

CHIRP MARITIME FEEDBACK

Issue No: 30

3/2011

EDITORIAL

There is an essential prerequisite for CHIRP to flourish - we need mariners to send reports of near-misses and safety issues. For this to happen, it is of course necessary to use good seamanship and/or engineering practice to recognise that a situation is hazardous, to intervene as appropriate to correct it and to report it so that lessons can be learned.

In recent months we have been dealing with a number of reports which would make interesting reading. These include issues relating to fatigue and failure to report an accident. However, even though we do not disclose identities of people or vessels, publishing even an outline of these reports could risk breaching the confidentiality of the report. So the reports we select for publication do not necessarily represent the wide spectrum of issues with which we deal.

A report by the UK Marine Accident Investigation Branch in May 2011 described the tragic death of a Chief Engineer in the lift shaft of a container vessel. (The report can be accessed on www.maib.gov.uk). The investigation found that all the safety barriers that could have prevented the accident had been ignored, reset or circumvented. This was the third fatal accident in an 8-month period on board ships of this company.

The MAIB investigation found that, although the safety management system was compliant with the international standard, there were serious failings in its implementation. Few risk assessments were completed, safe systems of work had not been established and work permits were not used appropriately. Communication between crew and shore management was ineffective, and underlying problems were not identified. Although this company has an in-house near-miss reporting scheme, no near-misses were recorded on this particular vessel in the 6-month period before this accident.

Near-miss reporting provides a powerful tool for identifying problems and safety issues in an organisation. Major companies have their own schemes and the willingness of mariners to report near-misses is one indicator of a good culture of safety. Nevertheless, there may be occasions when mariners are reluctant to send a report to their company. If so, CHIRP provides a means for reporting a near-miss or safety issue in complete confidence. We were pleased recently to hear of a major company in which such use of CHIRP, as a supplement to its own near-miss reporting scheme, is encouraged and included in its Safety Management System.

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- The Corporation of Trinity House
- Lloyd's Register Educational Trust
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- The Standard P&I Club

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 REPORTS

OFFICER OF WATCH NOT WATCHING

Report Text At 0520 local time, own ship was heading 120 degrees at 18.5 knots, and was approaching a potentially busy crossing area in the Southern North Sea. The visibility was 7 miles, wind SE force 5, moderate sea.

We detected vessel XXXX at 12 miles and commenced radar plotting, and also tagged the AIS identity on a separate radar. Own vessel was about 5 points on the starboard bow of XXXX.

At 7 miles, the navigation lights of XXXX were sighted.

At 5 miles, XXXX was on a near steady bearing with a CPA of 0.1mile and crossing ahead at 0.3 mile. Own vessel placed into hand steering.

At 4 miles, we flashed at XXXX with our aldis light. At 3 miles, we again flashed with the aldis light and called on VHF 16, subsequently changing to a working channel. XXXX replied that our AIS was not seen on his ECDIS display or detected on his radar, he stated that he would make a turn to port and make a round turn.

Own vessel commenced turning to starboard. At 2 miles, XXXX was seen to start turning to port, own vessel continued turning to starboard to ensure a safe passing distance.

When XXXX was heading about 270 degrees, she called own vessel - working channel used. XXXX stated that our AIS identity was transmitting false information of 000 degrees heading and 0 knots. I asked about a

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visual watch and a radar watch, answered with no answer other than an apology.

Own AIS checked and all appeared OK. Later in the morning the vessel entered the German Bight reporting area and contacted the VTS. Our AIS was working correctly.

I believe this case highlights the growing problem of watch keepers not keeping a safe visual watch or even a radar watch but simply relying on the AIS on an ECDIS display and probably doing duties other than keeping a safe watch. Unless XXXX had serious radar problems then there is no way that our large vessel would not be detected by radar.

CHIRP Comment: The manager of ship XXXX carried out a full investigation of this incident. It transpired that at the time of the incident, a junior officer was on watch. He had been engrossed in a routine task of plotting navigational warnings rather than being attentive to the traffic situation. This was contrary to the Master's standing orders. The company promulgated the lessons from this throughout its fleet.

We pose some questions to other managers and senior officers. Are you confident that such a non-conformance could not happen on your vessel? What assurance processes do you have to minimise the possibility of this?

ANGST WHILST ANGLING

Report Text: My angling boat was engaged in fishing operations in the approaches to the Solent. I was at anchor displaying a black ball. I had AIS class A and B running and the vessel is fitted with a large commercial radar reflector. It was daylight and visibility was excellent.

I saw a large ship travelling east down the Solent and then watched her turn south onto a direct collision course with my vessel. When she first turned she was about four miles away so I had no real concerns at that point. However, when she had halved that distance and shown no deviation, I started to become concerned. I checked AIS and saw that she was travelling at 12.8knots and confirmed she was on a direct collision course.

