MARITIME FEEDBACK

No: 2 Winter 2003/04

EDITORIAL

Our second edition brings a new set of reports that CHIRP hopes will stimulate as much, if not more, reaction than the first. Thanks are expressed to all those that have taken the time to comment whether through telephone calls or correspondence and to all the organisations and publications that have carried CHIRP material.

A warm welcome is extended to CHIRP's newly appointed Trustees; Captain Stephen Bligh, CEO of the Maritime and Coastguard Agency and Captain John Hughes, former Director of the Oil Companies International Marine Forum, who join Rear Admiral Stephen Meyer, Chief Inspector of Marine Accidents and Mr Philip Wake, CEO of the Nautical Institute on the CHIRP Board.

The Maritime Advisory Board has now been selected and the Members can be seen on our website www.chirp.co.uk. The last meeting was held on 14 January 2004 and CHIRP would like to thank the Honourable Company of Master Mariners for again allowing us to use HQS Wellington as the venue.

The website should have a new look by the time this issue is published and CHIRP should soon be able to offer a secure e-mail facility. More information soon!

Some of the issues raised to date have been remedied quite quickly and others require a little more work! To keep you informed about progress and obstacles we have encountered we've included a "Report Update" section.

CHIRP continues to receive and welcomes reports from non-UK reporters wishing to raise safety issues in confidence.

Reports are published only with the agreement of the reporter and are edited only to remove identifying text. They represent the safety concern(s) from the reporter's perspective, based on the information available to the reporter.

A final note of thanks to all those that have submitted reports whether from ship or shore; keep them coming!

Mike Powell
Director (Maritime)

REPORTS

Maritime Reports received in Period: 22

Key Areas:

- Fatigue
- Pilotage exemption certificates
- Gagging of smoke alarms
- Gangway safety nets
- Incident reporting
- Flag State investigations
- Working on deck

FERRY FATIGUE?

I have been working on ferries for a number of years and serve on a two weeks on, two weeks off rotation. I consider this rotation pattern essential, particularly in winter months, when the weather is frequently bad and the tours particularly tiring. I have recently discovered that a 2nd Officer has been employed on a six month contract, without leave provision, and is "filling in" on ships as required, but essentially giving continuous service. He has served on 3 ships to date in a very short period and my concern is that his service time on each of the vessels is insufficient for him to become familiar with them and his continuous service is bound to result in fatigue and perhaps errors, particularly in winter conditions.

Although this report might in some circumstances have been considered an employment terms and conditions issue and therefore outside the scope of the Programme, it involved a genuine safety concern.

CHIRP raised the concern with the operator, who responded promptly and comprehensively. The operator stated the individual concerned received and will continue to receive the required rest periods. In addition he had also been given leave. CHIRP was also assured of the individual's familiarity with the vessels concerned.

Fatigue, particularly cumulative fatigue, is a major issue across transport modes but is controlled to varying extents in different modes. A major research programme on fatigue in seafarers is in progress at the

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You can also e-mail us at confidential@chirp.co.uk - visit our website at www.chirp.co.uk

Seafarers' International Research Centre, Cardiff University. The study is supported by MCA, HSE, maritime trade unions and employers. Ferry crews are one of the groups being studied. The results are currently being analysed and may well help identify ways of ensuring that both safety and well-being are not compromised by the patterns of work required at sea.

Levels of manning and fatigue are safety issues and CHIRP welcomes reports on them.

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FIT FOR SERVICE?

The seaman is employed as a deckhand on a coastal service. He has been employed for many years on the same run.

For very many years he has been an insulin dependent diabetic. He recently collapsed face down with a "hypo" sustaining a wound which required several stitches and he also reported later that his nose was streaming clear fluid.

He was referred to a local hospital, where a compound skull fracture was confirmed and was kept under close observation until the leak ceased.

I am concerned that he may not be fit for work as a seaman.

CHIRP referred this report to the Chief Medical Adviser to the Maritime and Coastguard Agency, who provided the following comments:

"The purpose of medical fitness standards is to reduce the risks to the vessel, other crew members and the individual from ill health or injury while at sea. In this case only the person with the condition was injured and this was a consequence of the insulin treatment used to control his diabetes rather than the illness itself. If he had been alone on bridge duties such a collapse or even the more common impairment of cognition associated with a 'hypo' could have endangered the vessel and all its crew.

