# CHIRP FEEDBACK

Issue No: 10

## What's in this Issue?



**Number of Reports since the Last Issue: - 14**

**Report Topics Have Included:**

Near Collisions
In Port Communications
Sailing Vessel Collision
Vessel Access during Cargo Operations
Fitting of Smoke Alarms
Pilotage Exemption Certificates
Port Marine Safety Management

### BACK ISSUES

Back issues of CHIRP FEEDBACK are available from our website: www.chirp.co.uk

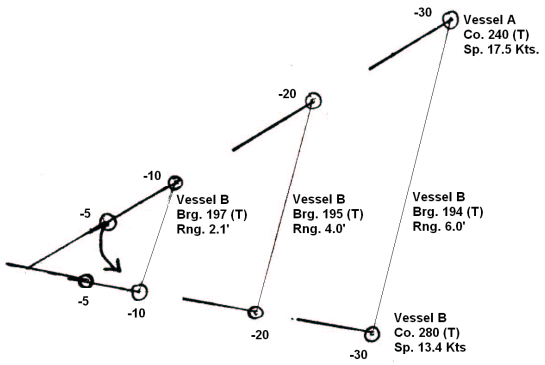
# REPORTS

REPORTS ARE PUBLISHED ONLY WITH THE AGREEMENT OF THE REPORTER AND ARE, AS FAR AS POSSIBLE, IN THEIR OWN WORDS, EDITED ONLY TO REMOVE IDENTIFYING TEXT. THE SAFETY CONCERN(S) RAISED ARE BASED ON THE INFORMATION PROVIDED BY THE REPORTER AND THEREFORE REPRESENT THE REPORTER'S PERSPECTIVE.

# MERCHANT SHIPPING

## NEAR COLLISION 1

***CHIRP*** Comment: **The following incident has been reported to CHIRP by a company wishing to share its experience with others. The Maritime Advisory Board welcomes this report and wishes to encourage other companies to share their incident data in circumstances where they believe others might benefit.**




**Company Preamble:** One of our ships had a Near Miss (collision). The facts are as reported by the Master. (His comments are unprintable). The report was circulated to our fleet with my comments appended. The Duty Officer concerned was a properly certificated officer. He was the Third Mate carrying out the Second Mate's watch (1200 to 1600) as the Master had just sacked his Second Mate for incompetence and was sailing short handed for one voyage. The Master had kept the 0800 to 1200 watch himself and handed over to the other officer at 1200 but was still on the Bridge.



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**Report Text:**

Time : 12:30 Ships time

Wx : Sea slight Wind BF 3 Vis Good

Location: Vessel approaching TSS.

No navigational danger or ship within 5 NM on stbd side. Other ship being tracked on radar since 11:45. ARPA indicates other ship crossing ahead of Own Ship TCPA 10 mins, CPA 0.35 NM ahead. Master on Bridge. Duty off came and stood on steering position close to helmsman. Duty Off alters course to Port. Other ship maintains course and speed. Own Ship passes very close astern of other vessel (ARPA shows CPA as zero). There has been no communication with the other vessel, the VTS or with the Master who was standing on the Bridge wing a few feet away.

**Company Comment:** It is not the intention to explain the collision regulations; however, the action taken by the duty officer is a clear violation of Rules 15 & 17 of the Collision Regulations. a) Rule 15 (Crossing Situation). This makes Own Ship the Stand-on vessel. b) Rule 17 (Action by Stand-on Vessel). Own Ship is required to hold her course and speed. A power driven vessel which takes action to avoid collision "shall if the circumstances of the case admit, not alter course to port for a vessel on her port side".

If the Duty Officer was concerned about the other vessel, he should have made efforts to contact her. Further, with the Master standing close by he also failed to express his concern to the Master and finally compounded the error by altering course to Port in direct contravention of Rule 17 (c).

Notwithstanding the presence of the Master on the bridge, the Duty Officer remains in charge of the vessel unless relieved. However, Duty Officers are required to keep the Master advised of any navigational hazards or developing close quarter situations. If an officer does not seek the assistance of the Master standing close by when he feels there is a risk of collision, would this officer call the Master at night?

For some reason, it is a common practice among young officers to alter course to port in crossing situations as above and also in head-on situations or near head-on situations governed by Rule 14.

Please discuss this case with your deck officers and ensure that they are fully aware of:-

(i) The dangers in alterations of course to port when taking action in accordance with Rule 14 or Rule 17(c).

