EDITORIAL

CHIRP MARITIME PROGRAMME

As you may be aware, although CHIRP is governed by an independent Board of Trustees, the Maritime Programme is funded by the UK Department for Transport. As you would expect with any use of Public funds, the cost effectiveness of the Programme is subject to close scrutiny by the Department and in the current economic circumstances this is particularly the case.

The independent review of the Maritime Programme in September 2009 endorsed continued funding. Nevertheless, future funding of the Maritime Programme will be subject to the further review of Public Expenditure that is ongoing. In response to this, the Trustees have conducted a more recent review of cost elements of the Maritime Programme, as a result of which there will be some changes to how information on the Maritime Programme is disseminated.

Firstly, MARITIME FEEDBACK will henceforth be published as two newsletters, one for the Commercial sector (including commercial fishing), the other for the Leisure sector. This arrangement is similar to that for the CHIRP Aviation Programme, which has operated successfully for many years.

The Leisure newsletter will be available only in electronic format via the CHIRP website www.chirp.co.uk. This includes the facility to download the newsletter and also to request an e-mail alert when a new newsletter is posted on the website. Disidentified reports will also be made available for publication in boating journals.

We realise that some leisure sailors may have preferred to continue to receive a paper copy of MARITIME FEEDBACK. However, with wide internet access, we can no longer justify the significant costs associated with publication and distribution of the paper version.

The situation for the Commercial sector is rather different as many mariners do not have access to the internet whilst on board ship. We therefore propose to print paper copies of the Commercial newsletter for distribution to ships.

Both the Leisure and Commercial newsletters will be available to everybody via the website.

The continuing aim of the CHIRP Maritime Programme is to promote maritime safety by following up, on an individual and confidential basis, reports of hazardous incidents and safety concerns, and by promulgating information on the lessons learned. Please give tangible support to this aim by sending reports of hazardous incidents/near-misses and safety issues.

So please:
- Do be the person who does something to correct an unsafe situation.
- Do share the learning from near-misses by reporting hazardous incidents.
- Do be assured that reports to CHIRP are treated in absolute confidence. Please give me a call if you would like to discuss this.

Chris Rowsell

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.

COMMERCIAL SECTOR

DISTRACTION ON BRIDGE

Report Text: This incident I would rate as a potentially hazardous one, interfering with the effectiveness of the Bridge Team.

I had boarded the ship at the pilot station for inward transit to the berth. The Pilot/Master exchange was completed with no problem and we proceeded inwards. About 45 minutes into the Pilotage, the bridge door was flung open and a Superintendent strode onto the Bridge and proceeded to give the Master a good 5 minute tirade in the middle of the Bridge. I was not particularly concerned at this time, the ship was on a straight run with no other traffic around - it was slightly distracting but, if anything, it was extremely embarrassing for the Master to be on the receiving end of this language in front of me, the helmsman and the officer of the watch. After a while the Superintendent disappeared and everything settled down and carried on as normal, including discussions on the berthing arrangements, all
that had been previously discussed at the exchange but which is often best repeated before it happens. Subsequently the Superintendent returned and started having a loud conversation with another person at the back of the Bridge. Again it was an 'overbearing' conversation and by now we were about ten minutes from where the complicated part of the Pilotage would commence. Everybody else on the Bridge seemed drawn to this loud conversation going on behind and it was starting to irritate me greatly. I turned and said very loudly "Excuse me!" I then proceeded to explain quite clearly and forcibly why his conversation needed to be terminated immediately. The Superintendent was initially taken aback. He recovered his composure after a few seconds, apologised, shook my hand and departed from the Bridge. The passage then proceeded without incident and the ship was safely berthed.

**CHIRP Comment:** One of the primary ways in which individuals can improve safety is by intervening to correct an unsafe situation. This the reporter did by interceding, politely but firmly.