The statutory medical standards for merchant seafarers and commercial yachtsmen (there are currently none for fishermen or leisure sailors) should have prevented such an incident. Insulin treated diabetes renders a person unfit for distant waters or for watchkeeping, although there is some discretion for non-watchkeeping coastal work; if the examining doctor considers that the condition is well controlled and the risk of a hypo is low. (MSN 1765 section 3.3).

In this case the seafarer may have failed to declare the condition at a medical, the medical may have been unduly lax or the doctor may have made a rational judgement based on the clinical history and the man's duties. Alternatively the treatment may have been changed or a meal missed – thus throwing the balance between insulin and glucose out of balance.

After such an incident the situation is complex. A return to seafaring, unless duties are very restricted, is unlikely to be acceptable. Also the effects of the skull fracture and any subsequent risks from it would need assessment.

The statutory medical standards used in the UK and elsewhere are based on current evidence and a cautious approach to the risk of impairment. It is, however, all too easy to reject seafarers on health grounds without any valid evidence of excess risk and so a balance must be struck both in the formal standards and in the way they are applied, so that risk is minimised but employment opportunities and skills are not discarded without good cause.

A positive approach by maritime employers to health promotion, as well as ready access to medical advice, can also contribute to reducing the risks from health related impairments of all sorts."

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PEC HEALTH WARNING

Vessel concerned is a regular visitor. Vessel is over 20m in length, carries passengers and therefore requires a pilot in line with the Pilotage Directions.

The CHA *(Competent Harbour Authority)* granted a PEC *(Pilotage Exemption Certificate)* for the vessel to a person employed by a local firm. He was not the bona fide master or mate of the vessel in question and did not satisfy the requirements of the Pilotage Directions with regard to qualifying trips, assessment and examination for that type of vessel.

The issuing of a PEC to a person other than the bona fide master or mate is in breach of sect. 8 of the Pilotage Act 1987.

The Pilotage Act 1987 states at s.8:

"….a competent harbour authority which has given a pilotage direction shall, on application by any person who is bona fide the master or first mate of any ship, grant a certificate(… referred to as a "pilotage exemption certificate") to him if it is satisfied……..

(a) that his skill experience and local knowledge are sufficient for him to be capable of piloting the ship of which he is master or first mate (or that and any other ships specified in the certificate)….. . "

"Bona fide" according to Osborn's Concise Legal Dictionary 1993 means:

"In good faith, honestly, without fraud, collusion or participation in wrongdoing."

If the facts are as reported then, in CHIRP's view, the operation described would not comply with the

requirements of the Act irrespective of whether the Pilotage Directions with regard to the qualifications for PEC had been complied with or not. A pre-condition for the use of a PEC is the individual's status as the "bona fide master or first mate" of the vessel to which the certificate applies.

CHIRP expects to publish more reports on PEC in the future, but can say that this does not appear to be an isolated case. Given previous incidents involving PEC, CHIRP wishes to highlight this issue to CHA and emphasise awareness of the potential risks to safety of not complying with the requirements of the Act.

CHIRP has learned that the MCA is currently in talks with the Department for Transport's Ports Division with respect to the transfer of certain operational functions, including responsibilities for the Port Marine Safety Code.

The following comment has been received from the MCA:

"The extent of the Maritime and Coastguard Agency's responsibilities for this issue are currently under discussion, however we can say that in the interests of navigation safety Competent Harbour Authorities should ensure that PEC are issued and used in accordance with the Pilotage Act 1987."

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GAGGING SMOKE ALARMS.

My wife and I traveled on a RO-RO Passenger ferry. On entering our cabin I noticed that a plastic cup had been jammed over the Smoke Detector. I reported this to a person at reception who politely said she would report the matter. I was not satisfied my report would get to the Master.

Later on, after sailing I happened to see the Chief Officer in an alleyway, so I mentioned the matter to him. He was very concerned and took me to the Bridge to see the Captain who was very grateful for the information. Listening to me on the bridge was a junior Deck Officer, who in my opinion unwisely, volunteered the information that some passengers who smoked routinely did this to stop the smoke alarms being set off!

