

# MARITIME FEEDBACK

Issue No: 20

Autumn 2008

## EDITORIAL

### ASK "WHAT IF....."

If a company is planning to build a new industrial plant, it will be required to identify the possible risks, evaluate them, determine how to mitigate them, and to document all this. However, a "Risk Assessment" does not always require large documentation. Indeed, the practice of good navigation, seamanship and engineering practice entails frequent assessments of the risks associated with the operation of the vessel.

Such risk assessments will often be carried out mentally, although it is best, if possible, to talk through the situation and assessment with someone else. The Royal National Lifeboat Institution trains its crews in dynamic risk assessment". The importance of this is well summarised by the report of a difficult rescue described on the RNLI website. "The actions were truly representative of a helmsman completely in control of the situation. His appreciation of the risks to his own crew balanced against the changing situation, allowed him to make some excellent decisions. His thorough and dynamic risk assessment ensured his crew were only committed when absolutely necessary after exhausting all other options."

Risk assessments are essential practice whether you are on a yacht, a fishing vessel or a commercial vessel. For example, if you have a boat and will be going out to sea, consider what would happen if your propeller becomes fouled. If the wind is blowing towards the shore, how much time will you have before the boat is aground? Are you allowing sufficient sea-room off the shore? Is your anchor, chain and warp sufficient to hold the boat in the prevailing conditions? Do you have a radio? Who would you call?

As another example, if you are on a commercial vessel and are about to enter an enclosed space, STOP!!! Remember the fatalities reported by the Marine Accident Investigation Branch. Consider what if the oxygen level is depleted? What if there is gas? What if you enter using breathing

apparatus and it fails? Is back-up immediately available? Follow the procedure in your vessel's Safety Management System for entry into an enclosed space.

***In summary, ask "What if....." and think through beforehand what you will do if it does happen.***

Chris Rowsell

### NAVIGATIONAL NEAR-MISS

**Report Text:** Our Harbour Authority operates a port VTS Information Service. The VTS also monitors vessels transiting the adjacent sea area, although there is no direct responsibility for this.

On the particular day, the duty VTS Operator was alerted to a small cargo vessel entering a safety zone around an outlying island. The VTS Operator called on VHF channel 16 to alert the vessel it was standing into danger. After the 3rd call to the vessel a response was received indicating the ship was hard to port.

The vessel proceeded to clear the area without incident. The Harbour Authority forwarded details of the incident to the local Coastguard office.

(Note: the reporter attached a snap-shot image from the VTS equipment showing the track of the vessel entering the safety zone and skirting the island.)

**CHIRP Comment:** We forwarded the report to the manager of the ship. He subsequently sent us the response of the Master which in summary was that

- The area is well known to him. He was on the bridge for the passage of the area.
- There was a strong following current and a Force 6 following wind. The visibility was good.
- The vessel was being set south by the tide towards the island. The master was however expecting that when the ship got closer to the island there would be a counter current to the North.
- The Master stated that "The depth at location is very deep which makes it no risk. On the radar I circled a cpa to the safety zone of 0.5 nm. It's my opinion that I haven't been within that distance. I already had corrected the course twice with 5 degrees to the North. I don't know if this could be tracked ashore. There was a vessel ahead on a reciprocal

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

*course. This is why I always keep as close to the starboard outer limit of the fairway in order to ensure there is no doubt about my intentions."*

**CHIRP** appreciates the manager's action in following this up with Master. We would however comment that, from the track of the vessel shown on the VTS, it is appropriate to consider this as a navigational near-miss with significant risk, typical perhaps of many near-misses that go unreported. These may well involve mariners who are properly qualified, conscientious and take pride in their navigation skills.

So what can a ship manager do to reduce the risk that his ship will be involved in a navigational incident? Some large companies carry out navigation audits in which a senior Master or navigator carries out trips on vessels to monitor the navigational practices and advise on areas for improvement. The concept is the same as that for auditing any critical area of a company's activities, whether technical or financial.

In a small company, it may not be feasible to have specialist navigation auditors. However, a superintendent during a visit to a vessel in port can obtain a level of assurance, for example:

- By looking at the vessel's passage plan for the previous voyage and discussing it with the Master.
- By discussing with the Master and navigation officers how they apply parallel-indexing techniques.
- By checking that navigation equipment is working and charts are corrected up to date.

And if you are a yachtsman, does any of this apply to you? During your next voyage, ask yourself whether you are applying all the proper navigational practices. Or better still, ask a qualified person to give you a critique.

