

MARITIME FEEDBACK

Issue No: 19

Summer 2008

EDITORIAL

FIVE YEARS OF **CHIRP** MARITIME

The **CHIRP** Programme was initially created for the aviation sector in 1982 and expanded to cover the maritime sector in mid-2003. So this is an Editorial opportunity to comment on the reporting of hazardous incidents.

Shipping companies with a well-established safety culture have their own in-house near-miss reporting programmes. It sometimes comes as a surprise to those not closely involved in the management of ships that managers endeavour to maximise the number of reports of near-misses and hazardous incidents. In some good companies there is an expectation that each ship will produce a number of such reports each month. Does that mean that the manager wishes to encourage such incidents? No!!! However, we all know that near-misses do happen. So, yes, we do want to encourage the reporting of such incidents to learn from them so as to avoid future accidents.

Is the shipping industry succeeding in developing an open culture in which individuals feel free to report near-misses? This no doubt varies from company to company. In **CHIRP**, we do occasionally notice a difference between the perception of the manager who is keen to receive near-miss reports and the perception of the individual who feels that he or she may be disadvantaged in some way by submitting a report. In such circumstances we believe that **CHIRP** fulfils a valuable role by providing a conduit in which the confidentiality of the individual is guaranteed.

From time to time we receive reports in which the writer expresses robust views that all infractions or non-conformities should be treated as criminal acts. Whilst this may be appropriate in infrequent cases of extreme negligence, the threat of criminal or disciplinary action in lesser cases is not consistent with a drive towards an open culture in which people are not afraid to report near-misses and hazardous incidents.

For all mariners, including leisure sailors and fishermen, here is a self-assessment test on your safety consciousness during the last year:

Question: How many hazardous incidents or situations have you observed?

If your answer is zero, it is probable that the incidents have happened but you did not identify the hazards.

Question: How have you taken action or intervened to

correct a hazardous situation?

To improve health, safety, security and environmental protection, individuals need to intervene or take action. This may require courage, not in the sense of putting oneself in harm's way, but rather in overcoming natural reticence to intervene. So don't be reticent, say or do something to correct the hazard.

Question: Have you shared the learning from a hazardous incident by reporting it to a near-miss reporting programme, for example **CHIRP**?

***CHIRP** can only flourish if it receives reports. So please don't leave it to someone else to contact us.*

Chris Rowsell

ANXIETY AND AN APOLOGY

Report Text: While dodging* in the vicinity of a North Sea oil field, my Platform Supply Vessel (PSV) was heading 060°T at 1.5kts. a cargo vessel was heading 102° (T) 11kts, approaching from abaft my port beam and passing very close, Closest Point of Approach (CPA) 0.175m. to this vessel and close to the whole rig operation. When challenged on VHF 16, the Officer of the Watch of the other vessel altered 5° to port to pass close between my vessel and another PSV one mile away. The OOW of the other vessel did not appear aware of the rig-shift which was notified on Nav-tex for the previous two days.

(*The reporter subsequently clarified that "dodging" is steaming at very slow speed into the weather whilst awaiting orders. The PSV's were not connected to the rig at the time.)

CHIRP Comment: We passed a disidentified copy of the report to the manager of the cargo vessel. Soon after, he sent us a reply from the OOW as follows:

I was indeed heading 102 degrees. In good time I observed 2 PSV's which were laying still with a distance of 1 nautical mile between them. I made the decision to go between them leaving approximately 0,5 nautical miles to each PSV. As I came closer I observed that the PSV more to the south was making 1,5 knots, heading 060 degrees. I was contacted by the PSV that he was concerned about our CPA and I made the judgement, based on the fact that the PSV did do 1,5 knots and the clear visibility and good weather conditions, that a course alteration to port of 5 degrees would leave me an satisfactory CPA to both PSVs. Because the PSV did not contact me again I reckoned that my action satisfied the PSV also. At no time did I experience that this was a close quarters situation. I am sorry for any inconvenience my actions may have caused the reporter on the PSV.

