

CHIRP MARITIME FEEDBACK

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EDITORIAL

Welcome to the latest edition of **CHIRP Maritime FEEDBACK**. I am pleased to report the number of reports received continues to increase, the scope of the subject matter widens and the ability to learn from every report remains as important as ever. I am indebted to the 15 Ambassadors promoting hazardous occurrence reporting and to the Maritime Advisory Board whose expertise and guidance is always readily available.

We have published 8 pages of reports 4 times in the past year, back to the level of information provided 10 years ago. Unfortunately we still see areas in the industry where progress in the approach to safety of seafarers has not changed since that time. In particular, compliance with the COLREGS and all too often seafarers presented with manuals that have inappropriate advice and/or information that lacks sufficient detail to perform even routine maintenance and operational tasks. Perhaps the procurement departments need to better understand what they are acquiring; they should try talking to the end users before awarding the next supply contract!

This edition includes concerns on the safety of passengers on cruise ships and ferries, navigational practices on high-speed craft used to service offshore wind farms and added precautions for recreational craft users.

We are very interested to learn more about the hazardous occurrences in the offshore sector. We encourage the submission of more reports relating to DP operations and the agreed role of the client/charterers representative when onboard. It is recognised there are many managers and charterers that employ experienced DPO's who operate with the highest levels of competence in the industry, but the clarity of roles and responsibilities is not always clearly stated in the SMS or the related safety interface documentation. In such cases problems arise; reports will enable CHIRP to discuss potential safety lessons learned.

We now have over 1,200 followers of Maritime CHIRP Facebook page; items of general interest are now posted on a weekly basis.

My thanks for the interest and support shown for International CHIRP Maritime. Stay safe wherever you are!

John Rose Director (Maritime)

Please note all reports received by CHIRP are accepted in good faith. Whilst every effort is made to ensure the accuracy of any editorials, analyses and comments published in FEEDBACK, please remember that CHIRP does not possess any executive authority.

REPORTS

HIGH-SPEED CRAFT – INADEQUATE SEA ROOM

Report Text: A video filmed for the Internet at a wind farm location shows two vessels involved in a high-speed pass in the wind farm safety zone at very close quarters. The Video was filmed from the Vessel 'B'. Vessel 'A' is capable of 30 Knots and so is Vessel 'B'. Without actually knowing the speed of the vessels but going by what I can see, I would say both vessels were flat out, a 60kt approach speed. The main factor is that the boats were very close as their bow waves clearly overlapped as they pass.

CHIRP contacted all parties. Owner "A" replied: The master of the vessel stated the high-speed passing had been an opportunistic controlled event in near perfect conditions for an impromptu photo/video opportunity. He stated the distance between the vessels had at no time been less than the required 50 metres in the safety zone. A call received from their client at the wind farm expressed grave concerns over the activity and potential for a major incident. In an internal enquiry, all persons onboard stated a minimum 50 metres distance was maintained. The owners reviewed the report; they identified the potential for things to go seriously wrong whilst involved in unnecessary close passes and the implications of such acts. They reminded staff of the company's Safe Navigation policy and stated this activity would not happen again.

The Owners of Vessel 'B' indicated their vessel speed was 35 knots. The masters of both vessels had agreed to do a high-speed pass in order to get video footage of each other. Headings and speeds were agreed prior to the pass, along with an agreed 50 metres clearance that was upheld at all times in the pass. They stated as the vessel can stop in its own length there was no case to answer. They had closed the incident report with no actions taken.

The Marine Coordinator at the wind farm location advised the vessels tracks had been mapped using AIS data and the information would be used in discussion at their periodic safety meeting.

CHIRP Comment: 50 metres clearance is inadequate at this speed. The action was foolhardy and does not meet the expectation of the ordinary practice of good seamanship. The risk assessment was inadequate by not fully allowing for the consequences of failure, in particular mechanical failure. Emergency stopping was described to be within the ship's length. If true, it is highly likely the action will cause serious injury to passengers and crew. Another concern observed elsewhere, crew boats often use 'tramlines' to and from the wind farms without an allowance for distance to ensure the safe separation of transits.