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### HUMAN BOOM PREVENTER

**Report Text:** I observed a fleet of chartered yachts racing. There was a fresh 5/6 SW breeze. The boats were running downwind under spinnaker. On several boats, a crew member was on the foredeck acting as a human boom preventer. It was totally unnecessary and in my view a very dangerous practice in these conditions. There is no way they could have prevented an involuntary gybe should it have occurred. There was a severe risk of injury or man overboard

I feel a warning should be issued from a safety perspective particularly as these were charter boats and the individuals involved may not be experienced or seasoned racing crew.

**CHIRP Comment:** We wrote to the manager of the flotilla. He replied as follows:

*"I can confirm that all our racing yachts are supplied with*

*a mainsail boom preventer which we brief should always be rigged when going down wind. This line is clearly identified from any other line aboard by being very bright colour.(they are bright orange) These are identified in the yachts inventory and checked as correct by the skipper before each charter starts.*

*The dangers of gybing are briefed to clients before each charter though clearly we do not go through the complete drill. Uncontrolled gybes and the dangers from the boom and main sheet sweeping the cock pit are also briefed. Regarding the quality and experience of the crews of our yachts these comply with the MCA code of practice, that skippers and mate are required to be experienced prior to charter.*

*Please thank the reporting yacht skipper for bringing the issue up. I am always interested in safety issues."*

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### BALTIC ENCOUNTER

**Report Text:** The following report was from the officer of the watch of a large commercial vessel in the Baltic:

- At 10:30 UTC, My attention was drawn to a tanker calling Sound pilot repeatedly on channel 16. I took the vessel under closer surveillance. Since the vessel was calling for Sound pilot, I figured that she will continue to route D from the Anholt crossing. I noted that her CPA was going to be close if she did not change her course. Keeping in mind that she was the give away vessel, I monitored her progress and kept my course and speed.

- At 10.56 when our TCPA was 9 minutes and CPA 0,4 miles, I gave the vessel a call on ch. 16 and then changed to Channel 6.

From XXXX: Vessel YYYY, this is XXXX on channel 6. I am just wondering what is your intention. Are you going to turn to starboard soon and pass me from my stern?

From YYYY: No I am going to keep my course and speed.

From XXXX: No, this is very dangerous, our CPA is only 0,4 miles. You have to turn to starboard now, I will also turn to starboard.

From YYYY: OK

- At 11.02 UTC. By now, I had alerted our captain to the bridge and we monitored YYYY still slowly turning to PORT and therefore maintaining a collision course with us. When the distance between our ships was about 1 mile and we were still on a collision course, the decision was made that we would turn hard to starboard and get away from YYYY once and for all.

Our turning circle to starboard could be made with less than a 0,15 mile radius and our speed was dropped very quickly to 4 knots.

As we were executing our complete 360 degree turn to starboard, YYYY called us on VHF on channel 16.

From YYYY: XXXX what are you doing?

From XXXX (captain now on the radio): Since you are

not following the rules of the road, we are now turning hard to STB

From YYYY: OK

At 11.12 UTC The situation with YYYY was over after we had executed a 360 degree turn to starboard. YYYY continued her journey via route D, calling Sound Pilots on ch. 16 just like before the incident.

**CHIRP** Comment: **We sent a disidentified copy of the report to the manager of vessel YYYY. Their initial response was that "the Master of YYYY strongly complained that the turn to starboard of XXXX had endangered the vessels safe passage and has reduced the CPA from 0.6 to 0.4 miles.**

*He also explained that his vessel was a give way vessel at 10:30 hrs as stated by the OOW of XXXX but at this time the vessels were at a of about 15 miles.*

*With a quick estimation, 9 minutes before the CPA the vessels were at a distance of about 4 miles. Thus YYYY was very close to crossing the course of XXXX and therefore there was no need to make a course change.*

*Therefore the OOW replied that his intention was to maintain his course and speed.*

*Please also note that the master was on bridge throughout and was monitoring his OOW con."*

**CHIRP** responded to the manager of YYYY as follows:

**"Thank you for having followed up the report. We observe that the issue appears to have arisen due to a different perception between the bridge teams on the two vessels as to the acceptable margin of safety. The bridge team of YYYY considered that it was safe to pass approximately half a mile ahead of XXXX. The bridge team of XXXX considered that this margin of safety was too small.**

**In CHIRP, we do see the issue of margin of safety reported quite frequently. This was addressed in the editorial to MARITIME FEEDBACK Issue No. 18 with the headline "PLEASE RESPECT MY SAFETY MARGIN!!!"**