One to watch out for!

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RIGGING OF GANGWAY NETS

I was on a cruise vessel and I was disappointed that on arrival, it was evident that neither accommodation ladder had been rigged with a safety net. I questioned this with the security crew present at the time, and they declared that they did not require one. On boarding I asked if I could speak to the vessel's Safety Officer, only to be told by the information desk, no one was available. I requested the procedure for making a complaint to the Master.

I was given a piece of paper. I addressed a note to the Master and vessel's Safety Officer, informing them that it was a requirement to supply and rig a safety net and also that its absence would leave themselves and their employer exposed if any incident around the ladders occurred. No action was taken.

On a subsequent port call it was again noted that no gangway net was rigged. I again raised it with the people at the gangway, who swipe the identity cards, but they knew nothing of the requirements. I asked for the procedures to complain to the Master and again, I got a piece of paper. I was also told by the Receptionist that a net had never been rigged there in the six month's he had been on board. My letter again pointed out the requirement under regulations to have a net at the gangway and near the quayside. No action was taken.

I later saw a Senior Second Officer heading for a restaurant, so I asked him whether it was policy to rig a net. He informed me it was a requirement to have a net out, and they complied with that. I suggested he checks this out the next time we arrived in port.

Next port, again, no gangway net, again, I raised it with reception, and I addressed another note to the Master, pointing out that members of his crew were willfully neglecting their responsibilities. Reception informed me that the Security Officer was in charge of the gangway. On my return from a trip, the Security Officer was present at the bottom of the gangway, so I queried him on the lack of a safety net. He informed me, that they complied with the requirements, and a net would be difficult to rig. No action was taken.

I never saw a Deck Officer at the gangway, and the only Deck Officer I saw during the week was the Senior Second Officer I spoke to about the gangway net.

Unfortunately, the vessel gave a very poor impression, from the time of boarding. This impression was carried on throughout the voyage, on a number of activities. The safety culture appeared poor, I did not go looking for examples, but I was disappointed at the way the vessel appeared to be run, especially as it was under a reputable flag.

I fully understand how impossible it is to comply all the time with every regulation, but I feel the vessel should at least get the basics right.

In the UK this issue is covered by the Means of Access Regulations 1988 which state at s.9(2):

"The master shall ensure that when access equipment is in use and there is a risk of a person falling from that access equipment or from the ship or from the quayside immediately

adjacent to the access equipment, a safety net is mounted in order to minimise the risk of injury."

Other flags or ports may have similar requirements, but the issue of ensuring safe access is a matter of common sense not just whether there is a regulation or not.

CHIRP contacted the operator of the vessel and was informed an internal audit had identified the same issue and gangway nets are now in use.

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Weather Deck Working and Incident Reporting

At around 1600 the Bridge OOW (*Officer of the Watch*) was informed that myself and a colleague were going to work on the after deck. I then proceeded to the after deck, whilst my colleague went off to prepare some other equipment.

Whilst awaiting his return the ship came about without warning and a wave engulfed me as I turned to flee. As I turned, I slipped, but being uninjured continued to the safety of the after weather door.

I reported this incident to the Bridge immediately. The Master, 1st Mate and 2ndMate were all present on the bridge at this time. I Informed the Master of the incident to which he replied – "Well if you don't tell us you're on the after deck what do you expect?" I told him that we did inform the bridge, and the 2nd Mate who took the message piped up and admitted to the Master that he had indeed been informed a few minutes ago.

A meeting was held in the Master's cabin regarding the incident. To my surprise the agenda wasn't to address my concerns over the near miss but to coerce me into changing my statement. The Master wanted me to rewrite the report so that the description of the wave that came over me was no more than a spray. It was also insinuated that I had exaggerated my statement and that my motives for submitting the report were questionable. The debate was lively and coercive and resulted in me agreeing to look again at the wording of my report.

I didn't learn until much later that the reason we came about quickly was due to an anti-collision manoeuvre which, had it not taken place, would have placed us within two cables of another vessel. I also received an explanation when I was on the bridge collecting information for the incident report that I was forgotten about!

