

CHIRP FEEDBACK

Issue No: 28

New Year 2011

EDITORIAL

CONFIDENTIAL REPORTING

In selecting reports for publication in this issue, we have an over-riding constraint in that we will not publish a report if this could compromise the confidentiality of a sensitive matter. This means that we are not able to publish some reports that would illustrate well the value of a confidential reporting programme, as in doing so might give a clue that a seafarer has reported his or her concerns to CHIRP.

We addressed the subject of confidential reporting at a recent safety conference where we postulated a situation in which a seafarer is concerned at standards on board his/her vessel, but feels unable to get these resolved. Ideally, the seafarer should feel able to discuss the concerns with senior officers or with the Designated Person Ashore (DPA). However, even if the DPA genuinely believes he has an "open door policy", some seafarers may still be reluctant to raise issues.

In such circumstances, the seafarer can report their concerns to CHIRP. We will first discuss the issues with the seafarer and agree the course of action. If he/she is unwilling to contact the DPA directly, CHIRP may offer to do this. If the issue involves a serious breach of regulations, we may propose that CHIRP should alert the appropriate authority. Whatever action is agreed, we do not disclose the identity of the seafarer.

In previous issues of this newsletter, we have given an update on the status of the future funding by the UK Department for Transport of the CHIRP Maritime Programme. At the time of writing, this has been agreed until the end of this financial year, but we await a Ministerial decision regarding the longer term.

If you wish to show practical support for this Programme and for learning from near misses, then please be the person who reports the hazardous incident. Don't leave it to someone else!

Here is a suggestion for a New Year's resolution:

In 2012 I will play my part in improving maritime safety by watching out for hazardous incidents and reporting them.

We look forward to hearing from you.

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

PIRACY IN SOUTH CHINA SEA

Report Text: I was Officer of the Watch on the mid-night to 0400 watch. My vessel was on a course 040°, speed 19.5 knots, off the Anamabas Archipeligo. There were a few commercial vessels and fishing vessel in the area. At about 0100 hours I also observed two small unidentified targets appear on our radar screens to the NNW at 12 miles. I also saw thick low clouds forming and developing in that direction. The two targets became lost in the rain clutter.

At 0200hrs we received a distress call alert from a tanker in the vicinity advising that they had been boarded by pirates. About thirty minutes later, there was a call on VHF Ch 16 from the tanker advising that the pirates had departed with stolen property.

Lessons learned: Thick low clouds and rain may provide a hiding place for pirate craft. Keep a careful radar watch on such areas, adjusting range and rain clutter accordingly.

CHIRP Comment: The Oil Companies International Marine Forum, with the support of other industry organisations, has published "PIRACY - The East Africa / Somalia Situation - Practical Measures to Avoid, Deter or Delay Piracy Attacks." This can be accessed via their website www.ocimf.com.

Whilst it specifically refers to the East Africa situation, it contains advice which may be applicable in other areas and to all types of vessel.

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

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OVERTAKING OR CROSSING?

This is a summary of a report from the Master of a vessel that had sailed from a port on the East coast of the UK in daylight and good visibility.

Report Text: We had just left port and were steering 045 degrees and doing 12 knots. A Roll-on/Roll-off vessel heading to the North according to the AIS was coming up behind us and was going to overtake on our starboard side at a distance of 8 cables. That was the situation when I came up to relieve the Mate for his dinner.

I went to the aft end of the bridge to have a look at a nearby fishing vessel as it had gone into the radar blind spot. When I was satisfied that it was going to pass clear I returned forward and noticed the collision alarm on the radar. The Ro-Ro had altered course to port and had closed the Closest Point of Approach to 0.5 cables with a Time to CPA of 5 minutes. I put the wheel over to port and steadied up on a northerly course and opened the CPA up to 0.8 cables again. I kept my eye on the ferry and within minutes it was altering course to port again. I called the ferry up on VHF channel 16 to ascertain that she had seen me and the officer on watch asked me to go to channel 06 and said to me that he had an alter course position to get to and he would pass ahead of me. I said that was OK but could he please wait until he was past and clear off me before he altered course again. I slowed down to approx 9 knots and the ferry was doing approx 17 knots. I was restricted in slowing down any further due to the fishing vessel astern of me. The mate came back up to the bridge at this point and the ferry altered course again and crossed our bow at half a mile. The mate called up the ferry and asked if he thought half a mile is an acceptable distance to cross ahead of another vessel and he said since he was going much faster than us then there was no problem. We then watched him cross the stern of the other supply boat at approx half a mile again.