**CHIRP** received a further response from the manager of YYYY stating:

*"We fully agree with your comments. Although the bridge team of YYYY considered the CPA of 0.6 miles safe, taking into consideration the area and the recommended routes followed by the vessels, this should have been communicated in advance to the OOW on XXXX.*

*We consider the issue as a near miss and therefore it will be distributed to all managed vessels in order to be used as training material during the onboard training sessions."*

**We have included this correspondence in full because it illustrates how different perceptions of an appropriate margin of safety can lead to concern and possible confusion. We are pleased that the OOW of XXXX reported the incident and that the manager of YYYY followed it up and promulgated it as training material through his fleet. This illustrates the positive benefit of near-miss reporting.**

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## YACHT & FERRY

**Report Text:** Approaching port in my yacht with one other person on board, wind East force 4, we observed a ferry outbound in the buoyed channel. I was under full sail, directly downwind, with the genoa goose-winged out. We were on starboard tack, doing 5 knots speed over ground.

By the time the ferry left the end of the channel, the distance between us was, I estimate, 2 miles. My course was 270T, his appeared to be the reciprocal. (I have no radar or AIS capability on board). We watched intently for him to alter course. At one stage he appeared to alter slightly to starboard, as if to pass behind us and on our port side, but within a few seconds resumed a course directly towards us, on a steady bearing. By this time I was very concerned, and called him twice on VHF Ch 16 (using "XXXX company Ferry just departed (name of port)"), there was no reply to either call.

With the range now less than 1 mile, I elected to get out of the way. A rapid change to starboard was out of the question with the genoa poled out – I therefore gybed the yacht and altered course 90 deg to port, onto 180 degrees. T. When I did this I believe the ferry altered slightly to port, and she passed about 200m. on our starboard side.

### Lessons Learned:

- I would now have second thoughts about rigging the spinnaker pole in circumstances where I might encounter shipping. Nevertheless, I was clearly the stand-on vessel and there was no navigational constraints that I know of that might have prevented the ferry from altering course in plenty of time. Why did he not apply ColReg. 16?
- I will seriously consider fitting an AIS receiver so that I can identify a ship and call it directly.
- Your Spring 2008 editorial is very appropriate! "Please respect the safety margin of the other vessel!!!"

**CHIRP** Comment: **We sent a copy of the report to the manager of the ferry. He responded, in summary, as follows:**

- *The manager had discussed the incident with the Master.*
- *The ferry had left the berth approximately two hours after low water. The wind was recorded NE-Iy 1-3 knots.*
- *With no restrictions in open sea, the power driven vessel with a reciprocal course towards a sailing vessel should give way to the sailing vessel.*
- *The ferry maintained her Easterly course in the channel, adjusted to counter the offset of tidal stream.*
- *Ferries leaving this port are restricted by their draught both in the buoyed channel and beyond it as they have to avoid a shoal area to the South. Until clear of this area, a ferry is to be considered as "vessel constrained by her draught" Art 3 - h.*

- Leaving the buoyed channel, the sea bottom configuration restricts ferries in altering course. The passage in between the buoyed channel and the 10 m depth line to the East is to be considered as "Narrow Channel". (Refer to rule 9, b.)
- Yachts approaching this port are often not sufficiently aware of the third dimension (draught) of ferries from and to the Port. There is a local instruction that frequent movements of large vessels take place and small crafts are advised to keep well clear of such traffic.
- The lack of communication in this case is acknowledged. Vessels approaching or leaving this port are keeping watch on VHF CH 14 but should maintain watch on Ch 16 as well.

In commenting on this report, we are conscious that we are doing so from the comfort and safety of the **CHIRP** office and not from the cockpit of a yacht or the bridge of a ferry!

Often **CHIRP** receives reports in which the perception of the situation from the cockpit of a yacht is different from that from the bridge of a commercial vessel. In this case, the yachtsman believes he has right of way but becomes understandably anxious as the ferry comes towards him. On the bridge of the ferry, the navigator is constrained by the shoal area from altering course to starboard and may be reluctant to alter course to port in case the yacht alters to starboard (which she might do if she was using its motor as well as sails.) Perhaps the navigator of the ferry keeps on, hoping that the yacht will get out of the way, which in this case she does.

It is useful in such cases to remind ourselves of the relevant International Regulations for Preventing Collisions at Sea (the ColRegs).