Later another near miss report was brought to me already completed with a statement that was not my words or hand, I was asked to sign it. I refused and asked that the original form that I completed and signed be submitted instead.

I would be keen to see Masters and Safety Officers to take heed of best practice in these matters. That is, interfering with witness statements and putting unnecessary pressure on their crew will lead to legal difficulties. A statement is only one persons view of events, the Masters and Safety Officers can submit their own statement as can witnesses or others involved in the process.

On the facts of this report there were failures in procedures and communications with respect to the control of weather deck working. Resources must be allocated to properly monitor operations where personnel are at risk. This incident could quite easily have had a different and more tragic outcome.

CHIRP supports open reporting and the reporter here is quite correct to suggest it is important not to try and influence another's view of an incident. A report may always be supplemented by additional information.

Another interesting question is why did the ship's senior personnel feel it was necessary to alter the report? Does this tell us something about the culture of the organisation they work for and the way it responds to incidents?

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Loss of Control, Loss of Ship.... Loss of Life

I have been a sailor for more than thirty years. The ship was inspected and passed sound by the port authorities. It was my first time with that captain.

The ship left port after I had seen it loaded. The crew were of mixed nationalities.

We sailed slowly for approximately 48 hrs because of strong head winds about force 8 to 9. I was aware of problems on deck. I was told that at 0900 that the bosun and a seaman had noticed that the starboard anchor was loose with 5 metres of' slack. At about 2030 on the same day, I realised that there was a serious problem and noticed that the ship was listing to starboard.

At 2345, an able seaman came to my cabin, and told me that the ship was sinking. At about that time, the captain, who did not speak English, told us to abandon ship.

Shortly afterwards, I saw the captain and the mate and some crew members already in a life raft attached by a line to the rail on the port quarter of the ship. They shouted to us to join them but we decided it was not possible. We went to the other life raft on the starboard quarter and found that it was not there. I supposed that it had already been jettisoned. We then went to launch a semi-rigid zodiac on the port quarter. There were four other crewmen with me.

Before leaving the ship, I had activated an electronic distress beacon (Sar.Sat/Epirb) and left it in a coil of rope on the stern of the ship. At that time, I gave

another (Sar.Sat/Epirb) to one of the others, who gave it to someone else. It was not activated and was subsequently lost. An AB had set off three parachute flares. We noticed that the life raft with the captain and others was adrift; the painter was cut at the life raft end. This was the last time we saw them. I think that the captain had not activated the ship's automatic distress signal before leaving the ship; although the ship had a VHF radio; a short wave radio and a cell phone. I do not know why he did not.

We had great difficulty launching the zodiac with the davits, the line being fouled and the zodiac being filled with water from the ship's engine cooling system. In the zodiac there was a Mariner outboard motor, a tank of petrol and a gallon of fresh water. We couldn't use the outboard motor because it had been completely submerged. There were no paddles or food. Eventually, we managed to free the zodiac from the ship and drifted to leeward away from the lighted and still floating ship. By now it was probably 0200 hrs.

We drifted all night and all the next day. The wind had dropped to about force 3. We had only some peanuts and some multivitamins to eat. We baled out the zodiac with a hard hat because there was no baler in the boat. We approached the coast and at about 2200 hrs and were taken by the breakers. The zodiac stayed upright on the first wave; it was overturned by the second wave and the third wave brought me, and two others onto the rocks. The remaining two were not seen again and are still missing. One managed to climb the cliff; I had more difficulty but eventually succeeded in getting on shore. The last person was stuck and I went to try and find help. I was in farmland and saw light from the road and tried in vain to stop a vehicle. I returned to help with a rope that I made from agricultural plastic that I found in nearby greenhouses; but he had gone. I feared that he was drowned.

Just before daybreak, I returned to the road and a lorry stopped for me and I was very pleased to find that one of the crew was already on board. We were taken to a town and told them about our missing colleague. They went to look for him and found him about 10 kilometres away. He had been assisted and fed by locals and was then taken to the local clinic.

This is a dramatic and tragic report, but perhaps what is most tragic about it is the apparent absence of any proper investigation and report into the loss of this ship and some of its seafarers by the Flag State.