CHIRP Comment: We do not have data recordings from either vessel, but, from the report and also from information received from the manager of the Ro-Ro, we surmise that the reporting vessel had initially been proceeding on an Easterly course out of port before picking up her North Easterly track, whilst the Ro-Ro was Northbound. If the vessels were in sight of each other at the time, this would imply that this was a crossing situation, with the reporting vessel being the give-way vessel. Even though the reporting vessel may subsequently have altered course to port onto her planned North Easterly track, this would not have changed the crossing situation into an overtaking situation, or relieved her of the obligation to keep clear of the Ro-Ro. As the stand-on vessel, the Ro-Ro would have been obliged to keep her course and speed.

If this interpretation of the situation is correct, it highlights the importance of

- Early identification of the traffic situation on leaving harbour.
- Recognition that a crossing situation may exist with another vessel broad on or abaft the starboard beam.

- Comprehensive description of the traffic situation when the watch is being handed-over.
- Not giving precedence to keeping to the planned track over compliance with the ColRegs.

INCORRECT AIS DATA

Report Text: It would appear that for the last couple of weeks the AIS heading information on a vessel regularly visiting our port has been incorrect. This could result in some considerable confusion in a close quarters situation at sea.

CHIRP Comment: We immediately contacted the ship's manager, who contacted the ship. It transpired that the heading information being transmitted by AIS was about 25 degrees in error. The fault was rectified.

This highlights that, in assessing a traffic situation, absolute reliance should not be placed on the accuracy of information being transmitted by AIS, or on a single source of information. When possible, check the accuracy of the AIS data being transmitted by your vessel.

IMPEDED BY LEISURE CRAFT

Report Text: My vessel was proceeding out from her berth under pilotage with an experienced bridge team and pilot on the bridge. The vessel was constrained by her draught and displaying the appropriate signals. Approximately one mile ahead was another large vessel.

Upon leaving the berth we had an escort launch for the initial part of her passage. There were a large number of pleasure craft in the area. After departure of this escort, a number of speed boats approached the vessel and came within metres of the ship's side, seriously endangering themselves in the process.

Subsequently, as we approached a large turn in the channel, a sailing vessel crossed the buoyed channel and ahead of us at a very close range. Five short blasts were sounded but with no apparent response from the sailing vessel.

During the subsequent passage, two more pleasure craft impeded our passage and caused great concern to the bridge team and pilot. On each occasion 5 shorts blasts were sounded by my vessel. Appropriate sound signals were also made prior to the commencement of the turns.

The local Harbour Master launch was asked to reprimand the vessels however only one of them could be found amongst all the other pleasure craft in the area. The names/sail numbers of the vessels were taken by the pilot so that he could make a report to the Harbour Master.

CHIRP Comment: We contacted the Harbour Master who advised that he was already fully aware of this incident reported. The patrol launch provides escort to the majority of large vessels transiting in the area where these incidents took place. However it is not always possible to allocate a launch to each individual vessel. Therefore, education of recreational sailors in the area is a key priority. He and his staff give presentations to the recreational sector highlighting many of the issues

raised in the report.

It is of concern that a minority of leisure sailors do not recognise the risks to themselves by un-seamanlike manoeuvres or to the anxiety thereby caused to other mariners. The close approach of small craft may also lead to security concerns.

Harbour Authorities put considerable effort in trying to improve matters, as this Harbour Master has described. At major ports, forums for all port users, commercial and leisure, have been established. In some areas, experienced volunteers endeavour to persuade transgressors to improve their boat handling and seamanship.

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.