Rule 18 (d) says:

**"(i) Any vessel other than a vessel not under command or restricted in her ability to manoeuvre shall, if the circumstances of the case admit, avoid impeding the safe passage of a vessel constrained by her draught, exhibiting the signals in Rule 28." (These signals are three red lights in a vertical line, or a black cylinder.)**

**"(ii) A vessel constrained by her draught shall navigate with particular caution having regards to her special condition."**

If this were a case in an Admiralty Court (which it is not!) and if the Editor were a judge (which he is not), he would interpret the application of the ColRegs to this report as follows:

1. If the ferry is constrained by her draft, she should communicate that to other vessels. The ColRegs stipulate the signals for this. She could also have communicated this by VHF.
2. It would have been prudent for the ferry to have

slowed down.

3. Although there is shoal water to the South, there is open water to the North. It is therefore contentious to argue that the area to seaward of the buoyed channel is still a "narrow channel or fairway."

The yacht acted prudently in taking action to avoid a collision. As he points out in the lessons learned, consideration needs to be given to the safety of running with the genoa poled out if the single crew member, perhaps inexperienced, may have to bring the pole in quickly. Had the wind been stronger, there may also have been a reluctance to gybe. In such a situation (and referring back to the Editorial), ask yourself well beforehand "what if I need to alter course quickly....."

### GALVANIC CORROSION

**Report Text:** The owner of a traditional gaff-rigged yacht advised that the mast had been lost when sailing in wind of 15 to 20 knots. This was caused by the failure of a splice on the starboard forward shroud of main mast. On examination it was found that a copper wire lightning conductor, which had been routed down the shroud, had been touching the splice through the rope serving. This had resulted in corrosion of the galvanised wire.

**CHIRP Comment:** A reminder of the care needed to avoid galvanic action between dissimilar metals. The Editor still remembers an incident on a vessel on which he was serving when the aluminium radar tower secured directly by steel bolts toppled over!

### USEFUL LESSONS

**Report Text:** A yacht was on passage under motor off the North coast of France in daylight but with impaired visibility (circa 1.5 miles) due to driving drizzle. The crew had spotted and tried but failed to avoid a seaweed patch which proved not to be seaweed but extensive coil of rope floating just below the surface. The engine stopped. The skipper, who was below at time immediately suspected rope and looked over stern and identified strands of circa 25 mm rope. Jib unfurled but due to minimal wind unable to maintain course under sail. Crew unable to free rope and in poor visibility and rocky coast immediately to south, Skipper concerned at vessel drifting. Skipper called CROSS Corsen using DSC (PanPan not necessary) and notified coastguard of situation. Taking into account the coastline, lack of wind, tide and visibility CROSS Corsen decided to launch a lifeboat with diver aboard. The lifeboat reached the yacht within 45 minutes by which time visibility had improved. Having seen the rope, lifeboat crew decided diver should enter water despite the swell. The diver released substantial quantity of thick rope from the propeller (See photo). Rope so substantial that crew of seven unable to pull rope on board so lifeboat crew decided to take rope in tow.

Following check of engine for damage, the yacht proceeded under power to a port. Skipper and crew very impressed by French lifeboat and decided to make donation to SNSM.

**Lessons Learned:** as reported by the Skipper:

**Lesson 1:** Skipper should brief crew clearly to keep clear of patches of seaweed. What looks like seaweed in poor visibility may prove not to be seaweed but rope floating just beneath the surface.

**Lesson 2:** We were not in an immediately threatening situation. However with a rock strewn coast just a mile to the south, minimal wind, strong tides and poor visibility we definitely made correct decision of calling the coastguard before we drifted into a more dangerous situation.

**Lesson 3:** We were lucky that the engine and bearings appear not to have been damaged. However it is definitely worth carefully checking couplings and bearings following any incident affecting the propeller.

**Lesson 4:** When sailing in foreign waters, ensure that you know the procedures for contacting the local coastguard.

Comment from Skipper: Further legislation necessary to stop fishermen or other commercial mariners from dumping large quantities of thick rope at sea.



**CHIRP** Comment: The Skipper's action in notifying the Coastguard was prudent. (In different circumstances, if the skipper had assessed that he was not in imminent danger but needed urgent assistance, it would be appropriate to send a Pan-Pan signal.)

He has provided a clear and pertinent summary of the lessons learned.

The fouling of propellers by fishing gear and discarded rope is a significant on-going problem which **CHIRP** is continuing to highlight. This links us to the Editorial; as small boat owners, we know the risk exists. So consider what we would do if it happens, as the reporter has described in his lessons learned.

