

CHIRP FEEDBACK

Issue No: 24

Autumn 2009

EDITORIAL

FEEDBACK ON CHIRP

As we mentioned in the Summer 2009 newsletter, the **CHIRP** Maritime Programme is sponsored by the Department for Transport as part of their commitment to improving maritime safety. Although the Programme is governed by an independent Board of Trustees, the DfT does need to be assured that it is cost-effective. For this reason the maritime programme is subject to periodic independent review. This was carried out in September.

The Review Board concluded that **CHIRP** is adding value to safety in the maritime sector by following up individual reports and promulgating information on incidents and issues. The report of the Review Board will go to the Department of Transport for their consideration.

One of the aspects considered by the Review Board was the relative functions of the **CHIRP** Maritime Programme and the Mariners' Alerting and Reporting Scheme (MARS), run by the Nautical Institute. The output from MARS is a monthly bulletin of reports with expert commentary. As a member of the Institute, your editor always looks forward to reading this bulletin in the Seaways journal.

The difference between the two programmes is that **CHIRP** provides a closed loop process for the reporting of incidents and issues raised by mariners in the commercial, fishing, leisure and offshore sectors. Each report is individually followed up with the relevant company or organisation, where possible, and subsequently closed out with the reporter. MARITIME FEEDBACK, is used to promulgate lessons learned from selected reports and to promote reporting. The roles of **CHIRP** and MARS are therefore complementary but different.

We thank all those who sent in their comments for the Review. Looking ahead, the most tangible way for mariners to demonstrate support for **CHIRP** is to send in reports. Our message is:

- We are not in a perfect world. Near-misses are happening.
- Lessons learned from near-misses can help prevent fatalities and injuries. Please report them.

Chris Rowsell

THE VALUE OF CONFIDENTIAL REPORTING

The value of confidential reporting has been succinctly described in a recent article by "Watchkeeper" published by BIMCO in September which we reproduce below with their kind permission.

We live in an unforgiving world where the "culture of blame" is well established, legal liabilities abound and the concept of an "honest mistake" has become almost redundant. That is perhaps why a system that enables people to report hazardous incidents in a confidential manner is very valuable indeed.

Confidential hazardous incident reporting has its roots in the aviation industry, where death is more readily evident and the consequences of such an incident can be more severe. The idea of "no-blame" reporting has become quite well-established over the years. A pilot makes a mistake, perhaps turning a control knob clockwise when he ought to have turned it the other way. He realises his mistake, takes the corrective action and disaster is averted. But he realises that if he could make this mistake, others might do so with catastrophic results, and a programme is in place to enable him to report his lapse. It could be that this points to a potentially serious design deficiency, or something that can be easily prevented by a small "tweak" in the design, or additional training. But the mere fact that such a system was available has encouraged its use, and saved lives. The fact that the reporter will not be blamed, or thrown out of his job on account of this lapse, is a further encouragement to use this system.

It is some years since the UK Department for Transport, conscious of the value of such incident reporting programme to aviation decided to fund the establishment of a marine equivalent, the Confidential Hazardous Incident Reporting Programme (CHIRP). It has now been in operation for more than five years and is beginning to make a positive impact on marine safety. Interestingly, although it is a UK initiative, it welcomes reports from ships and seafarers sailing under any flag. It is successfully reaching the leisure boating industry as well as commercial shipping and trying hard, with limited success, to penetrate the fishing industry, where too many deaths and injuries still take place.

It is, of course a wholly voluntary system, and it is individuals who report incidents to its headquarters in Farnborough, in the UK. And while initially attitudes in the shipping industry might have been suspicious of something akin to "whistle-blowing", there has been growing support for CHIRP and encouragement of its aims in the industry. Good companies have processes for "near-miss" reporting, but experienced people also recognise that the

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

embarrassment of a mistake might prevent an individual reporting an incident. CHIRP encourages openness and a public spirit, through its promise of absolute confidentiality.

CHIRP also takes action to address incidents, in a navigational near-miss, for instance, contacting the owners of the "other ship" to find out what went wrong. In a recent report published by CHIRP about a navigational incident, a range of failures were identified by the company of the ship complained about, and all were being addressed.

Of course, knowing that CHIRP is there, and what it does is very important, this being undertaken by regular reports published as CHIRP Feedback several times every year in newsletter form. As a result of this, it has been possible to detect certain trends, and these can be addressed. Some might be obvious; like regular failures to keep a good lookout, and poor knowledge of the regulations. Others are more singular, but no less important, such as a cook concerned at the risk of poisoning from food kept in a press in the mess for too long, or equipment failures. CHIRP is proving increasingly useful, as confidence in it grows.