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FREEPOST RSKS-KSCA-SSAT, CHIRP, 26 Hercules Way, Farnborough GU14 6UU (UK only)
reports@chirp.co.uk Freefone (UK only): 0800 772 3243 or +44 (0) 1252 378947

MAINTENANCE AND IMPACT ON REST HOURS

Report Text: At 0200hrs on three successive nights, crew members were awoken by loud machinery noises and vibrations being transmitted through the ship's structure. On each occasion the noise persisted intermittently for between 2 and 4 hours until 0600hrs. The sound level in a cabin was measured by a crew member as between 78 and 86dB. It was apparent that the noise and vibration was being caused by the deck ratings using mechanical scaling equipment on the car decks below the accommodation and passenger areas. The occurrence of the interruption to crew members' sleep was reported to the chief officer on the first morning at the head of department meeting. He acknowledged that the job is unsuitable to be carried out during the middle of rest hours; he apologized and gave assurance that this would not happen again. However, the following morning and after each subsequent occurrence it became clear that the deck ratings were disregarding his instruction to postpone the scaling of the decks. On the third morning the ongoing problems were highlighted informally to the captain by several crew members, nevertheless, the scaling continued at 0200hrs each night until I left the vessel. All crew members, inclusive of the master, have agreed that this job should have been carried out at refit. However, refit was only 5 days, so it could not be accommodated into the refit plan.

Lessons Learned: The ideal solution for all parties would have been to have the job executed at refit, when workers were living ashore in hotel accommodation. However, due to commercial pressures, refit was only 5 days long and other jobs took precedence. In addition, the Chief Mate, was either not succinct in his communications to the deck ratings, or, individuals deliberately subverted his authority, be it for malicious interruption of sleep, or impatience at not being able to carry out the job.

CHIRP contacted the ship managers, who stated the source of the noise was from mechanical deck scaling needle guns and the use was scheduled/restricted to 1 hour before to 2 hours after watch handover to minimize disturbance. The instruction was not communicated clearly to the crew and the company will seek to improve in this area. In addition, works of this type will be carried out whenever possible during the annual dry docking and their general policy is to use deck blasting machines over mechanical methods, as these both provide a better solution and minimize any disruption to the crew.

CHIRP Comment: It is clear the complaint from members of the crew was not fully addressed by the Master and Chief Officer at the time and this compromised the requirement for the crew to be properly rested. If the scope of work is not within the SMS, the adoption of a best practice 'Management of Change' process will cover situations where for example, refit work is incomplete before returning to sea. If seafarers encounter occasions where there is a breakdown in the Ship's SMS, **CHIRP** will always make time to review a hazardous occurrence report.

Readers are encouraged to read "Time to wake up to the consequences of fatigue" in the publication "ALERT!" edition 13 January 2007, available free to download from www.he-alert.org

COLLISION AT ANCHOR

Summary of the report: The reporter's vessel was at anchor, the weather was fine with good visibility, no strong current or abnormal wind/sea condition. The OOW noticed a vessel approached the anchorage making some strange manoeuvres. The reporter tried to contact the approaching ship on VHF but he didn't receive any response, he then sounded several blasts on the whistle and called the captain. The vessel under way made contact with the anchored vessel and caused some scratches to the hull. The port authority was informed. The other vessel explained the contact was due to a problem with main engine.

CHIRP Comment: A vessel under way is expected to keep clear of a vessel at anchor as a matter of good seamanship. [COLREGS Rule 2 (a)]. Similarly a vessel approaching an anchorage must do so without endangering other vessels or anchor too close to other anchored vessels.

A recent Safety Alert Bulletin from a major tanker charterer was issued after they noticed a significant increase in the number of incidents involving contact with other vessels at congested anchorage locations, this in a few cases resulted in a breach of the hull. They identified causal factors and identified areas for improvement that they agreed we could share with others.

Causal factors identified:

- Bridge team's failure to correctly assess the strength and direction of the local tidal currents and winds prior arriving, whilst at and manoeuvring in the anchorage;
- Manoeuvring own vessel too close to vessel(s) already at anchor;
- Lack of proper navigational watch keeping practices whilst at anchor;
- Swinging circle not plotted or used as a monitoring tool, especially during swinging of anchored vessels in different directions;
- Lack of monitoring clearances from adjacent anchored vessels during change of tide;
- Inadequate monitoring of prevailing weather and weather forecasts, such as local seasonal winds, thunderstorms, passing squalls etc., leading to dragging of anchor; and,
- Unavailability of vessel's main propulsion for immediate use, when required.