(ii) Their obligation to call the Master whenever in doubt. The guiding principle should be "If in doubt whether you are in doubt - call the Master".

***CHIRP*** Comment: **The Maritime Advisory Board considered the Company's comments and believes the following additional points and information may add value to the analysis of this incident:**

- **The ARPA indicated the other vessel was passing ahead (even if closely) and there is a risk that this apparent accuracy may have had an impact on the judgement of the OOW and Master.**
- **Guidance on acceptable passing distances in the Company and/or Master's Standing Orders may have been of assistance.**
- **The sound and light signals prescribed by Rule 33(d) should have been made. As a general rule VHF should not be used in collision avoidance.**
- **At no time does a reduction in speed appear to have been considered as an option.**
- **The Master was clearly experiencing some difficulties with the officer complement and could have used this situation as a training/mentoring opportunity instead of permitting it to develop.**
- **If the Company has identified that incorrect alterations to port are common place in the circumstances outlined, then it should consider taking steps to identify why this is the case and identify appropriate remedial measures, such as a fleet circular backed up with additional assessment and training.**
- **The acceptable action in this case would have been a large alteration of course to starboard in accordance with Rule 17(c) (a round turn) or a reduction in speed.**

## NEAR-COLLISION 2 – RESTRICTED VISIBILITY

**Report Text:** In poor visibility we detected a vessel on radar fine on the port bow. The plot indicated he was passing clear down the port side; I was unhappy with the CPA and asked the watch officer to alter to stbd. As we started to swing, the watch officer observed the other ship at about 2 miles altering to port which would have put us in a close quarters situation or worse. We immediately went hard a port and passed down the stbd side of the other ship and close enough to read her name despite the poor visibility. When I called the other vessel to ask why she had altered to port, the reply was "We agreed to pass green to green". I don't know to whom he spoke, but it definitely was not my ship. In this case the situation was salvaged by the alertness of the watch officer - proving that thankfully, not all youngsters lack the requisite qualities.

***CHIRP*** Comment: **There are a number of aspects of this report which the Maritime Advisory Board found of interest:**

- **Often in these circumstances the other vessel detects the initial alteration and reverses its own initial alteration, resulting in a collision. This was a very lucky escape. It is possible that maintaining the starboard alteration and/or reducing speed may have been a better option.**

- The issue of passing distances also features in this report. The Board is concerned that vessels appear to continue to use clear visibility values in restricted visibility situations. A vessel's optimum sea room must be adjusted in accordance with the prevailing circumstances and conditions. As an example, in open water restricted visibility situations there is nothing to prevent vessels pushing out the boundaries adopted in clear visibility to give additional margins of safety. In more confined waters options such as speed reduction may have the same effect.
- VHF has been used to try and negotiate a deviation from the Rules and a misidentification has occurred. The Board emphasises its previous advice that compliance with the Rules is sufficient in almost all circumstances and VHF conversations should be avoided.
- If VHF conversations are considered necessary then they should be used to confirm compliance with the Rules and not negotiate a deviation. Steps should be taken to confirm the identity of the other vessel beyond doubt.
- The MAIB investigation into the collision between the "Lykes Voyager" and "Washington Senator" (downloadable from their web-site) illustrates very well the consequences of not following established best practice.

## NEAR-COLLISION 3 – AT ANCHOR

**Report Text:** Own ship had come down during the course of the day and had anchored in the Northern anchorage earlier that evening at 22:00 hrs to await the pilot the following morning. The weather that day had been misty, but had gradually lifted during the day. At the anchorage, the wind was quite strong and there was the usual strong current. 7 shackles of cable were used and after anchoring, the ship lay facing the S, pretty much into the wind. Our main engine was on 10 minutes notice of readiness.

At 23:45 hrs, the 3rd Officer called me, summoning me to the Bridge immediately. As I was getting up, the whistle started sounding, which prompted me to get a move on.

On opening the Bridge door, I saw a white steaming light on the stbd bow, a white steaming light and a green sidelight on the port bow and all the lights of the accommodation block on a ship passing very close ahead of us. I estimated the distance to be approximately 50 metres.

The 3rd Officer told me he had monitored the ship coming into the anchorage and had watched him alter to port. It was shortly after this that he realised the other ship was being set onto us and called me.