STRUCK BY CRANK HANDLE

Report Text: The incident. The Chief Engineer and Second Engineer were attempting to start the lifeboat engine. This is a hand start engine with a starting handle. The Chief engineer was rotating the handle when it slipped off the starting shaft and hit him in the face. There were no visible injuries to be seen directly after the accident but soreness and bruising was felt later in the day.

Apparent cause of accident. On inspection of the starting handle after the accident, it is clear this was not the correct approved starting handle for this engine but appears to be an extremely poorly fabricated handle with origins unknown and totally unsuitable for the job.

When starting the engine the correct handle is manufactured in such a way that a clutch pin (pawl) engages with a keyway on the starting shaft. This stops the handle slipping off the shaft. The starting procedures and precautions as laid out in the manufacturer's manual, and the Life Saving Appliances manual, clearly states to use only the correct starting handle, and not to use the handle if it is damaged in anyway. The handle was not inspected before use. The correct handle which was also in the boat was not used.



Actions taken to prevent re-occurrence. Incorrect handle removed, to be disposed of. All crew informed of this accident at a drill/meeting where safety precautions & procedures in starting the engine refreshed again. Copy of starting procedures placed inside the engine compartment. The accident also used to highlight importance of risk assessment at a shipboard toolbox talk, where all crew members were involved in formulating a risk assessment for this procedure.

CHIRP Comment: This painful accident had the potential for more serious injury. The manager has taken learning from this specific incident to highlight the importance of assessing the risks of a task before carrying it out, including work which may at first sight appear to be routine.

This particular risk with a crank handle can also occur on some fishing vessels and leisure craft.

As advised in Issue 26 of this newsletter, reports of primary interest to the leisure sector will be published in the full edition of MARITIME FEEDBACK and is available on our website: www.chirp.co.uk, but not in the hard copy distributed to ships.

Maritime & Coastguard Agency 24hr Info No:

0870 6006505

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

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LEISURE SECTOR

RESCUED FROM SEA

Report Text: My partner and I were looking forward to a pleasant day out on our recently acquired 38 ft motor yacht. A couple were to join us. The forecast was dry and sunny but with a South West force 4-5 wind. Our destination was only 30 minutes away.

On the return trip in the late afternoon, conditions had now worsened, with wind strength at 20 knots with 30knot gusts. We had just got our yacht up to a prudent 18 knots checking all was ok with engines, course etc, when we noticed three sets of arms waiving frantically. As we got closer we heard plaintive cries for help. The lads, aged between 15 and 22 were in the water, and worse still a fast ferry was bearing down on them.

What to do? We dare not move out of the way for fear of the ferry running them down if she did not see them. We moved over to them, stopped, and I put out an "ALL SHIPS" on channel 16, stating who we were, where we were (roughly), and what we were doing, and asked the ferry to bear away and slow down. Thankfully he did! I also added that any assistance from any rescue services in the area would be greatly appreciated.

The Coastguard responded immediately informing us that the R.N.L.I. RIB was to be dispatched!. We now set about getting the casualties aboard.

My guests went aft, leaving me to the helm and responding to what seemed like the world and his wife calling me for information. I was at the same time being given updates and instructions from aft, but felt strangely insular from what was going on back there. I was advised that one of the casualties had now slipped under the bathing platform, and that I should not use the engines. This left us to the mercy of the wind and we turned broadside and started rolling through 30% or so.

To my horror I noticed that the third casualty was drifting. He was 20-30 metres away. I gave one of my guests the task of not letting him out of sight.

As I couldn't use the engines, I went aft to see what I could do. The dinghy is on davits, which means access to the bathing platform is very restricted when it is up. The horseshoe lifebelt had refused to detach from its carrier and the light and floating line were all tangled up.

My idea had been to lower the dinghy, thereby releasing a great deal of low deck area, and also possibly using the dinghy as a first stop rescue point before getting them onto the boat, but I was too late. With a superhuman effort, one of my guests had been able to get one of the casualties on board. The other was trying unsuccessfully to squeeze himself between the back of the platform and the dinghy. The space looked no wider than the width of a letter box, but between us we managed to drag him aboard also.