Areas to focus on:

Vessel operators are encouraged to review their safety management system and provide adequate guidance to vessels considering the below points but not limited to:

- Pre arrival/departure planning in adequate detail (i.e. appraisal, planning, execution & monitoring) including contingency, and site-specific risk assessments;
- Evaluation of the prevailing congestion status at the port's designated anchorages;
- Identifying a suitable anchorage position in consultation with Port Authorities/VTS prior to entering the anchorage area;
- Whilst approaching an anchorage, avoid passing close ahead of other anchored vessels;

- Evaluation of adequate length of anchor cable to pay out with due consideration to the prevailing conditions, holding ground and sea depth, and
- Plot vessel's swinging circle on GPS, paper chart and ECDIS if available. Ensure the vessel has adequate clearance to swing about the anchor. Once anchored, the actual swing pattern to be ascertained and ECDIS/Radar/GPS alarm limits adjusted if available.
- Swing tendencies of vessels in immediate vicinity should also be monitored, especially at change of tidal streams;
- Calculation and marking of tidal streams where applicable and in known areas for strong tidal effects;
- Maintaining robust anchor watch at all times including checking of vessel's position at regular intervals;
- Echo sounder and anemometer limit alarms, where fitted to be re-adjusted as appropriate after anchoring;
- Monitoring of weather at all times and an action plan available, in case of unexpected adverse weather or anchored vessel's swinging in different directions;
- Inserting a visual marker, on the windlass, to indicate any instances of the brake slipping;
- Maintaining vessel's main engine in an appropriate state of readiness;
- Use of a Bridge Navigational Watch Alarm System (BNWAS), if available whilst at anchor;
- Clear standing instructions on calling the Master well in time, based on the developing situation specific to that anchorage location;
- Emergency contact list of local support services (such as pilot, tugs etc.) to be available at all times;
- Vessel operator's internal navigation audit to include an evaluation of above best practices, whenever possible; and,
- Bridge Team Simulator training provided to deck officers and Masters that includes scenarios with weather changes, such as but not limited to:
 - Approaching and anchoring in congested anchorages
 - Dragging of own vessel in congested anchorage
 - Other vessels at anchor dragging or maneuvering vessel drifting towards own vessel at anchor, which could result in a contact incident.

COMMENCING A VOYAGE INTO DANGER

Report Text: My vessel was on passage from Buckie to Erith steering 090 at about 8 knots. About 2 miles north of McDuff/Banffa tanker got under way from a position South of me and crossed ahead eventually reaching a speed that put it on a fixed bearing and the risk of a close quarters situation. He then called me up to ask "my intentions" and if I would pass astern of him. I altered course to starboard and passed safely astern. In my opinion, it would have been more prudent for him to allow me to pass before he left the anchorage/increased speed. (Action by stand on vessel).

Just an observation. Nice fine day, 1645hrs, force 4 wind ENE, sea height 0.5 metres, good visibility. No doubt the OOW on that vessel would deem that he has nothing to reply to because I was on his port bow.

Lessons Learned: Always keep a sharp lookout and never trust other vessels to act in accordance with the ordinary practice of seamen.

CHIRP Comment: OOW on a ship must not start a passage from a non-hazardous position, get underway and put the ship at risk of collision. The OOW's responsibility is to comply with the COLREGS and operate in accordance with the ordinary practice of seamen.

SAFETY OF PASSENGERS ON FERRIES AND CRUISE SHIPS

CHIRP has received three reports expressing concern over the overall safety of passengers on UK registered ferries.

Report 1: A passenger expressed concern over the procedures for mustering passengers and their evacuation from a local ferry. The MCA was contacted and they advised, UK ferries before entering into service must demonstrate the capability to conduct mass evacuation of passengers within prescribed time limits. MCA staff confirmed the reported ship had been regularly audited and that all the safety regulations have been met.

Report 2: The ferry was engaged on a private charter. On departure, the master advised through the public address system, passengers should listen carefully to the following important safety announcement. Thereafter nothing happened. Five passengers mentioned they did not hear an announcement. The crew had not advised the master that the taped message had not worked. A crew member was requested to go the bridge and inform the master, thereafter the taped message was immediately played.

Lessons Learned: If the master cannot hear the public announcement taped message on the bridge, then a crew member should provide the master with positive confirmation that these messages have been played and heard in the public areas.

Report 3: A passenger highlighted the indoor corridors were tiny, pitch dark at night with no emergency lights fitted. Safety notices were posted in cabins and supported by signs to assembly stations, but safety precautions were not announced to passengers before sailing.