For superintendents and managers, this report may act as a prompt to consider one’s own style of communication and management. It is paramount that the ship’s staff must not be distracted from operating the ship safely. If an important discussion is needed, it is a useful discipline to first ask the question: "Is this a suitable and safe time for us to discuss...?"

If it is not safe, the Master or Officer should say so. (For example, "I have to concentrate on navigating the ship right now, but when we get alongside I will be able to give you my full attention.") The Master is responsible for the safety of the vessel; shore staff must be careful not to undermine his/her authority in this, but rather should reinforce it.

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**OVERTAKEN IN THE ALBORAN SEA**

*Report Text:* My vessel was sailing in the Alboran Sea (the westernmost part of the Mediterranean) approximately ten miles west of the Cabo de Gata Traffic Separation Scheme. It was just before midnight. Traffic conditions were not too dense, maybe there were about eight to ten other ships around. There was a strong westerly wind force 7, very rough seas and a strong westerly moderate to high swell. There was a good visibility. Our vessel had reduced her speed because of the sea conditions and was doing around 7.5 knots.

At 2330 hours local time, we made way for a vessel that was approaching us on an opposite course. Our original course was 259° and we changed to a new course of 285° in order to pass the other at a safe distance. When I changed our course I noticed a vessel astern of us at a speed of approximately 22 knots and to make sure that she would pass us at a safe distance I started to plot this vessel. After 15 minutes we passed the oncoming vessel and we returned to our original course of 259°.

After we returned to our original course I noticed that the CPA with the overtaking vessel was nil. I kept monitoring the CPA which remained nil.

When the vessel was approximately 1.7 miles away, I called her on the VHF. After going to a working channel, I asked her duty officer what he considered to be a safe passing distance with other ships. He then replied that we need to keep our course and speed and that he will pass with no problem. Since the duty officer did not reply to my question I again asked him what he considered to be a safe passing distance, whether he considered 1 cable or 2 cables or more a safe passing distance. I then heard him laugh on the VHF and he then informed me that it might be zero cables. My reply to him was that I found him very funny but that I would like him to pass us at a safe distance of minimal 5 cables, half a mile. By this time the vessel was at a distance of about one mile.

He was then called by the Vessel Traffic System station on VHF channel 16. By this time I noticed that the overtaking vessel had started to change its course. Her duty officer informed the VTS station that he was changing course and that he now had a CPA of 5 cables and that he did not understand what "this guy" wanted. The vessel passed us at a distance of 5 cables just before midnight.

**CHIRP Comment:** We sent a disidentified copy of the report to the manager of the overtaking ship and we received a comprehensive reply. The company had contacted the Master who had not been on the bridge at the time, but had discussed the report with the duty officer. The officer stated that he had another vessel ahead of him on the same course, less speed, plotted on the radars. The CPA was zero with TCPA 15 minutes or more. At the same time there were a few vessels on the port side on the same and opposite courses. On his starboard side he had a vessel on an opposite course, CPA about 1 mile and TCPA a few minutes.

The Officer talked to the vessel being overtaken and said that after the vessel on the opposite course on his starboard side had passed clear, he would pass the vessel being overtaken at a safe distance. The person on that vessel then started asking him questions as to what he considered to be a safe distance. He took exception to this questioning as he construed them as instructions from the other ship. He categorically denied that he was laughing. The Officer stated that the VTS station subsequently called him on the VHF and he explained his intention, by which time the CPA was 0.6 to 0.7 miles. It is not the role of CHIRP to attribute blame but rather to facilitate learning from hazardous incidents. In this respect, we make the general comment that it is often the case with reports received by CHIRP that the OOW on the give way vessel where there is a small CPA does not appreciate the anxiety being felt on the bridge of the stand-on vessel. Rule 8 of the ColRegs specifies that "Any action taken to avoid collision shall, if the circumstances of the case admit, be positive, made in ample time and with due regard to the observance of good seamanship."