We thank the reporter for sending us the report, the manager of the cargo ship for following it up promptly

MARITIME FEEDBACK is also available on the **CHIRP** website - www.chirp.co.uk

A Maritime Safety Newsletter

from **CHIRP** the Confidential Hazardous Incident Reporting Programme

and the OOW for his open response and apology.

This is an example of an incident in which there was a different perception on the bridges of the vessels as to what constitutes a reasonable margin of safety. There is not an absolute answer to this as it depends on the circumstances. Close passing may well be inevitable in confined waters but would cause concern on the open sea. **CHIRP's** request to Officers of the Watch, and indeed to those in control of any craft, is to bear in mind how your action, or inaction, will be perceived on the other vessel. In applying the Regulations for Preventing Collisions at Sea, let's try to avoid causing anxiety to others.

We also add that information from Nav-tex should be included in the passage plan and noted on the chart.

MEDICAL INDISPOSITION

Report Text: The Captain of a ship reports that, whilst serving, he was suffering from an injury and reported to the port doctor. He was declared medically unfit and advised to sign off. However an immediate relief was not forthcoming. The ship was engaged in busy operations and short passages in bad weather. The Captain continued his duties under severe pain. He made several requests to be relieved. After two weeks he advised his intention to sail no further and was thereafter relieved.

The Captain has asked what other masters would do in such circumstances.

CHIRP Comment: Whilst we have the reporter's permission to publish this report, we do not have the ship manager's perspective of it. We are therefore commenting on the generalities of such situations rather than on the particular circumstances of this report.

As a Captain, managing a situation when a key member of the ship's personnel is indisposed is difficult, and even more so when that person is yourself. There is a natural tendency to struggle on with one's duties even if this is painful. It may be helpful to hypothesise what you would do if the indisposed person were to be, say, the Chief Officer, rather than yourself. In such a case, you would probably either relieve him or her of normal duties, allocate the essential tasks to others and defer non-essential items. You should be particularly aware of the risk of fatigue. If there is such risk, you should consider what can be done to allow some rest before continuing with critical operations. For example, delay sailing by some hours, postpone voyaging through a difficult channel, etc. Tell the ship manager what you are doing and why.

If it is not the Chief Officer, or other key member, but yourself that is indisposed, apply the same guidelines. Remember, if you are in pain, then perhaps your performance and possibly judgment may be affected. You will receive no thanks for having struggled on if the ship is involved in an incident.

If you are the manager of a well-run shipping company, you would put into place contingency measures for such a situation, although with tight availability of officers this may be difficult. You would keep the master updated

on this. And if the master phones you to advise that key staff are showing signs of fatigue so he is delaying sailing by six hours in order to allow some rest, your response will hopefully be along the lines of "Well done Captain. I fully support this. Are you sure that six hours will be sufficient."

We would welcome correspondence on this subject.

RACING IMPAIRED BY POTS

Report Text: A sailing club was preparing for one of its regular dinghy races. The normal starting area off the club was severely hampered by many lobster pot lines floating on the surface without counter-weights. There are practical constraints on moving the starting area. Navigating through the lines in a rescue boat would be severely hampered. Is there any legislation to have these lines weighted or positioned away from the shore?

CHIRP Comment: **CHIRP** continues to receive a large number of reports about fishing gear, including some in which disabled craft have had to be towed to safety by a lifeboat.

As we have previously mentioned, the Maritime and Coastguard Agency (MCA) has recently issued Advice to Fishermen and Yachtsmen on the Marking of Fishing Gear. This is available on the MCA website. The guidance includes

- Fishing gear should be clearly marked with buoys and flags.
- Action should be taken to avoid the dangerous practice of lines floating on the surface.
- Owner of the gear to be marked on the buoys.
- Gear should be sited outside navigable channels.

As further information, we add that:

- The leaflet is advisory. Regulation of fishing matters lies with the Sea Fisheries Committees, Harbour Authorities and Devolved Administrations.
- The advice has been developed with input from the fishing industry. However many lobster pots are laid by non-commercial fishermen.

We are under no illusion that we are going to see an immediate improvement. Nevertheless we believe that the MCA advisory leaflet is a helpful first step in addressing the issue. **CHIRP** continues to encourage reporting of incidents as they provide evidence of the need for on-going progress.