REPORTS

CHIRP receives reports on a range of hazardous incidents that have occurred within the commercial, fishing and leisure sectors of the maritime community. Here are a number of reports which will be of wider interest, together with the "lessons learned" as described by the reporter. The **CHIRP** comments have been reviewed by the **CHIRP** Maritime Advisory Board which has members from a wide range of maritime organisations, full details of the membership can be found on our website - www.chirp.co.uk.

OFFSHORE SECTOR

ENGINE ROOM PROCEDURES

Report Text: My offshore support vessel was standing by a drilling rig. We were using our dynamic positioning system. The ship's propulsion is generated by four diesel electric generators. The propulsion system is combination of two bow thrusters and two stern azimuth pods. The engine room watch consists of one engineer always on watch. The charterer's standing orders are to maintain constant watch in engine room during DP operations, and, depending on power load, 2 or 3 diesel generators are always to be running.

On this occasion, the weather deteriorated. Rain squalls were frequently passing with wind gusts up to force 7, with swell to 1.5 metres. The engine room was attended but only one generator was running.

In summary:

- A combination of a squall and big waves resulted in large power demand from propulsion system.
- The second diesel generator started in auto mode but did not put itself on line. This resulted in alarms in the machinery space.
- The third diesel generator then started in auto mode but did not put itself on line, with further alarms.
- The fourth diesel generator started in auto mode. This did put itself automatically on line and delivered

the necessary power to the propulsion system.

- The time frame was 6 minutes from increase from power demand till the fourth diesel generator could deliver the necessary power.
- During those 6 minutes, the vessel drifted from its position by several metres.
- Subsequently, in response to the alarms, other engineers were called to the engine room. The other diesel generators were put on line manually to deliver more power.

There was no damage but what could happen in such circumstances? Losing position close to a rig could lead to contact with it. Furthermore, with only one generator on line, there was an increased risk of a full blackout, resulting in a major incident.

Lessons learned:

- Follow the standing orders.
- The bridge watch officers, on seeing an approaching squall, should request additional generator(s) to deliver sufficient power.
- The engine room watch, on observing problems with the power management systems, should react immediately to avoid loss of position of the vessel.

CHIRP Comment: We are keen to receive more reports from the Offshore Sector, and also on incidents from all sectors relating to marine engineering issues. We are therefore pleased to publish this report. We endorse the lessons learned described by the reporter.

COMMERCIAL SECTOR

SITUATIONAL AWARENESS

Report Text: Own ship: a large sailing ship on a course of North under easy sail, wind on starboard beam, making COG of approximately 030 at 4.5 knots owing to tidal stream. AIS operating in correct Nav Status, navigation lights (including all-round red over green sailing lights) on, moderate visibility (not less than 4NM throughout this incident). Other ship first tracked on ARPA radar operating on 12NM range scale with course approx 260, speed 7, small CPA. OOW called me at about 2330 when other ship was at 5NM with CPA of zero. On investigation, the following details were obtained from AIS, vessel's name XXXXX, a small cargo vessel.

As stand-on vessel, I elected to monitor the other ship and see what action he would take as some vessels take avoiding action much later than others. At 3.5NM he had taken no action and because he maintained a steady CPA of zero, I decided it appropriate to clarify his intentions. I called him by name on VHF, he responded and we switched to a working channel. I informed him that I was a sailing vessel, that he had a CPA of zero and enquired as to his intentions. His response was "OK, I see you".

I called again, reminded him that he was the give-way vessel and asked what action he would take to comply with Colregs. He replied that he would slow down and alter course. He took no further action to avoid me, or respond to further VHF calls or two series of 5 short blasts by both sound and light. At 2340, I started the engine and came hard round to starboard. This was

into the wind and slowed the ship right down. An alteration to port, although available in the conditions, would simply have kept me parallel to the cargo ship at about 5 cables whilst she slowly overtook me and I was unable to make a 360 turn to port as the wide swing this required would have put me in a close quarters situation with another approaching vessel. The cargo ship passed down my port side at 3 cables. Had I not altered, a collision would have been very likely.

Lessons Learned: The primary lesson is once again to keep a sharp eye on what is going on around, a good lookout and a good "seaman's eye". And perhaps more of a reminder than a lesson for many seafarers I expect – sometimes, the other guy just doesn't care and can't be bothered to comply with the rules. I tried light and sound signals and radio, but he just wasn't interested. I don't have any simple ideas of how to prevent a similar incident, and unfortunately, nor will I be surprised to discover it happening again sometime.