Whilst recognising that VHF is frequently used, considerable care is needed that communications are not misconstrued. The content and tone of inter-ship communications should be professional and concise. (Refer to the Marine Guidance Note MGN 324 regarding "Operational) Guidance on the Use of VHF Radio and AIS at Sea").
**FIRE FROM SHORT CIRCUIT**

*Report Text:* Background - During a previous refit, a new radar had been installed on board. During installation, all old wiring had been removed and replaced by new cables. The new system has been installed by a Servicing Company.

Accident - Because the cables were too long, slack had been left behind the chart shelf. Unfortunately the slack had not been secured and, during many years of the shelf being moved in and out, a shearing force had been applied to the 12 volt cables. This finally resulted in a short circuit which burnt the cable before the fuse went, as shown in the photograph:

Further investigation disclosed another cable from the radar installation being partly damaged in the same way by the same shelf. This was the 220 volt power supply. A short circuit on this cable could lead to an electrical fire on the bridge, causing major damage to the vessel.

Remedial action: After the wiring had been repaired, the following countermeasures were applied:

1) All radar wiring was checked for any kind of damage.
2) Slack in the cables has been picked up and the cables have been secured by cable ties.
3) Other bridge equipment has been checked for slack cables and signs of wearing.

Lessons learned: The work of service teams must be checked. It is strongly advised that service engineers carrying out such installations should be accompanied by an appropriate member of the ship personnel.

*CHIRP Comment:* As the reporter has correctly identified, the incorrect installation of the cables could have resulted in a major fire. This highlights the importance of having and implementing a good procedure in the ship’s Safety Management System regarding changes to the vessel’s equipment and systems. This should include, risk assessment, planning of the work and supervision.

**INSECURE GUARD RAIL**

*Report Text:* On the cruise liner on which I was a passenger, it was necessary to be transported from ship to shore by ships’ tenders. The safety rails on these tenders have to be assembled after launching. On nearing the shore landing stage, while the tender engines were being used to manoeuvre the boat alongside, a passenger on the upper aft deck almost fell over the stern when the guard-wire attachment "string" broke. If it were not for the passenger sitting next to him grabbing his arm, he would have fallen over the stern. Looking at this "attachment", it was obvious that it had been tied and cut a few times previously. This guard-rail attachment should have been either a shackle or pelican hook fitting.

I reported it to the hotel staff member on shore, and also to the ship purser desk, where I was assured that my report would be forwarded to the deck department, and I would be contacted. I am still awaiting contact.

*CHIRP Comment:* This incident highlights the importance of a proper procedure for managing reports of non-conformances. The person making the report, whether a passenger or a crew-member, should be given feedback on the remedial action taken.

We have alerted the manager of the ship.

**HYDROSTATIC (NON!) RELEASE UNIT**

*Report Text:* Whilst travelling as a passenger on a vessel, I noted that the hydrostatic release unit (HRU) on a life-raft valise had been incorrectly fitted. In the event of the vessel sinking (albeit unlikely) the liferaft would probably have been pulled down with the ship. I sent a message to the company. They promptly thanked me for having advised them and advised that the non-conformance had been rectified. They also advised that the valise contained a Means of Rescue rather than a liferaft. I attach a photograph of the incorrectly fitted HRU.

*CHIRP Comment:* The HRU had indeed been incorrectly rigged. As shown in the photograph, the painter had been lead through the shackle connected to the webbing securing the valise. Therefore, if the HRU had been activated, the painter would have remained connected to the webbing strap and thus to the ship.

In contrast to the previous report, the reporter was given prompt confirmation that the issue had been addressed.

There is a general lesson that the HRU was visible to the ship's staff but nobody had previously noticed that it
was rigged incorrectly. It is useful for members of the ship’s safety team to carry out walk-around checks of the vessel so that such aberrations are spotted and corrected.

Marine Guidance Note (MGN) No. 362 issued by the Maritime and Coastguard Agency, regarding the servicing of liferafts etc., highlights that there have been incidences of incorrectly installed HRUs resulting in compromise of the float-free arrangements of liferafts.