CHIRP contacted the ferry operator who requested their thanks be conveyed to the reporter for raising the concerns. The ferry operator then addressed each observation, replying:

- Safety documentation and information media are constantly reviewed in order to ensure their validity, they are subject to external scrutiny by the authorities.
- The Classification Society ensures that the make-up of evacuation routes is in line with SOLAS/National regulation requirements and so, whilst one might take a subjective view about the "narrowness" of companionways on board our vessels, it rests with the authorities to determine objectively and within agreed norms whether any issues arise, bearing in mind evacuation drills form a major element of annual inspections.
- Security officers make regular tours of the vessel whilst it is at sea in order to ensure that all is well. In an emergency situation, ships crew are trained to tour

accommodation areas in order to ensure not only that all passengers are aware that a situation exists but also to enable, if necessary, safe and speedy transit to lifeboat decks

- With regard to the visibility of exit routes, direction signs are mandatory and must conform to internationally recognised standards and this is without exception on board our ships.
- Evacuation plans must be approved by the classification society in order to verify compliance with SOLAS/ National regulation and this is evidently the case for all our vessels; evacuation systems and procedures are tested regularly and vigorously.
- With regards to information films, the regulations do not require this but we are currently in the process of developing a sophisticated video information system and had wished to have a finalised version of the film before responding to **CHIRP**. We are actively increasing the number of screens on board our vessels, largely in response to Division 190 regulations.
- Since receiving your note, a superintendent has travelled many times on our vessels and we can assure you that safety announcements on departure are made systematically and clearly; the messages contained therein are replicated throughout the ship and in cabins by static signs.
- Emergency lighting in cabins already exists and is considered more than adequate.
- Assembly points are clearly marked and entirely meet our obligations

CHIRP Comment: These reports highlight concern over whether existing regulations are appropriate for coastal ferries and the larger passenger ships being built today and the public's greater aversion to risk.

The company has replied in an appropriate manner based on current practice and while fully compliant with current regulations, they might consider what additional measures can be put in place to improve safety in addition to the safety video they are preparing. International regulations are a minimum consensus that could be improved upon for a specific type or service of vessel. The company could seek independent advice to see what other cost effective measures can be implemented to enhance current safety measures.

Should there be a new set of regulations for passenger ships? **CHIRP** believes this is a valid question and can share data and provide support for future work as it evolves. **CHIRP** is not a lobbying organisation but is very pleased to note there are other more appropriate organisations already actively engaged on this subject.

For example: The Nautical Institute are writing papers and articles on concerns relating to passenger ships, e.g. the existing regulations on mass evacuation from ships do not take full account of the size and mobility of passengers, the narrow corridors inside and outside the accommodation and access to enclosed lifeboats.

The International Maritime Rescue Federation has held three mass evacuation conferences in Gothenburg in the last 3 years.

IMO is reviewing whether the Passenger ship regulations are fit for purpose in this day and age and the IMO Secretary General stated at the ICS Annual Conference the intention to include domestic passenger ferries in their 2015 agenda.

CHIRP has been informed a conference/ seminar on the subject of passenger ship safety will most likely be hosted in the UK in 2015.

CLOSE ENCOUNTER IN HARBOUR ENTRANCE

Report Text: I along with a group of other small boats was entering the harbour on the full ebb tide. About 10 small boats were attempting this, with only a couple (including myself) able to make any headway against the spring tide. At full throttle I was making less than half a knot over ground and several of the smaller boats were unable to make any headway at all. At this time a ferry was approaching the harbour and another ferry was preparing to leave port. The close encounter occurred when against what I believe is normal practice leaving port, the ferry chose to leave – and pass the another ferry in the harbour entrance. The leaving ferry misjudged the tidal strength and when abeam of me (I was still in the harbour mouth at full throttle after several minutes entering the harbour) engaged his bow and stern thrusters pushing my boat and another 40 foot yacht sideways dangerously close to the rocks at the side of the small vessels channel. The ferry captain knew exactly the problem he was causing as he was clearly visible in the bridge window indicating he was going to use the bow and stern thrusters. The ferry captain choosing to pass in the harbour entrance during a period of strong ebb tide caused this situation – tide so strong it restricted the ability of many small boats to manoeuvre. He took no account of the many small boats entering the harbour and the danger he caused in passing the two ferries in the harbour mouth instead of either in the harbour or outside in the channel or over spit bank. Due to the strength of the tide (which was unusually strong) the time taken by most yachts to enter harbour was extended.

Lessons Learned: Vessels using the main channel in and out of port should not (and I believe normally don't) pass each other in the narrow harbour mouth. This is not necessary and imposes danger to any vessels using the small boat channel. The misjudgment of the navigation of the ferry that necessitated the use of the bow and stern thrusters should have been avoidable by a professional mariner. Captains should have it reinforced that using these thrusters in confined spaces when abeam of small vessels can create conditions in which those small vessels are put at risk. The thrusters create a water flow faster than the maximum speed of many small vessels (including my 35ft yacht!) and we are at the mercy of the ferry captain and can easily be washed onto the rocks that are only 15m distant. We were nearly wrecked by the actions of the ferry.