By AIS, the ship was identified. I believe this to be a gas carrier. She subsequently anchored further west of us.

What has happened to the art of seamanship? This ship took no notice of the effects of wind and current and got set down dangerously close to us. Any collision could have had catastrophic consequences.

***CHIRP*** Comment: This report was forwarded to the gas carrier's manager, who replied as follows:

"Our investigation has confirmed the vessel was in the area at the time.

We have no record of the incident or near-miss in our group wide incident/accident reporting database. The Master has since left the company and has declined to comment on the matter. We have decided there is not a lot of point in trying to contact the other watch-keepers on board as it is unlikely that they would be able to offer any form of explanation.

The vessel has a high freeboard in both ballast and load conditions and also deck compressor rooms which give her an unusually high windage area. The vessel had just been taken into management and we assume the Master in this case had underestimated this and found himself in this embarrassing situation.

What we have done is sent out a letter reminding ship's staff on the importance of near-miss reporting and our latest edition of our safety newsletter also had an extensive article on near-miss reporting. Also (not as a direct result of just this incident), as one of our ways of improving the actions of the bridge team, we have reduced the interval between bridge team training courses."

***CHIRP*** Comment: The Maritime Advisory Board is grateful that the vessel operator has made an assessment of the incident and responded positively to it; despite some time having elapsed between incident and the report to CHIRP. The areas they have chosen to focus on relate to the importance of incident reporting and bridge team management. The Board believes the following points may also be of assistance:

- The incident indicates a possible concern regarding the effectiveness of the procedure adopted for familiarisation where a new ship is taken under management.
- Despite the Master having left the company, the investigation might usefully have been completed for the benefit of other employees. Lessons related to selecting and proceeding to a safe anchorage considering factors such as leeway, set, drift and windage are likely to be of general application.

## VHF COMMUNICATIONS & PORT OPERATIONS

This occurrence which I am reporting occurs frequently. I was the designated dock & channel pilot for the vessel "A". Whilst preparing to sail, another vessel "B" was also manoeuvring. The problem was

that both ships were using the same VHF channel for intership communication resulting in an order on one ship being received on the other, this could have caused serious damage or injury. The order given on the "B" and received on "A" was to "Let go everything". I indicated to the master of "A" that I would prefer to give orders verbally without the use of the VHF and for other internal communication the master reverted to speaking in his native language (Not sure why he didn't change channel). I feel that the use of VHF when manoeuvring is becoming more problematic and an accident caused either by two ships being on the same channel inadvertently, or by malicious intent from some third party is not far away. As vessels approach a port under pilotage the helm/engine/thruster controls can come thick and fast and when all these orders are being relayed on an open public VHF channel I feel its asking for trouble. A 'wrong way' helm order may not have time to be corrected on final approach to a lock or berth and an inappropriate engine order could be catastrophic for the bow tug and its crew. If radio must be used to communicate internally then I think we should be using a low power UHF set which is unlikely to invite public access. However personally, I think just shouting the order is usually the most positive and effective. Both vessels were using VHF, though which channel they were using I am not sure. It is not only the ships of these two companies which have similar bridge procedures. This is a very common practice.

***CHIRP*** Comment: **This report has been forwarded to the UK Maritime and Coastguard Agency's Port Marine Safety Code Steering Group. The UK Maritime Pilots' Association has also indicated that it will survey its Members in order to try and ascertain to what extent others experience similar difficulties.**

- **Operational communications should be covered by a Competent Harbour Authority's risk assessment.**
- **Ensuring radio communications are properly prefixed will limit the risks of misidentification.**
- **Using alternative communication methods should be considered e.g. "Talkback" systems.**

## PILOT ROSTERS AND FATIGUE

***CHIRP*** Comment: **The following report was sent with a number of working rosters attached and concerns the fatigue implications of particular work patterns.**

**Report Text:** Marine pilots work a 24 hour 'on call' shift system. This involves a number of pilots on a rolling roster for a 24 hour period which involves covering work from 0830 one day until 0830 the next day. The base station has bunk rooms, kitchen and a lounge where pilots can rest up during breaks between ships. The shift system involves working blocks of 24hrs on call with 48hrs off between work periods. A pilot does a block of 3 or 4 working 'days' followed by 4 or 7 clear days before returning to work.