A principal aim of CHIRP is to raise awareness in order to prevent other similar accidents/incident. It is essential to learn as much as possible from accidents and to make that learning easily available to the maritime community.

Under SOLAS regulation I/21 and MARPOL 73/78, articles 8 and 12 each Flag States undertakes to investigate casualties and report to IMO.

This casualty does not feature in the IMO's Casualty Analyses document published by the sub-committee on Flag State Implementation, which can be downloaded from the Human Element section at www.imo.org.

CHIRP has contacted the relevant Flag State to enquire whether any report resulting from an investigation into this incident exists which might be made available on a confidential basis, but has not received a reply to date.

The report, which relates to an entirely non-UK operation, raises a number of questions with respect to the vessels structure, condition and operation. There were allegedly serious failings in the conduct of the evacuation, particularly by the master that raise questions with respect to ISM certification and training, amongst others.

CHIRP's Advisory Board is of the view that the absence of proper accident investigations, in circumstances similar to this, by some Administrations is a dereliction of their duty to the seafarers under their Flags and to the wider maritime community.

REPORT UPDATE

Helm Order Confusion

This report in MFB 1 concerned the reaction to the order "Steady" or "Steady as she goes" in coastal waters or river/canal transits and the potential risks of the adoption of a fixed mark by the helmsman as a reference rather than the compass in an area of strong current or tidal stream.

Correspondence supporting the report has been received and the IMO has suggested the UK (through the MCA) consider submitting an information paper.

A solution has been suggested:

"I cannot offer any more constructive suggestions other than perhaps an official IMO ruling to dispense with the order "Steady" as it stands, leaving only "Steady as she goes", and an absolutely clear injunction that any helm order containing the word "Steady" shall mean "Steady as she goes".

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Fire in Drydock

This report in MFB 1 raised a number of issues including the role of manning agencies in promoting seafarer safety.

Forthcoming regulations place an obligation upon manning agents to make;

"…all such enquiries as are reasonably practicable to ensure that it would not be detrimental to the interests of the work-seeker or the hirer for the work-seeker to work for the hirer in the position which the hirer seeks to fill."

A letter was sent to a representative number of manning agents pursuant to the issue raised with respect to their safety role.

The response to date has been less than impressive; only one company has replied, but CHIRP will keep on trying. Seafarers may assist by asking their manning agents how they plan to comply with the requirements of Part IV of The Conduct of Employment Agencies and Employment Business Regulations and draw their own conclusions from the answers given.

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OPERATING & MAINTENANCE MANUALS

This report in MFB 1 suggested that poorly prepared manuals risked promoting, rather than preventing maintenance errors. In aviation, manuals are part of the equipment certification process and are produced to a standard. The question was asked whether a similar system would help in the maritime sector?

An IACS committee is currently reviewing this issue and the other engineering issues raised. A letter to a number of Manufacturing Associations has elicited no response to date, but CHIRP will keep on trying.

Two extracts from some interesting and detailed responses from third parties are reproduced below:

"I believe that targeting manufactures for fault re: operating and maintenance manuals is not correct. As a marine equipment supplier, we typically provide numerous printer-original copies of operating manuals with our equipment. We see the shipyards (our prime customer), the owner, the owners technical representative, the charter company (if applicable), the port engineer, and others take copies of the manuals for their legitimate purposes. The crew is left with one, which the chief engineer may hoard.

Just a couple of observations:

Our manuals are supplied in both hard copy and electronic (CD) form. This is typical, in our experience, of what other marine equipment manufactures provide.

It takes a couple of hours to assemble a manual. So the fully burdened cost of producing and shipping a manual runs around USD 100-200. Shipyards and operators wince when they have to pay for additional manuals. The shipyards kick the crap out of us from a cost standpoint so there is no margin to provide freebies. Sorry, but this is a fact of life in a super-competitive cost environment.

Except for military jobs, we never see a specification referenced for the content of our manuals. Rather, the content of our manuals is driven by defensive engineering and liability practices.

And;

"In the case of nuclear power plant and aircraft (military and civil), there is no doubt that manuals are crucial for maximising efficient and safe working. Accordingly, the provision of manuals is required by law.

I wish that high quality deck and engine manuals for the shipping industry were available on board when I was at sea.