CHIRP contacted the Harbour Master who then reviewed CCTV replays. In his reply the Harbour Master confirmed the ferry acted correctly but was close to the perimeter of the 'small boat' channel, he discussed this with the ferry company and they issued an advisory note to their ferry captains to keep a wider berth from the 'small boat' channel.

The Harbour Master also advised small boat users of the need to be aware of the tidal streams in particular, and plan transits accordingly. A vessel with only 5 knots engine speed should not be trying to enter against a peak ebb rate of up to 5.5 knots, that is simply poor navigation.

CHIRP Comment: Owners of recreational craft are advised to make allowance for strong tides in their passage plans, particularly when entering and leaving port. In this case a simple risk assessment using all the facts known and in particular those available in port information books, charts and tide tales would have revealed, delaying entry into port by two hours would significantly reduce the risk and provide a greater margin of safety especially in the event of mechanical breakdown.

MAINTAINING A GOOD LOOKOUT

Report Text: Location: 34 nm West of Bishop Rock
Weather: Wind SE 12 knots, sea 5 feet from South, partly cloudy, sunshine, good visibility. My vessel: Sailing yacht "SY" was close hauled and sailed with mainsail and jib at 3.5 knots on course 070 degrees. Fishing vessel: "FV" approached us from port side on a southerly course at about 10 knots. No signals indicating fishing were displayed. No signals received by our AIS. No calls received on VHF channel 16. No action was taken by "FV", so we started our engine as a safety precaution. The "FV" came closer and closer without giving way. We know by experience that fishing vessels may pass quite close. Finally we gave full throttle ahead and passed about 50 meters in front of her bow. It was too late to take any other action from our side. We saw there was nobody in the wheelhouse. As they were very close to us, we could read the name and number. After 4~5 calls on the VHF radio, they answered first that they could not see us. When telling them that they had just passed us, they told us they were unaware of the situation and had not noticed us on their radar. We carry a radar reflector, up in the mast about 10 metres above sea level. We contacted a cargo ship earlier the same day checking the "range" of our radar reflector in rainy conditions. We were then 6 nm apart and they told us we were visible on their radar screen. This indicates that the "FV" had not had a look out for the last half hour. If we had not taken action there would have been a collision.

CHIRP contacted the owner of "FV" who knows well the wheel-house arrangement on "FV", the watch-keeper is positioned on the forward starboard side of the wheelhouse. The vessel works static nets (gill nets) and recovers fishing gear from a net hauler on the starboard side just in front of the wheel house, this forces the design of many boats to place the skipper in a forward starboard corner of the wheel house surrounded by the necessary navigation aids. The skipper is placed very close to the windows, getting all the sunlight and heat. Photographs were submitted to illustrate the improvements made in order to make the boat safer and easier to work, including the removal of a screen that was blocking vision when looking to port.

The owner shared a statement written out by the skipper of "FV" stating:

Steaming 192° at 9.5 knots between two fishing operations of 8.8 miles apart. Nothing seen on the radar, late afternoon sunshine glaring off the sea on the starboard side. Myself and one other crewman were in the wheelhouse. I passed the watch over with "Nothing to report", no radar targets or visual targets and went to the engine room to top up the daily service tank and was back in the wheelhouse within 10 minutes. There was nothing to report until a VHF call on channel 16 which was answered by myself, bringing to our attention a close quarter situation, where the yacht was visibly seen astern of us."



Lessons Learned by Owner of "FV": Quite clearly "FV" was the give way vessel and would have given way in good time if he had detected the target by any means visually or electronically. If the call from the yacht was made earlier it could have been avoided.

Also I question the wisdom of crossing the bow of "FV", reducing speed and stopping or paralleling the "FV" course until past and clear may have been better.

However I very much appreciate from first hand experience, comments after the event are easier to make. We have made an enquiry to a company, I will do my best to improve on the glare situation in the wheelhouse.

The skipper is a very conscientious man with good standards and is clearly upset over this, he has not taken it lightly, he repeatedly told me he couldn't understand not seeing the target on radar until well astern of him and after the event.

Operating good radars is something most of us in the static net fishery are quite good at because we have to keep a sharp eye on trawler activity to avoid gear conflict.

A trawler can show up in your area within a short space of time and we are obliged to give them the positions of our nets or they could tow them away, usually destroying the nets beyond repair. This situation is avoided by keeping a sharp look out something we are good at, but you are not going to get any man to see through direct sunlight

CHIRP Comment: The root cause of the close quarters situation was the fishing vessel not keeping a vigilant look-out. A contributing cause may have been the yacht not being seen due to the glare from the sun. With a condition of clear visibility, the watch keeper on the fishing vessel probably saw no reason to keep a close radar watch. The fishing vessel owner's prudent considerations of the ergonomics of bridge design and anti glare precautions taken were noted.