Diagrams showing the correct installation of various types of HRU can be found in MGN No. 343 on Hydrostatic Release Units - Stowage and Float Free Arrangements for Inflatable Liferafts.

Here is also a useful illustration from the safety training manual of a fishing company.

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COMMERCIAL & FISHING SECTORS

FISHING VESSEL LIGHTS & AIS INFO

Report Text: I was on a vessel on passage Eastbound through the Channel. Our vessel was not restricted by draft. The sequence of events described below occurred during the early evening in clear visibility but during the hours of darkness.

After reporting to Cap Gris Nez at Basurelle, course was set for the next leg to ZC 1 buoy. Radar plot using ARPA was continued and a number of small targets were noticed on the port bow. One of the targets was noted to be proceeding at a speed of 10 knots on the reciprocal course to the direction of the TSS. Initial visual identification by the lookout was for a vessel restricted in her ability to manoeuvre; this was confirmed by interrogation of AIS equipment. CPA from ARPA was showing a small 3 cable clearance on the port side.

Own vessel was being overtaken on the starboard side by two vessels. I contacted the closer of the two (a container vessel) and informed him that I intended to alter to starboard to increase my CPA with the vessel proceeding towards me. The OOW on the container ship was aware of the situation and agreed with my action. During the period we were closing it occurred to me that normally for vessels restricted in ability to manoeuvre, Gris Nez would include the details in the hourly broadcast. At around two miles distance I observed the lights of the vessel to be the lights for a vessel engaged in trawling (rule 26) but additionally showing two all round red lights.

These red lights could be for either:
1. A vessel not under command or
2. A fishing vessel, fishing in close proximity to others, when the net has come fast upon an obstruction. (ColRegs Annex II).

Since the vessel had been noted earlier doing 10 knots neither of these seemed likely. The vessel passed close down our port side, then altering course and reducing speed to pass very close under our stern.

After the fishing vessel had cleared I called Cap Gris Nez on Channel 13 to report the incident. They contacted the fishing vessel and a discussion was held in French, which unfortunately I do not speak. Shortly afterwards a photograph was taken of our AIS (a copy of which was provided to CHIRP).

CHIRP Comment: We liaised with the Channel Navigation Information Service Manager at Dover. He advised that in recent months, a number of fishing vessels have been engaged in “fly-shooting” in the Channel. This involves throwing a buoyed rope over the side, proceeding at full speed for a considerable distance, launching the net whilst making radical turns so as to return to the rope end. The fish are thereby corralled. In a Traffic Separation Scheme, such manoeuvres could cause confusion to other vessels and should not be carried out.

The reported incident is being followed up by the Authorities in France.

Contraventions of the Traffic Separation Scheme should be reported immediately to the UK or French Authorities, as the reporter did in this case.

We note that the skipper of a leisure cruiser was recently fined £20,000 by magistrates in the UK for proceeding for 26 miles against the flow of traffic in the South West Lane of the Dover Straits TSS.

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LEISURE SECTOR

A COSTLY GROUNDING

Report Text: I left the lock in my power boat. It was early afternoon, the weather was fine and the sea was a near flat calm. We were half an hour off a low spring tide.

I had three people on board and intended simply to run down the channel for 30 miles or so, cross over and then return, which would take about three hours. Although a reasonably experienced sailor, this was my first power boat which I had owned for about a year.

I was number two out of the lock gates, the boat in front being a large recreational fishing boat. As we entered the navigable channel, the fishermen cast their lines...
from rods. I backed off and came slightly to the port side of their vessel to ensure I didn’t snag their lines. My speed was no higher than six knots and they were doing the same sort of speed.

Without any warning my boat stopped dead. I immediately selected neutral on both engines which continued to tick over. Having made sure the other two people on board were ok and that they had their life jackets on I went below to check the integrity of the boat. There didn’t seem to be any damage and certainly there was no water entering the boat. I decided to try and see if the boat would move but it was stuck fast.