CHIRP Comment: We are publishing this report as it provides a good example of the prudent application of "defensive sailing". We note, in respect of the sailing ship, that:

- The Officer of the Watch had called the Master in time for him to assess the situation.
- There was good situational awareness.
- The risk of the situation was properly assessed and the possible actions weighed up.
- Engines were started and then used.
- The situation was carefully monitored until the other vessel had passed clear.

In contrast, although the watch-keeper on the cargo ship was apparently aware of his obligation to keep clear, he took no action to do so. We have alerted the manager of the cargo ship to the incident.

We also make the general comment that mariners need to be aware of the manoeuvring characteristics of large sailing vessels, and to take this into account when determining a safe closest point of approach.

OVERTAKEN IN DARDANELLES

Report Text: When I came on watch on my general cargo vessel at 04:00, we were just out of the Dardanelles. At that time a bulk carrier was behind us. The hours thereafter went uneventful. The bulk carrier was sailing on our starboard side running at 12 knots over ground and we were running at 11 knots over ground. We were at about the same course, 207 deg. Suddenly I noticed on my radar that the bulk carrier was closing fast to us. I saw that she had altered course towards us while we were still at her port side. Her new COG was 178 deg. According to the AIS data on our ECDIS the CPA was 0,18 nm with a TCPA of less than 12 minutes. There were only 2 ships around us several miles away.

I called him on channel 16, then switched to a working channel. I asked him his intention. He answered "I will keep my course and speed". He was clearly overtaking us and thus had to act according to Rule 13. My reply was that she had to go to starboard. The answer was "OK".

However, he took no action. When the distance was 0,5

nm, I altered my course to starboard to pass her behind her stern. The bulk carrier kept her course and didn't react.

As I see it, this is a clear case of an officer who alters course on the waypoint without thinking about the consequences.

CHIRP Comment: We sent a disidentified copy of the report to the manager of the bulk carrier. The manager followed it up with the Master, who had not been on the bridge at the time. The officer who was on watch at the time did not consider that there had been a risk of collision but was sorry if his actions were not considered safe by the vessel being overtaken. The Master has advised the officer of the importance of avoiding misunderstanding between vessels in an overtaking situation.

We note that the report gave the CPA data from AIS. We point out that data for collision avoidance obtained from ARPA radar is considered to be more reliable than that from AIS.

LEISURE & COMMERCIAL SECTORS

YACHT & FERRY

Report Text: My yacht was heading out from port. My position was 0.03NM from a navigation buoy marking a sandbank to starboard. A ferry steamed up behind us and I expected she would leave me to starboard. To my surprise she came up my starboard side, leaving me on her port side. There was no communication, no sound signal. She passed within 15 metres at high speed and turned to starboard in front of me thus putting us in the full wash. We were motor sailing so she was the overtaking give way vessel. We had our mainsail up which received a severe back wind.

I complained to the Coastguard who called the ferry and asked her to talk to me. The Captain said that "If he had caused discomfort he apologised but there was lots of traffic and he was restricted". There was no boat in the main channel and she was a long, long way out of the channel. There were no other yachts nearby, it was not congested and the main channel was free.

If she had been in the channel I would have given way but had not expected to have to do this so far out of the channel, close to the bank, in relatively shallow water. The close encounter was completely unnecessary.

CHIRP Comment: This report was one of a number we have received from yachtsmen regarding anxiety they have felt about the close passing of a larger vessel. We are concerned that the margin of safety allowed by commercial vessels is, on occasions, less than it could be. It is clearly the case that, when entering or leaving ports with busy leisure traffic, it is inevitable that ferries will pass very close to small craft. However, we do wonder whether this induces some watch-keepers on occasions to accept a very close passing distance in relatively more open waters where a greater margin of safety would be available.

We alerted the manager of the ferry to this report.

CHIRP encourages shipping companies and masters to

promote discussion with their officers regarding margins of safety and allowance for contingencies, e.g. engine or steering failure.

LEISURE SECTOR

UNMARKED WRECK

Report Text: Some years ago a yacht sank after hitting an unmarked wreck just to the east of the entrance to a marina. I visited the marina recently and on departing at low water, saw the wreck. It is extremely large and with numerous lethal protrusions. It was unmarked and unlit. It is submerged but within striking range of the keel of any yacht. Bearing in mind the speed of the west-east tide the wreck constitutes an extreme hazard. On previous visits there were, as per the chart two starboard hand buoys, albeit unlit but on this occasion there were no such buoys.

CHIRP Comment: We ascertained from the marina manager that the buoys had been temporarily removed during dredging operations. A Notice to Mariners had been issued and the Coastguard notified. The Coastguard advised that this type of information would normally be included in their Marine Safety Information broadcasts promulgated every four hours.