The reporter has commented on the need for further

legislation to stop fishermen and commercial mariners from dumping large quantities of rope at sea. There are already regulations about dumping waste at sea. Reputable commercial companies and their seafarers follow them but others disregard them. In the case of the reported incident, bearing in mind that rope is expensive, it may have been that the rope had been lost accidentally, rather than being dumped.

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## BATTERY EXPLOSION

**Report Text:** My yacht was lying alongside a marina, soon to depart on a voyage. I had switched off the Genset which had been charging the batteries. I reached out of the pilot house to start the engine, but could not quite reach the start key so came up the stairs, turned the key and immediately a large explosion happened.

I was dazed, looked into the boat to see the cockpit sole over the battery compartment had gone and smoke coming out of the battery area. I came back into the boat, turned off the battery isolators and grabbed the fire extinguisher and looked to see if there were any flames. I could see none, but a strong smell of battery gas. I opened the hatches to let air circulate and then left the boat.

Description of area and damage. The battery bay is mounted under the pilot house sole in a plywood box which has been glassed inside. Two catches secure a ½ inch ply top which runs in a rebate. The batteries are a snug fit within the box, relying on the box for security in heavy seas. A 1/2 inch vent pipe runs from the forward end..

Four lead acid batteries are mounted, connected into two banks of two feeding 4 isolators running domestic 1 and 2 and engine and generator start. The forward and aft most batteries are mounted under the lip of the boxes, such that the middle two batteries have to be removed to allow access to the fwd and aft electrolyte covers for maintenance. The electrolyte covers had blown off and the tops of the forward and aft most battery had blown in. There was evidence of the forward battery overheating.

The boat was built in 2004. An extensive refit had been carried out March 2007 which included the fit of a generator. I subsequently purchased the boat. No survey was required for insurance purposes.

According to the previous owner, the batteries had been replaced in 2007. We checked the electrolyte levels in the mid two batteries, but could not gain access to the fwd and aft batteries. I asked the previous owner how he had checked and filled the others and he stated that they had drawn up how the batteries were wired, disconnected them and removed the mid two such that access could be gained to the forward and aft pair.

I had made the decision to run the batteries as fitted and when the electrolyte needed topping up in the mid two, to disconnect and check the fwd and aft

batteries. I had noticed that the Battery Monitor showed charging currents of around 80 amps when the battery charger was first switched on. I had noticed a smell of battery gas when I had previously checked the area and had put this down to the high charge rates.

After the accident, an investigation was carried out. When the damaged wood was removed to allow access to the aft most battery positive post, there was evidence of arcing. It was clear that the terminal (secured with butterfly nuts) was loose. Corrosion around the post indicated the connection had been loose for some time. Although much of the electrolyte had been lost from batteries, residue remained in all, but the aft most battery, indicating that this had dried out. This battery was part of the bank which supplied the engine start circuit.

Conclusions.

The explosion was caused by a combination of factors.

- Batteries charging at a high rate causing build up of explosive gases in a very confined area.
- Engine start being instigated within minutes of charging being carried out.
- The small vent pipe was inadequate to clear explosive gases.
- Poor access/poor maintenance resulted in the inadequate tightening/loosening of retaining butterfly nut. The resulting spark when the engine was started caused a spark which ignited the explosive mixture.

This was an accident waiting to happen. The use of sophisticated charging systems, which can charge at high rates, coupled with compact battery stowage boxes will result in high levels of explosive gas until the vent clears the area. The use of butterfly nuts in an area subject of vibration requires a high level of inspection to prevent such a spark.

Generally if lead acid batteries are fitted in spaces such as the galley or saloon then the access must be easy to allow checking of all securing bolts. Positive ventilation should be considered.

**CHIRP Comment:** We thank the owner for having shared the report and conclusions. It illustrates the care that must be taken if fitting a high capacity generating set and, in particular, to the venting of the battery compartment.

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## 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.

## PILOTAGE PROBLEMS

**Report Text:** A manager has sent us two reports of incidents regarding pilotage in different parts of the world.

In the first, the Master was concerned that the pilot was making excessive use of his mobile phone whilst piloting the vessel. This was compounded by the pilot's refusal to take advice on his behaviour from the Master.

In the second report, the Master of another vessel was concerned that the pilot was apparently under such time pressure that

- a) He did not initially wish to spend time discussing the proposed plan for departure from the port.
- b) He was initially reluctant to the order to the tug to make fast to the ship – "There's no time for that!"
- c) The vessel passed too close to another moored ship.
- d) The pilot disembarked before the vessel was clear of the port entrance.