I got back to my helm and the radio. I was able to inform the Coastguard that we had picked up two of the casualties, that we had been joined by another cruiser, which was recovering the third casualty.

On later contacting the Coastguard by telephone, they informed me that the time taken between my All Ships

and getting the casualties aboard was eleven minutes, although it had seemed like an hour!

We now had three RIBs in attendance, and all trying to talk to me at once. Also the Coastguard was trying to establish that the casualties were now out of the water. The radio was not silent for a second it seemed. Quite a lot of pressure!!

The RIBs put three men on board to assist. We were instructed to take the two casualties we had recovered back into the nearby port, with the lifeboat-men on board. We were then joined on shore by a paramedic. One of the casualties was in a bad way with shock, hyperthermia, and had also swallowed some sea water.

We later learned that all three had recovered.

What were they doing out there? They had been washed off their jet-ski, although there was no sign of it on our arrival at the scene. They were all wearing wet suits, but only one had a life vest.

My observations of what went on in those few minutes lead me to muse how I might have done it differently.

Should I have called the ferry, got a reply, and then put out a MAYDAY RELAY, or have pressed the red button on my VHF, I don't know.

We do not usually wear lifejackets, however I had offered them to our guests, and they had refused. Once the operation had started, there was no time to don them. Obviously it would have been safer to have had them on already. We will probably alter our way of thinking on that one.

A good safety briefing may have helped.

I should have made sure that the horseshoe lifebelt was readily deployable.

CHIRP Comment: It was heartening to read of this successful rescue. Had it not been for the prompt action and seamanship of those on the motor yacht, on the rescue craft and on the ferry, the lives of the jet-skiers may have been lost. We are pleased to comment as follows on the "Lessons Learned" as described in the report:

1. The skipper acted absolutely correctly in identifying the risk from the propellers to those in the water near the stern, and therefore not using the engines, and in posting a look-out to keep sight of the third casualty.
2. As the persons in the water were in grave and imminent danger and immediate assistance was required, a MAYDAY RELAY call would have been justified. This would immediately have alerted the Coastguard. Alternatively, had the red button on the VHF DSC set been activated, the Coastguard would similarly have been alerted and would have responded to the yacht. In the event, the ALL SHIPS message was immediately heard by the ferry and by the Coastguard, who responded as if the call had been a distress message.
3. It is salutary to note the comment that, once the operation had started, there was no time to don lifejackets. There are a number of lessons from this:
 - The skipper should set an example and wear a lifejacket.

- Be courteous but firm with guests on boarding, perhaps saying something like "On this boat we follow RNLI advice to always wear lifejackets."
 - Despite the urgency of the situation, it would have been advisable to have taken two minutes to discuss the proposed rescue and the precautions for the rescuers. (In some shipping companies, such a safety check is referred to as "Take Two".)
 - The precautions would include donning lifejackets and possibly safety harnesses before working on the stern platform. Had one of the rescuers fallen overboard whilst trying to assist those in difficulty, the situation could quickly have compounded.
4. A safety briefing on boarding is indeed good practice.
 5. Safety drills, including man-overboard exercises, can be very valuable in training for "the real thing". They help to identify glitches, such as a tangled life-buoy line, and improve the confidence of skipper and crew in handling emergency situations. Such drills do not need to be arduous on a leisure craft and, indeed, can provide an interesting activity during the voyage.

CHANNEL ENCOUNTER

Report Text: We were approximately 11NM north of Cherbourg's outer breakwater, 2.5hrs into our passage towards the Needles Channel on our sailing yacht. My one crew and I were well-rested and both on watch. My crew was steering while I concentrated on navigation. We were both keeping a good lookout, especially as we were approaching the eastbound shipping lane. My vessel is equipped with a VHF radio, GPS and a stand-alone radar, but no chart plotter, AIS system or DSC-enabled VHF) We carry a medium-sized radar reflector permanently mounted on the mast.

