their chartered chase vessel operators.

We hope the publication of this report will promote the need for a better understanding amongst leisure yachts as to the dangers of sailing through an oil field and the potential hazards in marine seismic operational areas.

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.

INCIDENT INVESTIGATIONS

We receive accident reports from the UK's Marine Accident Investigation Branch (MAIB): These are free to download from their web site www.maib.co.uk

The reports include many useful conclusions and recommendations. Readers interested in the offshore renewable energy sector may be interested to read Report 23/2013, the combined report on the separate investigations into incidents involving wind farm passenger transfer vessels. One conclusion is the compelling need for the burgeoning offshore renewable industry to establish, at an early stage of its development, a shared safety culture. This is a sector of the maritime industry that has so far appeared reluctant to use **CHIRP** to report hazardous occurrences.

Report 24/2013 Berth Contact by MV Finnarrow and Report 26/2013 on the grounding of Fri Ocean, highlighted the need for improvements in the Safety Management System and concerns that fatigue was a contributing factor in both incidents.

A digest of the lessons from Marine Accident reports in 2013 has highlighted the need to ensure clear communication between departments and individuals. Casual communication, instead of careful planning, is unlikely to

produce adequate management of risk, encourage any allowance for changing circumstances and/or contingencies that may need to be developed.

BIO-DIESEL

Summary Text: The industry, apparently with minimal protest, has accepted a potentially dangerous compromise that will inevitably be the cause of more serious life threatening incidents than that reported. Increased awareness of the potential hazards of Bio-diesel is certainly needed. RYA advice in Maritime **Feedback** Issue No. 32 is useful. The author's experience may be useful to others as he is especially 'sensitive' to the quality of his diesel fuel. The author's boat has two naturally aspirated diesel engines and carries 1600 Litres in three elderly mild steel tanks where some rust and contamination is inevitable. The advent of Bio-diesel has not helped, nor the uncertainties of marine fuel content/quality in UK and across Europe. So the author's own practice is:

1. Drain off more frequently, at regular intervals and after every rough passage, a litre or so of diesel from the three tank sumps – inspect for water, 'black slime' evidence of algae and dirt.
2. Change the tank and engine fine filters at least twice a year.
3. The author has resisted buying a so-called 'Fuel Polishing' system as their filters are often 10 micron coarser than the tank filters that the author uses.
4. The author 'doses' the tanks liberally with one of the commended water dispersant additives and occasionally a biocide.

CHIRP Comment: Leisure craft users should consider the RYA advice and ensure they drain off and change filters frequently (and of course carry spares). **CHIRP** is interested to receive reports on incidents involving loss of power and disablement as a direct consequence of the Biofuel content of Marine diesel.

NARROW CHANNEL AND COLREGS RULE 9

In a recent email we were reminded of the incident on 22 March 2008, when the Ukrainian flagged oil rig supply vessel Neftegaz 67 collided with the Chinese flagged Panamax-sized bulk carrier Yao Hai in the western approaches to Hong Kong harbour. The damage sustained on collision caused the Neftegaz 67 to sink rapidly with the tragic loss of the lives of 18 of her crew. The finding of the court case raised concern in the maritime community over the application of the wording of Rule 9, which raises a very strong presumption that it applies only within a narrow channel or fairway. However the international conference that drafted the 1972 Colregs rejected a proposal to include a definition of 'narrow channel'. Therefore Mariners must decide for themselves whether or not a particular stretch of water is a narrow channel or fairway where Rule 9 applies.

I recall the USA's National Transportation Safety Board made an observation, it does "operators little good to learn months after an accident that a court has ruled that a particular portion of waterway, under a particular set of

circumstances was or was not a 'narrow channel' under the rules, and that the narrow channel rule should or should not have been applied".

CHIRP will be interested to receive reports on experiences in similar circumstances elsewhere in the world, including those experienced near the entrance to such designated channels.

PLEASE JOIN US ON FACEBOOK

We are encouraged by the enthusiastic response to our Facebook page and delighted to recognise the support from over 900 followers in 47 countries around the world. You are all helping us to make **CHIRP** more accessible to the global community of seafarers. We encourage more seafarers to join us. If you enter 'Facebook CHIRP Maritime' into your search engine, you will easily find us; or use the link from our website www.chirp.co.uk

Since the last publication of Maritime **FEEDBACK** we have published short articles on:

- Water Safety Duty of Care – What is it?
- Seafarers who act negligently may be liable for any harm sustained by their rescuers.
- Don't forget – new SOLAS, MARPOL Amendments are now in place.
- Do you have out of date pyrotechnics on board?
- If you're not on board with lifejackets, you're not on board.
- Defective Bridge equipment, none of the watchkeeping officers were sufficiently familiar with the operation of safety critical bridge equipment. (MAIB Report 22/2013)
- The skipper of a racing yacht has been made to pay over £100,000 in fines and costs after colliding with a tanker in a narrow channel.
- Will your life raft release when you most need it?



MAKING REPORTING HAPPEN

We are undertaking a joint initiative with The Nautical Institute to establish a group of voluntary Ambassadors around the world. The aim is to encourage the submission of MARS reporting of accidents and **CHIRP** reporting of hazardous occurrences. Briefing material and coaching will be provided to each of the Ambassadors. (See article in Seaways February 2014).

If you want to help improve the safety culture amongst seafarers in your local region, then please email: mars@nauticalinst.org or john.rose@chirp.co.uk