I tried calling the ship three times on channel 16 but got no reply. I then called Solent Coast Guard and made them aware of the situation whilst starting my engine and preparing to cut my anchor line.

The Coast Guard raised the ship and instructed them to go to channel 67. On 67 they made the ship aware of the situation and whilst talking to them I saw the ship turn to its port. The ship's radio operator said they had been monitoring channels 12,13 and 16 but had not heard us call although the Coast Guard did hear me. The ship confirmed it had turned to port to avoid us and then passed about three hundred yards in front of us.

I have several concerns:

Why was a ship this size not using the deep water channel but cutting a corner?

Why did it not respond to AIS, radar or radio?

Why did it not see us earlier?

When it made the deviation south onto a collision course why was this not recognised immediately?

CHIRP Comment: We sent the text of the report to the manager of the ship. The manager subsequently advised that, having looked into the circumstances, he did not believe that the ship had acted in any inappropriate manner, nor contravened any regulations.

In dealing with reports of close encounters between leisure craft and commercial vessels, we encourage those on the bridge of a ship to envisage the situation as it would have appeared from the cockpit of the boat, and vice versa. We make the following general observations about his report:

- 1) A vessel angling is not, in terms of the ColRegs, a vessel engaged in fishing. An angling vessel at anchor may be reliant on her anchor ball being identifiable as such by approaching vessels. We would estimate that this might be at a distance of about 2 miles or less. A vessel travelling at, say 12 knots will travel this distance in 10 minutes, so there is not a lot of time for an approaching vessel to assess the situation and to take avoiding action.
- 2) Until the boat is identified as being at anchor, it is possible that the bridge watch-keepers on an approaching vessel may assume incorrectly that it is underway. The movements of small craft may, from the perspective of a watch-keeping officer, seem unpredictable. There may thus be a tendency for ships to hold course and speed whilst watching to see what actions the boat may take. (In saying this, we are not condoning any non-compliance with the ColRegs).
- 3) Many professional mariners may regard a passing distance of more than one cable in confined waters as being adequate. Nevertheless, as seen from a boat, this may appear close.
- 4) Since the introduction of the Global Maritime Distress and Safety System (GMDSS), the primary means of distress and urgency alerting on VHF has been by Digital Selective Calling. As there is no longer a requirement for commercial vessels to keep a listening watch on channel 16, a small vessel should not rely on a call on channel 16 being received by an approaching vessel. Nevertheless, it is the general practice on many vessels to keep a listening watch on channel 16, although it should be borne in mind that a call on this channel might be missed amongst all the other communications. In contrast, a DSC call sounds an alert on the bridge of the vessel being called. (Note that a recreational craft will need an AIS receiver to identify the MMSI number of an approaching vessel if wanting to make a DSC call to her.)
- 5) The purpose of the deep draught channel is to allow safe passage by deep draught vessels such as laden tankers. There is no obligation on other vessels to use it.

In general, there does appear to be a significant risk associated with the decision to anchor an angling boat in this busy area that is being transited by various types of vessel. The bridge watch-keeping complement on these vessels may range from a large team such as on a

liner or warship to a single person on some other vessels. (Again, in saying this we are not condoning the failure of any vessel to keep a proper look-out) The risk can be mitigated by the angling boat keeping a good all-round look-out and proper situational awareness, being prepared to weigh anchor if necessary, and alerting the Coast Guard if a hazardous situation is arising. The angling boat in this report was commendably taking these precautions.

HAZARDOUS ASSUMPTIONS

Report Text: My yacht was entering harbour and approaching a short narrow channel. We were under sail and had a speed over ground of 9 knots in a strong wind. We could see a commercial vessel leaving harbour approaching the narrow channel from the opposite direction.

As stand on vessel I held my course expecting the commercial vessel to slow down and wait for me to pass through. Instead she increased her speed made a dash to get through the channel before me, so putting me, my vessel and my crew in danger. I was confronted with a vessel speeding towards me at maybe 10-15 knots and was about to enter the narrow confines of the channel with dangerous shoal water on either side. I was unsure of which side of me she would pass but as stand on vessel held my course thinking it would be even more dangerous to turn. Eventually the vessel (when only 50-70 yards from my bows) sounded one short blast and turned rapidly to starboard missing my bows by about 25 yards.

The commercial vessel should (as give way vessel) have waited for my vessel to pass through the channel before coming through herself and so avoided this frightening 'near miss' situation. A collision between my small yacht and this vessel might easily have caused fatalities.