Our yacht was on a heading of 000 degrees, fine-reaching into a west-north-westerly force four with some gusts, and there was a slight to moderate swell from the west-south-west. We were making between 4.5 and 5.0kts through the water under all plain sail. The weather was fine and visibility very good.

At 1133 BST I saw the first eastbound ship in the distance and noted its bearing as 315 degrees using the hand-bearing compass. As a check I also marked the ship as a contact on our radar..

At 1139 the ship, now close enough for its red hull colour to be clearly discernable, was still on the same bearing of 315 degrees, and a quick check of the radar showed the contact directly on the EBL indicating a possible collision. There was no shipping visible ahead of the red vessel, although a more distant vessel astern of it had also been sighted on a bearing of 300 degrees. At this stage I attempted to contact the red ship's bridge on the VHF. Although unable to properly identify the vessel by name at this distance even using binoculars, I called up the vessel "Red ship, red ship in approximate position 49 deg 54 min N 1 deg 30 min W" twice on Ch16, then on Ch13, but without any response.

I was now extremely concerned that this ship did not appear to be aware of our presence, nor of the

developing close-quarters situation. At about 1145, with the ship now less than 0.4NM away and on the same bearing of 315 degrees, I told my crew to bear away sharply (ie turn clearly to starboard) in an attempt to avoid being run down. Now sailing by the lee, with the wind almost dead astern, our attention was fully on ensuring that the yacht gybed safely around. When we turned to look astern, we saw the red ship at a distance of no more than about 300-400m altering violently to starboard, heeling as it turned.

After the red ship had safely passed under our stern, we quickly resumed our original course and I made no further attempt to contact it, my attention now focused on the next eastbound ship approaching in the middle-distance.

Lessons Learned: My immediate thoughts after this near-miss concerned whether the red ship had indeed be aware of us early on, and had - before we turned to starboard - originally planned to pass astern of us by a narrow margin. However I quickly came to the conclusion that this was unlikely as the CPA was always too tight and it would have been extremely hazardous to have risked doing so. This, and the fact that we had got no response to our VHF transmissions, confirmed my original view that the ship was completely unaware of our presence until the last moment (possibly it was only our changing aspect as we gybed around that alerted him to our position right on his bows). I also immediately decided to treat ALL commercial vessels in the shipping lanes with even more caution than usual, later on bearing away or gybing around early, despite being the stand-on vessel, to ensure that two other ships which were approaching on barely-changing bearings passed safely ahead of us. One of these vessels which passed close ahead of us, also didn't respond to my transmissions on Ch16.

My subsequent thoughts (not substantiated by any professional maritime experience) questioned whether commercial shipping now relies solely on other vessels, including leisure boats, being widely equipped with DSC and AIS - assuming that they will usually be contacted directly only using only modern digital means rather than traditional VHF broadcasts.

POSTSCRIPT: Concerning a reassuring encounter later on the same passage. Under power only and with navigation and steaming lights on, at 2145 BST off Bembridge Ledge on the Isle of Wight and heading north towards Portsmouth, a large ferry approached us heading south-west at slow speed. I was about to shine a 12v spotlight onto our deck, when a powerful searchlight from one side of the ferry's bridge briefly illuminated us, turning off after a second or two. Although surprised by how close inshore the ferry was operating, I was most reassured by its slow speed and use of searchlights.

CHIRP Comment: The yachtsman acted correctly in keeping a careful watch on the approaching vessel, and in not assuming that officer of the watch had seen him. It is important not to make such an assumption as it can be difficult to spot the white sails of a yacht amongst white-topped waves from the bridge of a ship. Furthermore, whilst the fitting of an effective radar reflector is very prudent, it still does not guarantee that

a yacht will be detected. (The MAIB report on the loss of the yacht Ouzo (Report No. 7/2007) describes the issues that can impact on the efficiency of radar reflectors.)

In saying this, we do not condone the failure of a ship to keep a proper look-out.

From the account, we share the assumption that the red-hulled ship had not seen the yacht until a late stage. The yacht took appropriate action to avoid collision under Rule 17 of the ColRegs when it became apparent that the ship was not taking appropriate action.