Whilst we obviously get tired after midnight we do not consider ourselves to be getting dangerously fatigued due to breaks during the 24 hour period and clear nights between working days. We would be very interested to know if there is a way of backing up this assumption.

***CHIRP*** Comment: **The UK Marine Accident Investigation Branch (MAIB) in its investigation in to the collision of the general cargo vessel "Orade" with the Apex Beacon, River Ouse, states:**

**"QinetiQ Centre for Human Sciences analysed the pilot's working hours and concluded that he was probably not affected by fatigue at the time of the accident. However, the investigation has highlighted that, despite pilots' hours being subject to the working time regulations, and despite the fact that some allowance is made for hours recently worked, when ordering a pilot for a particular job, much is left to the pilot's own view on whether he is fatigued and capable of safely carrying out the required task. In the MAIB's experience, the individual is not usually the best judge of that condition, and ports should proactively manage the risks associated with pilot working hours, bearing in mind relevant legislation and guidance."**

**The MAIB went on to recommend that The Port Marine Safety Code Steering Group:**

**"Develop appropriate working hours regimes for UK pilots, taking account of current regulations and advice on working hours."**

**CHIRP will await the output of The Port Marine Safety Code Steering Group on this subject and highlight its findings.**

**The MCA's 24hr Info No. is 0870 6006505.**
**(Hazardous incidents may be reported to your local Coastguard Station.)**

## LINE FEVER?

**Report Text:** Over the previous two nights I had encountered a vessel in an open water "channel" with banks on either side. On both occasions we were in a head on situation. Although I had one of the banks on my starboard side I altered course to starboard to open up some kind of CPA (0.4 nm), however the other vessel continued up the centre of the "channel" seemingly unable, or unwilling, to deviate from the set course line she seemed to be following.

On the following night of our encounter occurred further south and clear of the "channel". I was on the usual course as was the other vessel (A), when I detected her on radar at about 10nm (I identified her by AIS). Astern of me at about 5nm was another vessel (B). Once I determined that a risk of collision existed I altered course to starboard and opened up

a CPA of 1.5 nm. As before vessel A continued along her course line without any alteration and we passed at about 1.5 nm. Astern of me B had continued along her original track and the two vessels now closed each other on a head-on situation at a speed of about 30 kts. Both vessels seemed reluctant to alter course and finally, as they closed within 2.5 nm of each other, came the inevitable call on #16 "What are your intentions?"

"I have just altered to starboard and you come to port, what do you want to do?"

"Ok I will come to starboard and we will pass red to red"

(This conversation took place on #6)

They must have passed each other at less than 0.5 nm as my radar plot showed that both vessels altered their course by around 5 degrees to starboard and as soon as they were clear of each other altered to get "back on the line".

***CHIRP*** Comment: This report represents another example of vessels coming unnecessarily close. Rule 8 states:

**"(a) Any action to avoid collision shall be taken in accordance with the Rules of this part and shall, if the circumstances of the case admit, be positive, made in ample time and with due regard to the observance of good seamanship."**

Altering course by 5º at <2.5' with <7 minutes before collision and passing at < 0.5' in open water would, if the reported facts are true, appear to fail on all counts.

Modern navigation systems allow tracks to be maintained to far greater accuracy than in the past and in certain areas this has increased the risk of head-on or nearly head-on encounters. It has been suggested a "leave waypoints to port" offset would address some of these concerns and the Maritime Advisory Board endorses this approach.

Vessels adopting this approach should bear in mind that end on overtaking encounters are still possible if similar offsets are adopted or recommended routes are being followed and attention is drawn to the findings of the UK MAIB investigation into the collision between "Cepheus J" and "Ileksa".

# LEISURE

## TO DIY OR NOT TO DIY?

***CHIRP*** Comment: The Board is grateful for this report and a frank, honest and sober self-assessment, illustrating the affects alcohol.

- Alcohol not only slows your reactions, but also distorts your view of your own abilities.
- Only attempt repairs and modification that you are competent to undertake.
- Always check the function of controls and equipment after maintenance/repair.

**Report Text:** The skipper in his infinite wisdom had decided to take the throttle assembly apart in an attempt to increase the availability of reverse power. Due to his meddling in areas which are clearly above his level of expertise, a serious maritime incident was narrowly avoided only by the quick & decisive actions of crewmembers. To prevent the loss of reverse power again the skipper is to only undertake mechanical work whilst closely supervised and away from the influence of strong drink. Also padlocking the tool box may also be a good idea.