CHIRP Comment: We sent the text of the report to the manager of the vessel, who responded as follows:

Our vessel was approaching the narrow channel outbound. As he did so the Master noticed a sailing vessel under sail on the other side of the channel. Being committed to his passage through the narrow channel, he was expecting the yacht not to impede his passage as our vessel was only able to safely navigate within the narrow channel (rule 9 para b of ColRegs). Our vessel at no time increased her speed whilst within the channel and remained as far to the starboard side of the centre of the narrow channel as possible in case the yacht stood on into the channel.

In conclusion, our vessel complied with rule 9 of ColRegs. The Master also took additional action to make allowance if the sailing vessel should hold her course.

It appears that this was a situation in which, presumably, neither vessel wanted to meet the other in the close confines of the channel in strong wind conditions, but nevertheless did. We make the following observations:

1. Both vessels assumed that the other would keep clear. Both assumptions turned out to be not well-founded.
2. Had a collision occurred, there would no doubt have been lengthy argument as to the respective

interpretations of the situation and the applicability of Rule 9(b). The role of CHIRP is not to cast blame but to identify the lessons learned. However it is salutary to remember that it is unusual in collision cases for a court to find that one vessel was 100% liable and that no liability attaches to the other.

3. Fortunately there was no collision although we can envisage that the close quarter situation would have caused considerable anxiety on both vessels.
4. The situation could have been avoided if either or both vessels had held back to assess the situation before committing to the channel.
5. If you are on a power-driven vessel, bear in mind that an approaching yacht may unexpectedly alter course, if, for example, she is affected by a sudden gust of wind.
6. If you are in a yacht in a strong wind, remember that you must retain the ability to manoeuvre so as to comply with the ColRegs, whether as the stand-on or give-way vessel. The old maxim about shortening sail before you get into a difficult situation remains valid.
7. In general, ask yourself "What if..." (in this case, that the other vessel carries on.)

Although this report is from a yacht, we have included it in the Commercial section of this journal as we believe that the general lessons are applicable across all parts of the maritime sector.

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.

PILOT LADDERS

Report Text: In Issue 27, you had a report "Killer in Manila". I often board ships at anchor via the pilot ladder and take a keen interest in the state of the ladder as I am climbing up. Unfortunately once I have made the "leap of faith" from the service boat onto the bottom of the ladder it's too late. You are somewhat committed at that point.

Referring back to your article I have on one ship seen a pilot ladder that utilised shaped aluminium "clamps" instead of whipping thread on the manila main lines above and below that "vee" block at each tread. This was not something that had been put on by the ship's staff but was the system of manufacture from new. The aluminium "grippers" were vee shaped to accept the main lines with two wings on the outside of each side which were formed around the main line to seize the integral block in place and thus hold the tread. The aluminium blocks were quite sharp at the edges where they met the main line and would after a period of time cut into the rope.

CHIRP Comment: We thank the correspondent for the letter. A survey carried out in 2010 by the International Maritime Pilot's Association indicated that 13.5% of vessels in the survey had defects in the pilot boarding

arrangements. Although this is an improvement on previous surveys, it is still much too high. (The IMPA Safety Campaign 2010 report can be accessed via www.impahq.org).

If you are a mariner on a commercial vessel, are you satisfied that there are robust procedures for inspecting pilot ladders, and that these are being applied?

If you are a pilot and observe a defect in the boarding arrangements, you are urged to report the matter to the port state authority. If you are reluctant to do this, please contact CHIRP. Don't tacitly endorse such hazards by not reporting!

If a pilot ladder incorporates aluminium grippers or ferrules, as described in this letter, careful attention must be paid to the condition of the rope to ensure that it is not being cut or chaffed by the aluminium.

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.

FAILURE OF SNAP SHACKLE

Report Text: This is a large yacht where the rescue boat is stowed inside the hull via a shell door. The accident occurred during recovery of the rescue boat. Just as the rescue boat was being slewed into the tender bay, the port aft snap shackle of the lifting arrangement failed. The snap shackle attached the third leg of the lifting arrangement to the deck of the rescue boat. When this happened, the rescue boat swung downwards and to port, being held by the forward and starboard slings. Two deckhands had been seated in the rescue boat for hoisting and they fell into the water as the shackle failed. Each suffered minor injuries. Both wearing inflatable lifejackets remained conscious throughout and were recovered by other crew members. The cause was found to be failure of the snap shackle secured to the lifting point in the rescue boat. The yacht and its fittings were about 2 years old. The lifting gear was certificated for the load and had not been subjected to any severe loads since new. Regular inspections had been carried out as part of maintenance.

The lifting bridle snap shackles. Note that both the forward and port shackles have failed.



Fracture surfaces on port shackle. Note the corrosion especially in the bore of the holes for the pin.

CHIRP Comment: The manager has subsequently sent us a report of a metallurgical investigation of the failure of the shackle. The report noted that there was corrosion present on the surface of the material that had fractured. The features on the fracture surface indicate that they failed by a fatigue mechanism, cracks initiating at the bore of the hole for the pin.