The sailing vessel's claim there was nobody on the bridge has been denied but there was no reason for missing the 4 calls on the VHF prior to the yacht passing ahead of the fishing vessel.

The yacht appears to have acted in accordance with COLREGS rule 17B: "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."

CHIRP identified guidance from the MCA (i) MGN 313 (F) Keeping a safe navigational watch on fishing vessels, (ii) Fishermen's Safety Guide.

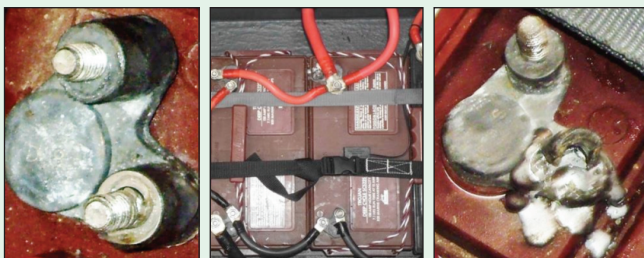
The following are important factor(s) identified by the MAC in past incident reports:

- Unqualified or inexperienced person in charge of the watch;
- Only one person on watch (regardless of whether a watch alarm was fitted);
- Poor lookout and/or radio watch being kept;
- Distraction by TV in the wheelhouse;
- Divided command, and
- Fatigue, alcohol, or prescription drugs.

POWER FAILURE – BATTERY NUTS

Report Text: Vessel built 2008 is an auxiliary sailing yacht. Incident: On leaving the marina berth for a day's duty as a Regatta Committee Boat in a borrowed boat, all the electrically-powered domestic accessories suddenly failed – no bow thruster, no anchor windlass, and no instruments. Problem: Subsequent investigation showed that the domestic battery pack (3 × 12V, 130 AH leisure batteries) had been linked in parallel, using wing nuts on the terminals. One wing nut had vibrated loose, causing arcing/sparking, hence localised heat increase, increased resistance and even higher temperatures. Final result was partial meltdown of the battery connecting terminal lug. The batteries are stowed under a screw-down panel under the galley floor.

Lessons Learned: Check the tightness of battery terminals at regular intervals. Suggestion: NEVER use wing nuts only to connect battery terminals. (But the evidence is, that was the way in which the builder had supplied the boat!). Far better and safer to use hexagon head nuts with lock washers, tightened with a spanner.



CHIRP Comment: Contact with the boat manufacturer revealed this is a modification; the current design does not use wing nuts on batteries and uses locking nuts.

MCA and NWA (National Workboat Association) Reference 8.5.4 States: Adequate provision should be made for securing electrical connections, e.g. use locking washers.

NON-COMPLIANCE WITH COLREGS'

Report Text: Own vessel was approaching Felixstowe from the North via Sunk TSS. The Ro-Pax ferry was approaching Felixstowe from the North via North Shipwash channel. I had plotted the Ro-Pax ferry on ARPA for at least 30 minutes, CPA was effectively zero. Visibility was very good, observed visually at 8nm. It was clearly a crossing situation with Ro-Pax ferry on my portside, green sidelight and fore and mainmast navigation lights clearly visible at a distance of 3nm. I called the Ro-Pax ferry to confirm his intention. His response was to advise that he was also proceeding to Felixstowe via North Shipwash. I pointed out to him that CPA was zero and asked what his intentions were. He stated that in his opinion I was overtaking him and should keep out of his way. I again advised it was not an overtaking situation and never was. Clearly a crossing situation and Ro-Pax ferry was the give way vessel. He asked if I wanted him to alter course 90 degrees to starboard or slow down. I replied that it was up to him to decide what to do to give way. At distance 2nm CPA was still zero called him again and asked him if he had reduced speed. He replied that it was taking time. He had clearly made no effort to slow down. At this point I told him to maintain his course and speed and I would alter course to port and further reduce my speed. This I did and passed astern of him. The master, third officer & helmsman were on the bridge with me.

Lessons Learned: Never rely on other vessel to obey collision regulations. He should have taken action as required by the collision regulations in ample time, before it became a close quarters situation.

CHIRP Comment: In the majority of cases, an early reduction in speed can be as effective as an alteration of course in order to avoid a vessel approaching from abeam or near the beam. Clearly in this report this did not happen. COLREGS Rule 17(a)(ii) states: The stand on vessel may take action to avoid collision 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.