I contacted the Harbour Control by VHF and informed them of my predicament. They could clearly see my vessel on the edge of the navigable channel. I did not declare an emergency but recognised that if I had ropes wrapped around my props and they were tethered in some way then as the spring tide changed to flood I would quickly have the stern under water. We were now on a turning tide!

I considered my actions for what seemed like 20 minutes but was probably no more than 2 minutes. I decided to try and raise the out-drive legs and free the boat. The boat continued to be stuck fast and I couldn’t see what was holding it back. I began to consider that maybe she was aground but my fear remained that I had rope around the stern which would hold her down!

Going over the side to investigate didn’t seem a sensible option. I decided to try and get free by driving her astern. Before doing so I got the crew to prepare to launch the life raft. This gave them something to do and also made me feel better!

I then got the crew holding on and powered the boat backwards. At just before full power she suddenly moved and was floating. The engines drove her astern for about 20 metre at which point I put the engines in neutral. Another check of the boat confirmed that there was no apparent damage and certainly no water ingress.

However, when I tested the engines the boat wouldn’t go above two knots! I had obviously damaged my out-drives/props. I crawled back into the locks and got back to my berth.

When my boat was lifted it was confirmed that I had driven my boat onto rocks. The props were almost nonexistent although I think that that’s more due to me driving it off rather than the initial incident. Another skipper informed me that he had replaced his engine in less than two weeks before.

Throughout my incident I was in touch with the lock control and they couldn’t have been more professional or helpful. I caused this problem and although my good intentions cost me a couple of thousand pounds I very much put the cost down to experience.

Lessons Learned.

i. Be more aware of the full effects of spring tides.

ii. Recognise how potentially dangerous it is for a boat to stop dead even from a low speed. The boat stops but the people don’t! At 30 knots I dread to think of the impact on the people on board.

iii. If you can avoid it don’t go out from restricted water at low water on a spring tide.

iv. Take more note of strong tidal flow.

v. Consider slowing down in a restricted channel rather than moving to the edge of the channel if you need to avoid a vessel in front of you. After all the extra 5 minutes means nothing when on this sort of trip.

vi. Lessons for others include don’t start your recreational activities such as fishing until other vessels can safely get round you even though you may be within your rights to so do.

vii. It turned out that several vessels had had the same problem as me in the weeks before. Immediately after my incident, warnings were being put out that there were some uncharted obstacles outside the locks. It would have been useful if this general warning could have been made beforehand although I tender no criticism of the controllers!

**CHIRP Comment:** We were pleased to read the reporter’s description of the lessons learned. It is always good that the skipper and those on board endeavour to identify the lessons from accidents and near-misses.

We also suggest the following general lessons:

1. **Passages should be planned.** A passage plan would have identified the risk of grounding. The techniques of passage planning can be obtained from an appropriate RYA course and certification.

2. **Sounding around using a pole or boat hook may possibly have given an indication on whether the boat was aground on soft mud or hard ground, or fouled by ropes, or possibly may have hit the sinker of a navigation buoy.**

3. **It appears from the report that the vessel was not in immediate danger whilst she was aground. It may well have been the use of full astern power in driving her astern from the grounding position that lead to the damage. With hindsight, it may have been useful to have spent more time considering the options. This could for example have included a tidal calculation to estimate when the boat would have re-floated with the tide without so much engine power. (If this had been adopted, use of an anchor to hold the vessel whilst re-floating may have been appropriate.)**

4. **In general, it is useful to think about contingency plans for various eventualities, including grounding, engine breakdown, man-overboard etc, and to discuss these with your crew. Where appropriate, contingency plans should be practiced, particularly man overboard.**

5. **It was prudent to contact the Harbour Control as soon as the incident occurred, as the reporter did, so they would be on the alert had the situation worsened. In other areas, it would have been appropriate to notify the Coastguard.”
Fatigue

Letter Text: Your editorial to issue No. 25 on the topic of “Fatigue” was interesting. Not in only its content but more importantly in what it did not include.