CONTROL OF MANUALS

Manuals must be classified as controlled documents. People are permanently employed in the nuclear power and aircraft industries for the sole purpose of updating and re-issuing manuals. These activities are in response to manuals whose contents have been affected by matters such as equipment modifications and changes to operating procedures. This updating and re-issuing is required by law.

In fact all documents pertaining to the efficient and safe running of these industries are kept updated. For example, commercial aircraft are built, flown, operated and maintained totally in accordance with controlled documents. These documents are subjected to a very strict document control system, and this control system is a major contributor to the extremely high degree of aircraft safety and reliability.

Can the shipping industry afford such a rigorous document control system? Does it need it?

In fairness, ships are primitive entities compared to nuclear power plant and aircraft. Moreover, personnel on ships have much more `hands on' control over their charges and, normally, much more time to deal with a critical failure. Nevertheless, a full set of controlled manuals on board a ship would greatly enhance the protection of that ship, her crew, her cargo, and the environment. There is also the fact that the increasing number of crewmembers whose first language is not English would greatly benefit from the provision of controlled manuals that are written in simple English. For the benefit of aircraft staff whose first language is not English, the aircraft industry produces manuals that are written in simple English. This is achieved with the aid of a publication entitled **AECMA Simplified English - Writing Rules and Dictionary.*

* AECMA = Association Europeenne des Construdeurs de Materiel Aerospatial, Paris.

I used the word `primitive' in the sense of equipment sophistication. For example, a container ship engine operating manual I prepared had, in addition to the

main engine, 55 sub-systems described, each description provided with illustrations. Many illustrations were complex piping diagrams. The plant items within each sub-system were not sophisticated but the number of sub-systems shows the very large coverage that may be required by ships' manuals.

MANUAL PREPARATION

Manuals must be written and illustrated by qualified technical authors and illustrators, who are entirely independently of the equipment manufacturers.

What authors write, and what illustrators illustrate, is based upon the manufacturers' published data. It is quite wrong, and sometimes very dangerous, for ships' personnel to solely rely upon manufacturers' data. Such data often contains flawed information and instructions, serious omissions, poor syntax causing ambiguities, plus poor illustrations.

A technical author acts as a completely independent technical editor of a manufacturer's publications. The author's completed work, in turn, is editorially edited and approved before the manual's publication.

As may be deduced, manual preparation is very expensive. It is not, perhaps, quite so expensive as a loaded bulk carrier breaking in two during a sea passage due to poor loading that, in turn, was due to the lack of a good quality loading manual.

Manual preparation costs, and the costs of controlling manuals, have been somewhat reduced in recent years by the introduction of user friendly PC word processing programs and CAD (computer aided design) programs.

We now have the ability to produce first class documents. There is no excuse for poor quality documents. Additionally, documents that are PC prepared are easily and quickly updated and re-issued. Documents in this context comprise operating and maintenance manuals, ships' GA (general arrangement) drawings, capacity plans, fire fighting plans, stability data, engine room piping diagrams, check lists, etc.

CURRENT MAIB INVESTIGATIONS

The following incidents are currently being investigated by the MAIB as at 28.01.04:

Vessel's name	Accident/ incident type	Date of incident
Wahkuna	Collision	28.05.03
Loch Ryan	Fatality	12.07.03
Lord Nelson	Accident to person	14.07.03
Breakaway Five	Fatality	19.07.03
Elhanan T	Foundering	14.08.03
Trident Six	Grounding	23.08.03
Motor cruiser (Loch Ryan)	Wash wave damage	09.03.03
Chelaris J	Fatality	01.10.03
Donald Redford	Collision with Hythe Pier	01.11.03
Titania	Contact	21.11.03
La Belle Trois	Fire onboard	29.11.03
H C Katia	Grounding	03.12.03
Onward Star	Missing fisherman	07.12.03
Nora	Fatality	08.12.03
Dart 9	Accident to person	08.12.03
Firth of Forth Boat	Missing persons	27.12.03
Telesis/Amenity	Hazardous incident	05.01.04
Roseanne/Sven Dede	Hazardous incident	07.01.04

MAIB reports are published on their website - www.maib.gov.uk

NEED TO CONTACT US?

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