## CHOOSING THE RIGHT SPOT TO ANCHOR!

***CHIRP*** Comment: In the following report a Harbour Authority has decided to share an incident for the benefit of others. The Maritime Advisory Board is grateful for this report and encourages others to do likewise. The Board also wishes to recognise the high quality of the results of the internal incident investigation.

**Harbour Authority Report Text:** A recent collision between a commercial ship and a small sailing craft at night gives us considerable concern that insufficient heed is given by leisure users not only to the status of the main navigation channel but also to basic safety and reporting measures.

On the night in question, a cargo ship which had departed port encountered a small sailing craft which had anchored directly in line with a pair of leading lights which indicate the deep-water channel.

It was a dark night. Although an all-round masthead light was lit, it was lost among street and vehicle lighting ashore. No additional lighting was provided to illuminate the vessel (e.g. deck lighting) as suggested in Rule 30(c) of the International Regulations for the Prevention of Collisions at Sea.

The sailing vessel did not present a conspicuous radar target to either the shore-based radar or the ship's own radar.

Although the sailing vessel had contacted the Coastguard to advise the location in which it was anchored, no call was made to the Harbour Authority to advise that it was at anchor in the main shipping channel, nor was similar advice received from the Coastguard.

A combination of the above factors resulted in a collision between the two vessels. Were it not for the last-minute avoiding action taken by the outbound ship, there is little doubt that the outcome would have been severe or fatal injury to the occupier(s) rather than the superficial damage caused to the anchored sailing boat as the ship scraped along the side of it.

Points which might be reasonably made include:

- Do not anchor in the main navigation channel. If this is unavoidable (due to an emergency, for example) you should contact the Harbour Authority immediately, advising position and type of vessel.
- Do study the relevant, corrected and up-to-date chart of the area,
- Do ensure that your vessel is adequately lit, taking into account levels of background lighting and other prevailing conditions,
- Do ensure that your vessel presents an adequate radar target by hoisting (or permanently fixing) a suitable radar reflector and
- Keep a good lookout and maintain a listening watch on the appropriate VHF channel throughout.

# EDITORIAL

There are a number of interesting developments to comment upon in this 10th edition of FEEDBACK.

The first item to note is there are two reports in this edition; one from a ship manager and one from a harbour authority, where the published information has been obtained through their Safety Management Systems (SMS) and they wish to share it.

CHIRP's mission is to promote safety by obtaining, distributing and analyzing safety related reports which would not otherwise be available, so we welcome this development and encourage other organisations to do the same. Where the source of a report is a company, CHIRP offers confidentiality in the same way it does to individuals and the Board performs a similar function in trying to ensure as many learning points as possible are identified, promoting resolution.

The next item to note is the current dominance of near-collisions in the CHIRP post-bag mentioned in the last editorial. Where possible, CHIRP brings these incidents to the attention of the "other" ship's management and has achieved some success in promoting positive responses. We believe this activity may be part of the reason so many near-collisions have been sent to us. Companies in receipt of such reports through their SMS may wish to consider reporting these encounters to the other owner/operators and/or their Flag Administration's accident/incident investigation body themselves. The more this is done the better the chances of realising improvements.

The reports received highlight two important areas; **competence** in the knowledge of the International Regulations for Preventing Collisions at Sea (Colregs) and **confidence** in their application.

Ship owners and managers expect that personnel employed with proper certification are competent. Colreg competence ought to be provided by training establishments and established by certificate issuing Flag Administrations, but, if the reports received are representative, owners may consider it prudent to establish competence to their own satisfaction through pre-employment screening. Tools such as the Shipping Industry Guidelines on Flag State Performance (see www.marisec.org) may be of use in determining whether such additional measures are necessary.

Confidence in application is to some extent derived from competence, but is also very susceptible to other factors such as company and shipboard culture, as some of the reports published illustrate.

CHIRP has not received a single near-collision report, where a reduction of speed has been used to resolve the situation and in nearly all of the reports it does not appear to have been considered as an option. It would be very interesting to hear from deck and engineer officers why this might be the case.

Finally, references to previous collisions which have occurred in similar circumstances illustrate a depressing inability to learn from past mistakes. We must improve in this area or accept the possibility that the list of accident investigations which follows will get longer.