The primary aid to navigation marking the channel is the leading light by which the white sector of the light indicates the safe channel. (As a general rule for safe navigation, it is not good practice to rely exclusively on a navigation buoy as the primary aid to navigation in case it is out of position.)

We also contacted Trinity House, which is the General Lighthouse Authority for England and Wales. There is a statutory requirement for a Local Lighthouse Authority to obtain the approval of the General Lighthouse Authority to remove a navigation buoy. This applies to temporary removal. Each situation is considered on a case by case basis.

We thank the reporter for having raised the issue.

DISMASTED

Report Text: Whilst on my 5.5 metre long catamaran, the mast fell down. Fortunately we were close in shore and we hobbled back home to the dinghy park! No one was hurt. No breakage or sail rips, just a spoiled day & some remedial work to do.

The fault was the loss of a shackle attaching the forestay to the hound on the mast. We do not know what caused the hound shackle to fail as it was lost. When we checked the rigging we also found that another shackle on the forestay had a stress fracture. This is a small stainless steel shackle, with a flat (rather than round) cross-section.

This might have had more serious consequence than our event. We are so lucky. (I understand that some years ago a mast came down in the boat park causing serious personal injury to a person walking by.)

I appreciate we were at fault. We check all the lower rigging at the start of each season. However, checking the upper rigging would require the mast to be taken down, which we had not been in the practice of doing. Unfortunately often the recognition of a potential

problem requires a chance event!

We will be replacing these 2 shackles with stainless shackles which are round in section (stronger) and with captive pins.

CHIRP Comment: The reporter has correctly recognised that the simple loss or failure of a shackle, which resulted in the mast falling, could, in different circumstances, have resulted in serious injury or worse. The report highlights the need for regular inspection of safety critical components, even if access is difficult. We are grateful therefore that the reporter has shared the learning from the incident.

READ THE RULES!!!

Report Text: Our yacht was sailing upwind on a port tack with approximate speed of 4 knots and 50 degrees to the wind, which was SW 3-4. We were in an area of clear water. Another yacht was approaching also on port tack coming from both upwind and behind us at approximately 6 knots at approximately 120-130 degrees from our port bow. We held our course and speed as best possible in order for the other craft to have space and time to take avoiding action. No action was taken on their part. When it was clear the other yacht was not going to take avoiding action, we tacked and sailed behind her. There was one person on deck of the other craft gesturing for us to get out of their way. It was also clear that this person was well away from the boats wheel and that the boat had probably sailed for some time under "blind" auto-helm. We continued until we had cleared the other boat.

Lessons Learned: As a crew we spoke about this incident at great length afterwards. As such we were happy with our actions; we did however agree that we will need continued vigilance regarding application by other boats of the International Regulations for Preventing Collisions at Sea. As a more general point we agreed on the importance of keeping watch at all times and not to assume that the boat can "look after itself" while under auto-helm.

CHIRP Narrative: Rule 13 of the International Regulations for Preventing Collisions at Sea provides that ".....any vessel overtaking any other vessel shall keep out of the way of the vessel being overtaken. A vessel shall be deemed to be overtaking when coming up with another vessel from a direction more than 22.5 degrees abaft her beam....." From the report, the other yacht was overtaking the reporter's yacht and therefore was required to keep clear.

There is an obligation on yachts, as with all vessels, to comply with the IRPCS and therefore, by implication, that the person on watch should know the regulations and be able to apply them. CHIRP encourages leisure sailors to obtain such competence by training, e.g. through an appropriate RYA course.

We are pleased to note that the crew of the racing yacht subsequently discussed the incident and determined the lessons learned.

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.

DEFENSIVE SAILING

Letter Text: In Issue #23 you have a report of a near-collision between two boats, one sailing, the other at anchor. As reported, the helmsman of the yacht, apparently on his own, could not see ahead and to leeward under the genoa.

I sail a 32 foot yacht single handed and keeping a lookout is difficult. However by taking in two rolls on the genoa I can see underneath it at almost all angles of heel, and in a heavy wind I probably need to take three rolls in anyway. The loss of boat-speed when sailing is negligible, and I can see other craft to leeward.

REPORTS FROM SHIP MANAGERS

Ship managers with well established safety management systems typically have their own in-house 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 or companies.