In the meantime, those involved in leisure sailing have to address the practical difficulties that arise, such as those described in the report. In this type of situation a Race Officer may wish to consider the following:

1. Is there a significant probability that the patrol craft will be required to provide assistance to competitors in the area hampered by buoys and floating lines?
2. What would be the consequence if it is unable to do, or if the patrol boat becomes disabled due to a fouled propeller? Take into account the weather and tidal conditions.

3. Is there an alternative of moving the starting area, e.g. by starting from a committee boat? Can the affected area be made a prohibited area for the race?

In the medium term, the best way forward may be to enter a constructive dialogue with the local fishermen to discuss the situation, as it is probable that neither party has exclusive usage of the area. Some of the solutions, (for example, shortening and/or weighting of lines, use of marker buoys with flags) are technically simple but need goodwill to implement.

LASER POINTED AT BRIDGE

Report Text: The vessel was entering port. A ferry was leaving. A green laser pointer sighted on port quarter of the ferry shining outward. Directed at Bridge of own vessel, light was so strong that Bridge team had to look away. It was quite a surprise that this light was so strong as to be painful to the eye, particularly at that range. Other vessel contacted and promised to deal with it. Own Vessel turned into approach channel on track despite this, light was again pointed at the bridge of own vessel, Bridge team looked away and vessel continued without further incident.

CHIRP Comment: This type of malicious incident has unfortunately become quite frequent worldwide although not generally against ships. If you are on the bridge of a vessel that is so affected, the general advice is:

- Do not look directly towards the light source.
- Concentrate on controlling the vessel.
- If your vision is temporarily affected, call others to the bridge to provide support.
- Advise the authorities as soon as possible.

A man was recently sentenced by an English court for four months imprisonment for shining a laser at a helicopter pilot.

REPORTS FROM SHIP MANAGERS

CHIRP Narrative: Ship managers with well established safety management systems typically have their own in-house near miss reporting schemes. Often such reports would be of interest to the wider maritime community.

CHIRP is pleased to receive and publish these. We respect the confidentiality of the reporters and do not disclose identities of ships.

FOOD POISONING

Report Text: Food was found to have been re-frozen after thawing. The re-frozen food products were removed immediately and destroyed. The manager reminded all the personnel in its fleet of the danger of re-freezing thawed food. If food is thawed and then refrozen, pathogens and micro-organisms can be allowed to grow, resulting in food poisoning, sickness and dysentery.

CHIRP Comment: It is sometimes the case that Health, Safety, Security and the Environment is considered as hSSE rather than HSSE, i.e. health issues do not receive sufficient prominence. So **CHIRP** is pleased to include

this reminder of the need for proper food hygiene.

Food poisoning can be extremely unpleasant and, in severe cases, life-threatening. This can apply across the maritime sector, on commercial ships, fishing vessels or yachts.

It is worthy of note that this manager has given prominence to this subject not as a result of an actual outbreak of poisoning but rather as a result of an early identification by ship's staff of the hazardous incident, i.e. the re-freezing of the thawed food.

MISTAKES AND LADDERS

Report Text A crew member was working in the engine room using a step ladder. He was standing on the third step when, without warning, the ladder suddenly gave way. He fell backwards onto the adjacent platform. Fortunately his injury was limited to bruising.

The incident was investigated by the ship's staff. Examination of the step ladder showed that the plastic hinges at the top of the ladder had failed, resulting in its collapse. It was noted that a previous breakage of the hinges had been repaired using glue, a steel plate and pop rivets. This set of step ladders should have been disposed of prior to this incident, as they were clearly not fit for purpose. Pre-use inspection of the ladder took place but the obvious defect was not noticed. With no traceable record of purchasing the ladder it is assumed that this was part of the vessels original outfit. The ladder has been removed from service and marked as broken. A new more suitable ladder is being purchased at first opportunity. The cause of this incident was the fact that the ladder had previously failed, and then fixed, when disposal was more appropriate. It has also been decided onboard that all portable ladders will be inspected for suitability and structural integrity. Any ladders found to be in poor condition or are unsuitable for shipboard use will be condemned and disposed of. Also as the crew member did not notice the poor condition of the ladders, it raises the possibility that pre-use equipment checks are not being carried out thoroughly enough. The Chief Officer is in the process of briefing the crew and officers on importance of proper pre-use equipment checks. This should in turn result in any defects being noted and reported before an incident occurs. In the future all portable ladders will be included in the ROLA (Register of Lifting Appliance) and will be subject to regular recorded inspections to ensure incidents such as this can be avoided. The inspection of ladders is also going to be part of the Shipboard Safety Officer's inspection regime to ensure deterioration of appliances doesn't get over looked.