# REPORT UPDATE

## ENGINE INTEGRATION ISSUES

More organisations are responding to the report issued in June of 2005. CHIRP welcomes these contributions and plans to continue facilitating positive dialogue with a view to identifying appropriate solutions, where relevant.

## OPERATING & MAINTENANCE MANUALS

CHIRP expects to publish its report on this subject in June of this year.

## CRANKSHAFT PROTECTION

CHIRP expects to begin compiling its report on this subject in the second half of 2006.

# CURRENT MAIB INVESTIGATIONS

The following accidents/incidents are being investigated by the MAIB as at 09.03.06:

| Vessel's name | Accident/incident type | Date of Incident |
|---|---|---|
| Portland powerboats | Collision between two junior racing powerboats in Portland Harbour. | 19/6/05 |

| | | |
|---|---|---|
| **Mollyanna** | Swamping and capsize of small trailer-sailer off Puffin Island, Anglesey with the loss of two lives. | 2/7/05 |
| **Sea Snake** | Grounding of powerboat at entrance to East Loch Tarbert, Argyle, Scotland resulting in three fatalities. | 10/7/05 |
| **Abersoch RIB** | Two people were thrown from speedboat and a third person abandoned the speedboat. All occupants were 16 or under. The vessel continued and one occupant received injuries by contact with the propeller. | 07/08/05 |
| **Big Yellow** | Passenger-carrying RIB suffered serious damage and flooding in St Ives bay, resulting in 8 passengers being injured. | 26/08/05 |
| **Harvest Hope** | Loss of fishing vessel after she snagged her gear on pipeline NW of Aberdeen | 28/08/05 |
| **Anglian Sovereign** | Grounding of the Coastguard ETV off Shetland. | 03/09/05 |
| **fv Blue Sinata** | Flooding of fishing vessel off Weymouth with one life lost. | 08/09/05 |
| **Lerrix** | Grounding of cargo vessel in the Baltic Sea. | 11/10/05 |
| **Harvester/Strilmoy** | Collision between fishing vessel engaged in pair trawling and offshore supply vessel in North Sea. | 4/11/05 |
| **Sammi Superstars** | Machinery failure during lifeboat drill on Korean-flag bulk carrier in Liverpool. Two crew members injured. | 7/11/05 |
| **Golden Bells II/Plato** | Collision between Golden Bells II and Plato about ESE of Kilkeel. | 22/11/05 |
| **Varmland** | Fall overboard from the upper platform of the accommodation ladder when in port, with one fatality. | 23/11/05 |
| **Dieppe** | Grounding of Dieppe on the approach to Newhaven Harbour. | 5/12/05 |
| **CP Valour** | Grounding of Bermudan flagged vessel in a position of Praia de Faja about 120 miles North of Fayal Island | 09/12/05 |
| **fv Lisa Leanne** | Fire on board whilst alongside the Fish Quay, Sutton Harbour | 10/12/05 |
| **fv Noordster (Z122)** | Capsize of Belgian registered fishing vessel, 11 miles off Beachy Head, resulting in two fatalities, one survivor in hospital and one crewmember missing | 14/12/05 |
| **fv Sovereign** | Grounding off Cairnbulg Point, no injuries or fatalities. | 18/12/05 |
| **Berit** | Grounding of cargo vessel off Gedser, Denmark. | 05/01/06 |
| **RFA Mounts Bay** | Inadvertent release of the 'Fast Rescue Boat' | 07/01/06 |
| **Jolbos** | Man overboard from Bulk carrier, resulting in 1 fatality, off Newport. | 08/01/06 |
| **fv Emerald Star** | Contact with the Texaco Jetty at Milford Haven. | 18/01/06 |
| **fv Green Hill** | Foundered at the entrance to Ardglass Harbour | 19/01/06 |
| **P&O Nedlloyd Genoa** | Loss of containers from vessel during passage. | 27/01/06 |
| **Rubino/ Linda Kosan** | Hazardous incident between Chemical tanker Rubino and LPG Carrier Linda Kosan, which occurred off the Humber | 21/01/06 |
| **Kathrin** | Grounding of cargo vessel on Goodwin Sands, Dover Straits | 12/02/06 |
| **Pride of Calais** | Machinery failure occurred whilst berthed in Dover, which resulted in the collapse of the gangway | 21/02/06 |

MAIB reports and incident report forms are available on their website www.maib.gov.uk and their 24 hr tel. no. is 02380 232527.

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