The OOW of the stand on vessel took prudent and early action to avoid risk of collision.

CHIRP observed in a past study using a ship simulator to review P&I club reports on 24 collisions, 17 of these would have been avoided if there had been an early reduction in speed; the end result revealed the ship lost on average only 20 minutes delay in the ETA.

It was noted many of the larger (bulk carrier) ships are not able to quickly reduce speed easily without causing damage to the main engine through cracks to the liners and casing.

TERRIBLE VHF COMMUNICATION

CHIRP has received 2 reports relating to action taken and confusion as a result of exchange of information via VHF.

Report 1 Text:

Vessel A: "Vessel B" what is it we need to do to go ahead?

Vessel B: Yes I am already altering my course to Port

Vessel A: Yes you are still altering your course to Starboard

Vessel B: OK, OK you cross to Starboard you will pass Starboard to Starboard

Vessel A: You want us to pass you will pass Starboard to Starboard?

Vessel B: Yes sir, I pass Starboard to Starboard

Vessel A: You had better stop altering your course to Starboard because I am altering my course to Port and you are altering your course to Starboard, so alter your course to Port

Vessel B: Starboard to Starboard you also alter course to Port Side

Vessel A: Yes I am altering my course to Portside but you are altering your to Starboard you alter your course to Port also.

Vessel B: Yeh, Yeh you alter course to Portside – OK?

Vessel A: Yes, you also alter course to Port and we will be passing Starboard-to-Starboard

CHIRP contacted the ship managers of Vessel 'A', they then conducted a near miss review and shared the following information.

The vessel was on a laden voyage from Port Hedland to China and was passing the Lombok straits steering a course of 346° with a speed of around 11 knots. The vessel then sighted an unknown vessel a little on her starboard bow on a nearly reciprocal bearing. VHF communication was initiated by the other vessel, to which our own vessel responded and agreed to pass starboard to starboard. However, erratic and confusing actions were taken by the vessel causing a near miss situation.

Investigation: Cause analysis:

- Use of VHF in collision avoidance, miscommunication,
- Failure to call the Master as specified in company procedures & master's standing orders.

Lessons learnt/preventive actions taken:

- Use of VHF for collision avoidance must be avoided in normal circumstances. The master briefed the bridge team on board and all the officers made aware of the hazards;
- Fleet circular was issued to alert the masters. Also all vessels to watch navigational occurrences closely and report near misses as observed. M-Notice (MGN) 324 was sent to the fleet for caution & guidance;
- Master was not called as per standing orders. The watch keeping officers were briefed and the need was emphasised to call master on any such situations of doubt, and

- Training needs identified. Company training centre has taken measures to include this incident in the training and briefing modules.

Report 2 Text:

A VHF conversation between two ships was overheard by the reporter, the officer of the watch (OOW) of a ferry asked a bulk carrier OOW and requested to pass 'Green to Green', and this was agreed. About one minute later the ferry made a broad alteration to starboard and passed 1.5nm ahead of the bulk carrier. Both vessels appeared to be at full speed (estimated to be 15 knots) this made for a close crossing. There was no communication to the bulk carrier so the bulk carrier called the ferry, only getting a reply on the second call. They moved to a working channel then the ferry's OOW said they wanted to go red to red. No apology or explanation given.

CHIRP Comment: The reciprocal courses (NW and SE) strongly suggests a risk of collision existed but this was not stated. Therefore, provided a risk of collision has been determined and confirmed, agreement to go 'Green-to-Green' is contrary to the COLREGS Rule 14. This is important because if the vessels would pass clear, green-to-green is acceptable. Crossing the bow of another vessel to slavishly adhere to a notion that the two may only pass red to red, introduces additional risk by creating the crossing situation of Rule 15 and is not what the COLREGS require. The stand on vessel may also need to make allowance for any vessel constrained by its draught.

The practice of using VHF to renegotiate the application of the COLREGS is inadvisable and cannot be supported. The Nautical Institute stated such activity is likely to distract the OOW from taking the necessary action in an early manner as prescribed by the COLREGS.

CHIRP recalls a report of a collision between two ships in a Force 10 storm. A review of both Bridge VDR conversations reinforced by the MRCC VHF record revealed the message heard on one ship excluded a key word in the VHF transmission, which meant a contrary instruction was heard to the action being taken, and this was a cause of the collision. The static electricity interference created by lightning had interfered with the VHF conversation.