The Company also added that ladders with plastic hinges are not well suited for shipboard use.

CHIRP Comment: Whilst at first sight this incident may appear to have been a technical failure of a simple piece of equipment, it was the result of non-conformities in applying procedures. Could the outcome have been worse? In slightly different circumstances someone may have fallen off the ladder and toppled over the rail to the deck below. So the ship's safety team is commended for investigating the

incident thoroughly, taking remedial action and sharing the learning through the company's reporting scheme. We thank the company for sharing it with a wider audience.

CHIRP endorses the point that care must be taken when purchasing equipment to ensure that it is fit for use in a marine environment.

Another company has advised that it has a Ladder Register. Ladders are checked quarterly in conjunction with the checks on Personal Protective Equipment.

CORRESPONDENCE

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

TOWAGE ASTERN

Correspondence: I am writing in response to the report in MARITIME FEEDBACK No.18, titled 'Collision in Port'.

I noted that the report was provided by the manager of the vessel and his version of events probably originated from the Master.

I know of no experienced pilot that would attempt this manoeuvre without full use of main engines, I suspect there was a misunderstanding on discussing the passage plan. To carry out this manoeuvre with a dead ship would of course require two tugs.

Regarding root causes of the incident, point 5. I must disagree with the statement 'towing a vessel astern with a single tug is not considered 'best practise'.

A lot of ports have physical constraints and the option of swinging the ship twice may not have been open to the pilot.

Towing a ship stern first is often the easier and safest manoeuvre. The tug provides stern way thus negating transverse thrust which can be a problem. Use of helm and ahead engine movements makes the stern completely controllable. Use of the bow thrust controls the bow.

I have no 'interest' in the reported incident nor do I know where it occurred. I have served as Master and am an experienced Pilot.

CHIRP Comment: We are pleased to publish constructive comments such as this.

PHOTOGRAPHS

Correspondence: I find MARITIME FEEDBACK an interesting and salutary read.

I carry a digital camera on my small cruising yacht. Its use would be limited to daylight 'events' but it would be worth a thousand words. Pictures to support a written report could really shame a perpetrator. 'A Miss Too Near' in issue 16 is brought home with the photo and you mention your willingness to receive photographs with reports.

Might be worth mentioning photos on your Report Form?

CHIRP Comment: We have indeed included on the revised Maritime Report Form a note that photographs, diagrams and/or electronic plots on a CD are welcome.

The letter also provides your editor for a mea culpa on a missed photo-opportunity. I had been off Plymouth in a motor cruiser to watch the start of the Trans Atlantic race. On the way back in we came across two men in a very small inflatable who had been offshore to see the race. They had run out of fuel. No lifejackets. We delivered them safely to shore. However, concentrating as I was on boat handling, I failed to take a photograph in support of the RNLI "Lifejackets - Useless Unless Worn" campaign!

However, here is a photograph I did capture illustrating not a hazardous incident but good practice. The line-handlers were wearing safety helmets, lifejackets and high visibility jackets. And hopefully protective footwear. A question for those involved in port operations - are the staff and contractors in your port properly equipped?



Maritime & Coastguard Agency 24hr Info No:

0870 6006505

(Hazardous incidents may be reported to your local Coastguard Station.)

Maritime Accident Investigation Branch (MAIB) reports and incident report forms are available on their website:

www.maib.gov.uk

**MAIB 24 hr Telephone No:
02380 232527**