In both cases, the Masters, with the full support of the manager, had reported the incidents to the appropriate local authorities. On subsequent visits to the ports, significant improvements have been noted.

**CHIRP Comment:** In previous editorial comment we have emphasised that willingness to intervene is a key attribute to improving safety. It is pleasing to note that these Masters, supported by their manager, have intervened and that, as a result, improvements have been achieved.

**On specific points raised in the reports:**

- Nobody conning a vessel in confined waters should allow him/herself to be distracted by making or receiving calls on a mobile telephone.
- Proper review and discussion of the proposed passage plan is essential. "Poor planning produces poor performance."
- In regard to the comment that "there is no time for that", the response is "there is always time for safety." (The Editor is reminded of this frequently as this is engraved on a small clock that was presented as a safety award to all personnel in a fleet.)

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## CHANGE MANAGEMENT

**Report Text:** Another manager has sent us a report of a hazardous incident that resulted from an improper change to the equipment on a tanker. It was found that a drain pipe from the accommodation air conditioning unit had been plumbed in to the drain for the inert gas system. (The inert gas system provides a protective blanket of inert gas, mainly nitrogen, to the cargo tanks.) The A/C drain had originally been connected to the bilge holding tank. However, whilst the ship was under the previous management of another company, it had been modified to discharge into the inert gas drain line.

As a result of the connection between the two systems, there was a risk that inert gas could have been blown into the accommodation via the air conditioning unit.

**CHIRP** Comment: **Whilst this report may at first sight seem highly specific, it does highlight that all changes to equipment, systems and procedures need to be carried out in the discipline of a robust change management procedure that is strictly applied. The procedure will include technical consideration of every proposed change, and proper authorisation. The change management procedure is a key part of the Safety Management System.**

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### 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.

### MEDICAL INDISPOSITION

**Correspondence:** I was rather concerned by your advice in the Medical Indisposition report in the September 2008 issue. I felt that the advice was not strong enough in stating that a vessel should not proceed to sea with a person in command who was declared 'medically unfit'.

I would be extremely concerned to learn that a vessel's master had been declared medically unfit and advised to sign off by the port Doctor, but had ignored the advice and proceeded to sea for a further two weeks in the absence of a relief. What is of more concern is that the vessel management company endorsed this (your report was unable to confirm this).

If the master was unable to hand over command to the Chief Officer, and the vessel still remain within its safe manning levels for the work it is involved in, then I believe she should remain firmly alongside until a relief is found or the master is declared fit for work again.

**CHIRP** Comment: **We were not in a position to obtain feedback from the manager on the case reported. Therefore we hesitated from being absolutely prescriptive in our comments. We would say as a generality that if a ship's master is declared medically unfit, the manager should discuss the situation with the master and obtain guidance from the flag state before any decision is made, with a normal presumption that the vessel should not proceed to sea unless, with proper consideration of the risks and management of them, approval to do so is given .**

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### MAIB SAFETY BULLETIN ENTRY INTO ENCLOSED SPACES

The Marine Accident Investigation Branch publishes

reports of accidents on its website. If you have not previously read these, **CHIRP** recommends that you do so. The reports are well written and provide an excellent source of information on lessons that can be learned.

The MAIB also issues Safety Bulletins highlighting particular safety issues. MAIB Safety Bulletin 2/2008 draws attention to three recent accidents involving entry into enclosed spaces:

- In September 2007, three seamen died inside the chain locker of an emergency response and rescue vessel.
- In January 2008, two seamen collapsed and died in a store on board a general cargo vessel. The chief officer entered the store to try to rescue the men, was affected by the oxygen-depleted atmosphere, but fortunately escaped.
- In June 2008, a seaman died on board a passenger ship after he entered an almost empty ballast tank.

The Marine Accident Investigators International Forum is researching the incidence of this type of accident with a view to the submission of a paper to the International Maritime Organization. To date, responses from 18 administrations indicate over 120 fatalities since 1991.

The advice from **CHIRP** is:

- ***If you are about to enter an enclosed space, STOP! Follow the proper procedure. If you don't know it, ASK!***
- ***If you see someone collapsed in an enclosed space, STOP! Call for assistance. The rescue team must have breathing apparatus. Don't become another fatality.***
- ***Don't wait for an emergency to become familiar with rescue equipment and procedures. PRACTICE!***

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Maritime & Coastguard Agency 24hr Info No:

**0870 6006505**

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

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

[www.maib.gov.uk](http://www.maib.gov.uk)

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