The yachtsman mentions that this ship and another did not respond to a call on VHF channel 16. Although many ships keep a listening watch on channel 16, it is no longer mandatory to do so. The advent of the Global Maritime Distress and Safety System has meant that all emergency, safety and routine messages are received without needing a dedicated listening watch. When a message is sent to and received by a specific ship, an audible alarm is sounded on the bridge.

Digital Selective Calling (DSC) is a component of GMDSS. Whilst it is voluntary for small craft used solely for leisure purposes, the UK Maritime and Coastguard Agency strongly recommends that these vessels have DSC radios. More information can be found in the MCA leaflet No 103 which can be accessed via www.mcga.gov.uk/c4mca/gmdss.pdf or by entering mca dsc in a search engine.

To send a message to a specific ship, you need to know its Maritime Mobile Service Identity (MMSI) which can be obtained from its Automatic Identification System transmission. Therefore it appears implicit in the recommendation to have DSC radio that you also need an AIS receiver if you wish to call other vessels to obtain assurance that you have been sighted.

In summary, our general advice to yachtsmen is:

- Be aware of the possibility that you have not been seen.
- Be prepared to take avoiding action, as prescribed by the ColRegs, in good time.
- Sail defensively.

NON-WATERTIGHT BULKHEAD

Report Text: Over the winter I had had the anchor windlass overhauled with new heavy duty cables passing through a watertight bulkhead to a new dedicated battery isolating switch placed in the fore-cabin under the bunks on my yacht.

We were carrying out a fast heavy weather passage coastal passage with the anchor locker constantly immersed in short steep waves. I heard water in the bilges, which had never occurred before. On lifting floor boards there was clearly a large ingress of seawater! Bilge pumps were activated and buckets employed and the level quickly reduced. A systematic check of all sea-cocks, rudder and prop shaft showed no ingress of water.

The engine and services batteries were dry. The engine was started, sails stowed and we proceeded to a sheltered bay to investigate the cause of the ingress.. The fore-cabin was inspected and revealed the

compartment under the bunks containing new battery etc. flooded.

When the water-tight bulkhead was inspected, the cause became obvious. The holes through which the windlass cables passed had been sealed with a sealing compound. This had all pulled away as the cabling in the anchor locker had moved/flexed in the rough passage encountered.

The cabling was secured and holes resealed. The flooded compartment was emptied, washed down with fresh water and all electrical components dried and sprayed with WD40. A drowned solenoid was later discovered to be the only damage and the reason for the windlass no longer working

Lessons Learned:

1. Inspect bilges more frequently.
2. Always fully inspect work carried out. The length of heavy cable between bulkhead and windlass contributed to the sealant working loose and if cables were secure, the seal would probably not have failed.
3. In retrospect, we were glad that this happened close to land at the end of a passage. We had considered crossing the Channel that day. An early season 'sea trial' in heavy weather is more likely to discover faults and problems than a quiet day.

CHIRP Comment: We endorse the Lessons Learned, as listed by the yachtsman. We would add the following:

1. Any holes drilled through a bulkhead for cables should be sealed with an appropriate bulkhead gland. If possible, it would be better if cables pass through the top of the bulkhead rather than the bottom.
2. On initially discovering the ingress of water, a precautionary call to the Coastguard may have been appropriate in case the situation had rapidly worsened. This would have ensured that the yacht's position was known and that the situation would be monitored.

YACHT UNDER POWER

Report Text: I was crossing the Channel in my yacht with one other person on board. We had left the Channel Islands in mid afternoon and were due to arrive at our South Coast destination at 0730. We were motor-sailing under mainsail but primarily using engine power. The autohelm was engaged and we were making 6 knots. While crossing to the west of the Off- Casquets Traffic Separation Scheme I was using our radar and AIS to track shipping. We had crossed north-east bound traffic without problem and were now encountering the south-west bound traffic.