CORRESPONDENCE

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.gov.uk/publications/

In particular we draw your attention to their MAIB Safety Digest 2/2014 a compendium of anonymous articles involving vessels from the merchant, fishing and small craft sector which draws the attention of the marine community to some of the lessons arising from investigations into recent accidents and incidents.

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.

In **CHIRP 36** we reported on the maintenance of rescue boats and launching equipment .

We have since received a near-miss report.

Report Text: An onboard safety trainer was instructing new hires on how to conduct an on-load release of a rescue boat. The training crew had completed the self-lowering of the rescue boat to a pre-determined height above the water.

The trainer removed the safety pin used to keep the main release lever from moving upwards. Continuing explanations, the trainer then nudged the on-load release lever up.

The boat released and dropped into the water.

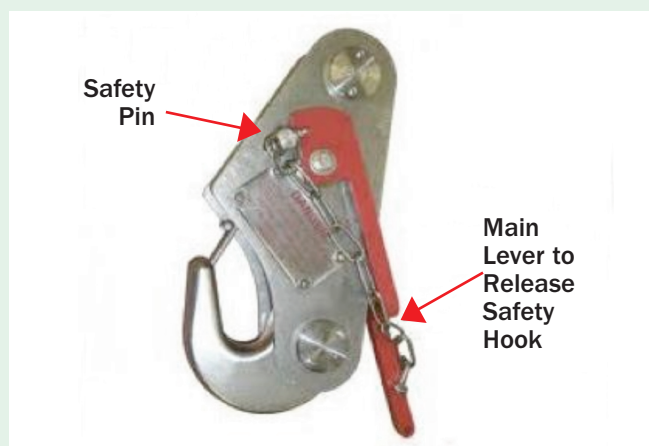
One Crewmember suffered minor neck and back discomfort as a result of the incident.

Lessons Learned:

- There are two methods for releasing the rescue boat from the hook- On load (hanging) and Off load (Rescue boat is buoyant) release. Conducting an On load release is a high risk task and should be performed in a precise and controlled manner.
- The Safety Pin for an On load release is removed only after a safety assessment has been conducted and the conditions listed below have been met:
 - The rescue boat has been set at the correct (Safe) distance above the water;
 - Sea State assessed for release, and
 - Crew members are ready for release (ready in the boat).

Preventative Actions:

- Off load release is the preferred method of deployment. On load release of rescue boats should only be performed when it is deemed the only option for deployment of the rescue boat;
- On load release should only be demonstrated while the rescue boat is supported either in the chocks or in the water, and
- The company is reviewing their training material.



ELECTRICAL FIRES ON SHIPS

Allianz Risk Consultants (www.agcs.allianz.com) recently published a warning relating to electrical systems on board ships. They are subject to considerably more hazards and exposures than typically experienced ashore. These additional hazards include: sea water; wetting; high humidity; vibration; constant motion; significant exposures to hot and cold temperature extremes.

Best practice recommendations:

- Ensure shipboard staff and any contractors permitted to undertake modifications to ships electrical installations are fully trained and competent with the current regulations required by flag state and/or class requirements.
- Whenever undertaking any modifications to shipboard electrical systems, always consult and seek approval with flag state and class authorities to ensure compliance with relevant electrical regulations.
- For UK ships, references are available within: MCA Marine Guidance Note MGN359 (M); Merchant Shipping (Passenger Ship Construction) Regulations 1998 & Merchant Shipping (Cargo Ship Construction) Regulations 1997 and British Standard BS8450 'Code of Practice for Installation of Electrical and Electronic Equipment in Ships'.

FIRE RISKS: SHIPYARD & LAY-BY REPAIRS

Allianz Risk Consultants recently published some common causes of fires aboard vessels in shipyards:

- Insufficient clearing and/or protection of combustibles from hot work sparks or slag and/or insufficient clearing along bulkheads of adjacent spaces;
- Fire watch not remaining on site after cessation of hot work as fire generates from hot slag or residual heat;
- Insufficient cleaning of coatings and/or residual product remaining on adjacent bulkheads in way of hot work;
- Failure to maintain conditions in a space and not following permit instructions;
- Welders entering and starting hot work in the wrong compartment or space;
- Person issuing the certificate not understanding the scope of work or a change in scope of work and repairs beginning without any inspection or testing;
- Improper inspection and testing by person issuing certificate, including improperly maintained equipment;
- Insufficient cleaning (scraping) of rust scale within a tank (impregnated with product), which leads to vapour regeneration, during hot work; and,
- Failure to lock out and secure a compartment, allowing the introduction of combustible product from inadvertent opening of valves or pumping product.

We are grateful to the sponsors of the **CHIRP Maritime Programme**. They are:

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