The manager advises that his company has replaced snap shackles in the lifting bridles of rescue boats with conventional shackles.

If you have experienced any failure with rescue boat equipment, please let us know.

As previously advised, reports of primary interest to the leisure sector will be published in the full edition of **MARITIME FEEDBACK**; this 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)



LEISURE SECTOR REPORTS

CONFUSING LIGHTS

Report Text: We were sailing our yacht in fresh conditions (force 4 to 5), and approaching a harbour and marina where we intended to stop for the night. The sea state was moderate, visibility good. We had noted from the (current UKHO) charts the presence of two fish farms on the approach and had taken care to keep well clear of the charted positions of both of these.

We had identified the lights at the harbour entrance and were heading towards these when we noticed red and blue flashing lights amongst the background of yellow street lights on the shore. This gave every appearance of being an emergency vehicle on shore.

We discussed what this was and continued to watch these lights whilst primarily concentrating on our target, the entrance to the harbour. We were then both surprised and shocked to find the blue and red flashing lights very close alongside our boat - on top of a small light-coloured buoy. No lights appear around this fish farm on the current chart, of any colour. We were lucky to not hit this, passing it some 2 metres away. We then safely entered harbour and berthed our boat.

The next morning we asked the Marina Manager about this light and he knew nothing about it. He telephoned the fish farm manager, who confirmed that all his buoys around the fish farm were lit by yellow flashing lights - as would reasonably be expected; even though these were not charted. There were indeed some (rather weak) yellow flashing lights elsewhere around this fish farm which we had also seen on our approach the night before.

I was still concerned about this and retraced our track as we left port later that day. We found the buoy approximately 5 ca due north of the entrance, exactly on our inbound course as indicated on the GPS inbound track.

I called the Coastguard to report this incident and was informed by them that red and blue flashing lights are locally agreed indications of a fish farm. I asked if this was notified to mariners anywhere and was told that, no, it was just a local authority matter (!). I asked the CG to note my concern that the uncharted and un-notified light had caused considerable confusion and also that I considered this most hazardous, which they agreed to do.

CHIRP Comment: We contacted the Local Aids to Navigation Inspector of the General Lighthouse Authority for the area. He was aware of the issue and had instructed the fish farm to change the lights. These would soon be changed to flashing yellow, as recommended by the International Association of Marine Aids to Navigation and Lighthouse Authorities (IALA).

Intervening to correct a hazardous situation is a key step in improving safety. By following up his concerns regarding the incorrectly lit buoys, the yachtsman helped to instigate corrective action.

CHECK AROUND THE BOAT!

Report Text: I chartered a yacht based in France. I did not have a lot of experience: I've done my Dayskipper Practical, Yachtmaster shorebased, and I've crewed on quite a few coastal and cross-Channel trips, and skippered in the Mediterranean, but this was my first bareboat charter in France.

Handover was straightforward, despite having very little French - technical names for most of the inventory were difficult to work out, but the shore crew were very good.

We set motoring to the next port into driving wind and rain, so we didn't get the sails out.

When we came to leave the next morning, it took us time to get out as we had a problem with the headsail. A sailor on another yacht pointed it out - we hadn't noticed it. The shackle pin securing the tack to the furling drum had fallen out. My wife had found it by the toe-rail when we moored the previous evening; we didn't know where it had come from but it looked useful so we had kept it safe. We hadn't yet used the sail, fortunately.

I couldn't pull the tack down enough to get the shackle pin in and it was too windy to pull out the sail so I used nylon cord to haul it as tight as it would go and put a multi-turn lashing on it.

At the end of the trip when we told the charter company, they said the owner had been using the boat and he had an alternative foresail - he obviously hadn't re-secured the headsail shackle, and presumably no-one else had checked it.

There was no problem with the sail for the rest of the charter - we had a most enjoyable week and I learned a lot!

Lesson learned - when you charter a boat, check the obvious bits of the rigging - would more experienced sailors have done this as a matter of routine?

Should the shackle pin have been moused?

If it had been less windy I might have thought of slackening the foresail halyard, unrolling the sail and pulling it down to reunite the shackle with the furling drum, but we had a windy week.

CHIRP Comment: We thank this yachtsman, and indeed all our correspondents, for sharing their experiences and lessons learned.

It is indeed good seamanship to check around a yacht when coming on board and before leaving the security of the harbour. As this experience has shown, the failure of a small component can lead to major difficulty. It is prudent to mouse all shackles where it is practicable to do so.

Notwithstanding these points, it is disappointing that the charter company had not already identified and corrected the deficiency before the client came on board, especially a fault that may potentially lead to difficulty at sea.