I had been tracking a particular tanker on radar and it then came into the range of my AIS receiver so I tracked it on our chart-plotter mounted in the cockpit. The AIS showed a CPA of just under a mile. I had to determine whether to pass in front or duck behind the tanker. In the last 5 minutes as the tanker approached I decided to duck behind it. I turned ninety degrees to starboard. Momentarily, as my bow swung around the AIS alarm sounded as our courses appeared head on. I passed

around 200 yards off the port side of the tanker. When clear of her stern, I resumed my course.

I called my crew onto deck (it was time for a watch handover anyway) and called the tanker on VHF ch16. I received an immediate response and we changed to a working channel ch8. I said that I was the yacht that had just passed close to her port side and asked had they seen me. The tanker replied to the effect of "what yacht". He asked my position, which I gave him and he said that he did not have me on radar. I was surprised at this as we had a large passive radar reflector hung from the crosstrees which should have given a 20m² paint and we were still within 1 mile of the tanker. The officer of the watch on the tanker spoke broken English and had struggled to understand some of what I had said. He said "what do you want me to do" - he seemed not to understand my concern. Needing to continue my own radar watch as we were not yet clear of the shipping, I terminated the conversation.

Lessons Learned:

1. Once the tanker appeared on radar I should have made an earlier decision to duck behind her.
2. I should have had a "tanker scarer" torch to hand, and a white flare. These were stored below in the saloon.
3. Was the tanker keeping a proper watch "at all times and by all means" and was their radar set correctly?

CHIRP Comment: **Our reading of the situation is that the tanker was on the starboard side of the yacht, which was being propelled by her engine, so the yacht was the give-way vessel. We would anticipate that the tanker must have been visible to the yacht when five miles away or more. As the yachtsman has identified in the "Lessons Learned", an earlier alteration to starboard would have been prudent.**

Rule 16 of the Col Regs says "Every vessel which is directed to keep out of the way of another vessel shall, so far as possible, take early and substantial action to keep well clear. In a case such as this, the risk in not taking action until a late stage is that if the approaching ship belatedly sees the yacht at a close distance and assessed that there is imminent risk of collision, it might alter course to port (albeit in-advicedly) at the same time as the yacht is altering course to starboard, thus exacerbating the situation.

As the yachtsman has also identified, a powerful lantern can increase the probability of being seen. The use this is prescribed in Rule 36 - *"If necessary to attract the attention of another vessel any vessel may make light or sound signals that cannot be mistaken for any signal authorized elsewhere in these Rules, or may direct the beam of her searchlight in the direction of the danger, in such a way as not to embarrass any vessel."*

We had not previously heard of such a light referred to as "a tanker scarer". This would be a misnomer because

- a) Tankers are generally at the higher end of the spectrum of ship quality.
- b) Mariners should treat each other with courteous respect. The aim should be to attract the attention of the other vessel, not to scare it.

As the incident occurred during the hours of darkness,

the tanker should have had a dedicated look-out as well as the officer of the watch. In good visibility and smooth sea, the lights of the yacht should have been seen by the tanker. This does call into question the effectiveness of the look-out being maintained on the tanker. We have alerted the manager of the tanker to the incident.

We also note also that the yacht was equipped with white anti-collision flares. Bearing in mind the serious accident to a yachtsman in 2006 when one malfunctioned, it is worthwhile checking that such flares are in apparent good condition and in-date, and any one who may use one is fully familiar with the instructions.

DIVE TO CLEAR A FOULED PROPELLER ???

Report Text: Whilst on passage in the Dover Straits, the wind had dropped completely so we were motoring at 5-6 knots. As we started to cross the North bound TSS lane, the propeller fouled and our speed though the water was reduced to 3-4 knots. Three ships had to be avoided crossing to South Foreland /South Goodwin buoy with difficulty.

We arrived off Dover East entrance, at the second hour of flood tide in dark at 2330hrs. We were trying to make the West entrance to avoid ferry traffic. We were in touch with Dover Port Control. We were soon making only making 1 knot, trying to get to back eddy from "knuckle" on harbour wall. No progress. A ferry avoided us by 200m. Thereafter we were towed in by a Harbour launch.

Next day I dived and removed 1-1.5m of 80mm square mesh green trawl net from the propeller. Fortunately, no damage was done to the propeller or shaft.