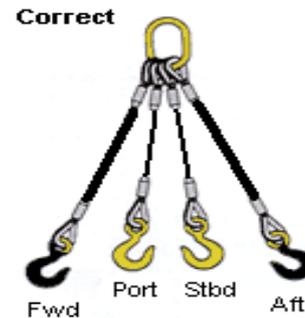
RESCUE BOAT FAILURE

Report Text: A vessel was lifting the six-man glass-reinforced-plastic rescue boat aboard as part of a routine training exercise, with two persons aboard, when one of the eyes for the four leg lifting bridle pulled out of the hull of the boat which was suspended approx 0.5m above the water. The boat was quickly returned to the water and to an upright position afloat. Although shaken by the experience, no staff were injured or fell out of the boat.

The bridle is designed so that two larger legs are attached fore and aft and take most of the weight, with two smaller legs to stabilize port and starboard.

A contributory cause to the failure, in addition to poor boat design, was found to be that the lifting bridle was attached to the davit incorrectly. Consequently the larger/longer fore and aft legs being the outer pair mounted on the master link, the shorter port and starboard stabilizing legs were outside the fore and aft legs making them shorter still and then taking extra strain for which they were not designed. It is important that, when using multiple leg lifting bridle, it is attached correctly.

The company has subsequently replaced these grp rescue boats.



CHIRP Narrative: This Company report resonates with a previous report about a grp rescue boat in which the stainless steel bolts securing a lifting lug failed. In this recent case the grp material around the lifting eye failed. If you are aware of any incident with a rescue boat, please let us know.

RISK FROM DRY ICE

Report Text: The morning after taking three months' provisions aboard the vessel, the chief cook proceeded to fetch some meat from the refrigerated meat room. Upon opening the door, he was affected by the atmosphere of the meat room. His eyes and nose were severely irritated by the atmosphere and he immediately closed the door.

The chief cook reported a 'smell' in the meat room to an officer who he encountered in the duty mess room. This officer subsequently entered the meat room to check for problems. After a period of 30 to 60 seconds he started to feel light headed and left the room.

Further investigation by ship's staff revealed the cause to be dry ice that had been packed with ice cream that had been received with the stores on the previous day. The remains of the dry ice were disposed of and the

meat room thoroughly ventilated.

The company is taking the following action:

- Publicise the incident to all vessels in its fleet, highlighting information contained in MSN 1254
- Ensure that industry guidance including M Notices and other publications that contain guidance for catering ratings are integrated into or highlighted in the catering ratings' handbooks.
- Investigate the feasibility of fitting of CO2 alarms to all unventilated rooms where frozen provisions are normally stored.
- Appropriate warning notices to be posted on the doors of rooms where frozen provisions are normally stored.
- Develop guidelines and best practice for the receipt handling and storage of provisions for ships' staff.
- Contact all approved suppliers to warn them of the dangers of supplying stores to ships with dry ice. All suppliers should be instructed to warn vessels of the presence of dry ice or other hazardous goods packed with stores.

CHIRP Comment: There is continuing concern in the industry at the prevalence of accidents associated with entry into enclosed spaces. This incident illustrates that an apparently innocuous operation, in this case taking stores packed with dry ice into the meat room, could have led to a serious incident.

We thank both ship managers for sharing their reports.

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MAIB REPORT

CHIRP Narrative: The reports of accidents published by the Marine Accident Investigation Branch are very informative, and contain a wealth of advice that, if applied, can help prevent future accidents. The reports can be accessed via the MAIB website.

A recent report by the MAIB described a tragic fatality in which a deckhand on board a scallop dredger fell overboard as he was emptying a dredge bag. He had been standing on the dredge beam, which was suspended and almost level with the gunwale, when the dredge bag lifting becket parted.

Despite the quick reactions of the skipper and crew, the deckhand sank below the sea surface. He was not wearing a lifejacket..

The MAIB investigation identified a number of safety issues including:

- Operation of fishing gear.
- The practice of not wearing a lifejacket or safety harness.
- A lack of understanding of risk assessments.



Marine 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

Maritime & Coastguard Agency 24hr Info No:

0870 6006505

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

LESSONS LEARNED

Describe the lessons learned as a result of the incident. Do you have any suggestions to prevent a similar event?



PLEASE PLACE THE COMPLETED REPORT FORM, WITH ADDITIONAL PAGES IF REQUIRED, IN A SEALED ENVELOPE (no stamp required) AND SEND TO:

CHIRP • FREEPOST (G13439) • Building Y20E • Room G15 • Cody Technology Park • Ively Road • Farnborough • GU14 0BR • UK

Confidential Tel (24 hrs): +44 (0) 1252 393348 or **Freefone** (UK only) 0808 100 3237 and Confidential Fax: +44 (0) 1252 394290

Report forms are also available on the **CHIRP** website: www.chirp.co.uk

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