I refer to the minimum manning certificate issued by flag state. This needs urgent attention.

As an example, a particular coastal vessel has a minimum manning certificate requiring 1, Master; 1 Officer of the Watch (OW), 1 Engineer, 2 AB’s and 1 cook/AB. Total: 6 crew members.

The Master and OOW work six hours on, six hours off. The engineer works day work, (providing all is well on board). The two AB’s allegedly keep a watch during the hours of darkness and as much day work as possible, not forgetting deck work for arrival, sailing and cargo work in port.

The two AB’s are assisted by the cook/AB when he is not on duty cooking and running the catering side of the ship.

On this class of ship, most Masters and Officers of the Watch are required to hold pilotage exemptions for the main ports that they trade to.

All in all, one has to ask the question “Is it any wonder that ships watch keepers fall asleep?”

Flag state and local port state control have to be held responsible for such ludicrous manning compositions. Can Port state control step in and hold a ship in detention if they consider that the manning composition is considered unsafe? I would argue, yes they can. If the manning composition is such that fatigue is the end result of the level of manning, then the ship is unsafe and can and should be detained. The ship should, in my opinion, also be detained if it is shown that the records of rest hours have been falsely recorded.

CHIRP Comment: In the Editorials, we are constrained by space on how deeply and widely we can address issues. In the Editorial in the previous issue of MARITIME FEEDBACK, we did not attempt to cover the subject of manning levels. Nevertheless, there is indeed an issue with manning levels, particularly on small cargo vessels trading in Europe on which the navigation watches are shared between the Master and one Mate. The Marine Accident Investigation Branch has flagged this, and the Maritime and Coastguard Agency has raised the issue at the International Maritime Organisation. However, there was strong resistance from a number of states to changing the convention requirements.

Scrutiny of records of hours of rest after some accidents with these vessels have demonstrated that there may well have been non-compliance with the regulations. In February 2010, the MCA announced a clamp-down on ships that are flouting hours of rest requirements. Ships operating busy schedules with small crews will be targeted. As well as hours of rest, surveyors will also be checking for compliance with the requirement for a dedicated look-out at night. The MCA will also be looking for evidence of the company’s audit of records. More information on this can be found on the MCA website in the February Press Releases.

We will be following with keen interest the progress of Project Horizon, a 30 month project which started in June 2009. It is researching the effects of fatigue on the cognitive performance of maritime watch-keepers under different watch patterns, using ship’s bridge, engine and liquid cargo handling simulators. Further information can be found on www.project-horizon.eu.

In the CHIRP Editorial, we encouraged mariners to report any concerns regarding fatigue. If you wish to report a concern in absolute confidence, please do contact us. We will discuss with you how best to progress the matter without your identity being disclosed.
LESSONS LEARNED

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

CHIRP is totally independent of the MCA and any organisation in the maritime sector

Name:  
Address: 
Post Code: 
Tel: 
e-mail:

1. Your personal details are required only to enable us to contact you for further details about any part of your report. Please do not submit anonymous reports.
2. On closing, this Report Form will be returned to you. NO RECORD OF YOUR NAME AND ADDRESS WILL BE KEPT
3. CHIRP is a reporting programme for safety-related issues. We regret we are unable to accept reports that relate to industrial relations issues.

Please complete relevant information about the event/situation

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Your Vessel

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Description of Event - Photographs, diagrams and/or electronic plots on a CD are welcome:

Your narrative will be reviewed by a member of the CHIRP staff who will remove all information such as dates/locations/names that might identify you. Bear in mind the following topics when preparing your narrative:

Chain of events • Communication • Decision Making • Equipment • Situational Awareness • Weather • Task Allocation • Teamwork • Training • Sleep Patterns

continued on reverse