Lessons Learned:

1. Always have face mask on board to be able to dive and clear fouled propeller. (The weather was calm so we could not sail to safety)
2. Patent "rope cutters" do not clear net debris!

CHIRP Comment: **We can envisage that being immobilised close to Dover Harbour entrance would have caused considerable anxiety and were pleased to read that a Harbour launch was able to provide assistance.**

We would make the following comments regarding the report and the lessons learned as described by the yachtsman:

If immobilised, an advisory call to the Coast Guard, as well as to Port Control, may be prudent.

If the yacht is being swept towards a hazardous area, prepare the anchor for letting go, perhaps attaching extra warps if additional length of anchor line is needed.

Rope cutters do vary in their effectiveness. Reports of comparative tests can be found on the internet.

With reference to the yachtsman's conclusion that a face mask should always be carried, we would advise that proper consideration should be given to the risks of diving to clear a propeller before undertaking this. Particular consideration should be given to:

- the swimming and diving ability of the person intending to dive;

- sea conditions;
- water temperature;
- the possibility of the diver cutting himself/herself;
- availability of protective equipment (e.g. face mask, wet suit);
- means of re-boarding the yacht ;
- potential support to the diver from others on board if anything goes wrong.

If outside assistance is available, the safest option may well be to take it, as the yachtsman did in this incident.

PETROL IN BILGE

Report Text: Twelve months ago, after having 2 new 150 outboards fitted to our recently purchased second-hand RIB, we had problems with water in the fuel which got past the remote fuel/fuel filter, and the two engine filters, one of which we understand was supposed to stop the engines if it detected water. As a result we had an expensive repair not covered by warranty. We tasked a local dealer to drain the water and test the tanks for leaks, as we had smelled petrol fumes. The boat has built-in petrol tanks, located under the deck.

Two months ago when perhaps for the first time we filled both tanks to the brim, we again smelled petrol fumes, and carried out a test of fitting extension tubes the fillers, and then immediately noticed petrol on top of the part of the tank we could see.

When we lifted the deck, I was shocked to see that the bilge was full of petrol and that electric control lines from the console to the engines had been laid loosely on top of the tanks, and that insulation had started to fray.

CHIRP Comment: It was fortunate that this situation had not lead to a major explosion. We ascertained that the RIB had been brought ashore and not being used pending resolution of the safety issues.

We were subsequently able to visit the reporter and the boat and noted that due to concerns on the integrity of the petrol tanks, new tanks had been ordered. Professional marine engineers were carrying out a thorough risk assessment of the arrangements of the fuel tanks and control lines. Their recommendations included:

1. Ensuring that, in the event of a petrol leak, gas would not be able to pass from the bilge into the console which contains electrics.
2. Passing the control lines through gas-tight ducts.
3. Securing arrangements for the replacement fuel tanks.
4. Fitting gas alarms in the bilges, if practicable.

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CHIRP

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PLEASE COMPLETE RELEVANT INFORMATION ABOUT THE EVENT/SITUATION

YOUR POSITION ONBOARD OR IN ORGANISATION		THE INCIDENT		THE WEATHER	
MASTER/SKIPPER	<input type="checkbox"/>	CHIEF ENGINEER	<input type="checkbox"/>	DATE OF INCIDENT	
DECK	<input type="checkbox"/>	ENGINE/ETO	<input type="checkbox"/>	TIME	LOCAL/GMT
CATERING	<input type="checkbox"/>	OFFICER	<input type="checkbox"/>	VESSEL LOCATION	
MANAGER	<input type="checkbox"/>	RATING	<input type="checkbox"/>	YOUR VESSEL NAME: <input type="text"/> TYPE: (TANKER, BULK CARRIER, FISHING, YACHT, ETC) FLAG: <input type="text"/>	
OTHER:					
TYPE OF OPERATION COMMERCIAL TRANSPORT <input type="checkbox"/> OFFSHORE <input type="checkbox"/> FISHING <input type="checkbox"/> LEISURE <input type="checkbox"/>					

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

continue on reverse



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LESSONS LEARNED

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



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