

# CHIRP MARITIME FEEDBACK

Issue No: 31

Autumn 2012

## EDITORIAL

### FULL AHEAD FOR MARITIME CHIRP

Earlier this year we were uncertain whether we could secure sufficient funding for the CHIRP Maritime Programme to continue. We regret that this caused a delay in the publication of this issue of FEEDBACK. We are pleased to advise that on-going funding has now been secured. We are very grateful to our sponsors listed below.

As with all organisations, we have had to look carefully at our costs. Printing paper copies of this newsletter is expensive and regrettably is no longer affordable. Therefore, this Issue is the last that will be printed and distributed on paper. Instead we encourage mariners to access the newsletter via our website. Please do go onto our website [www.chirp.co.uk](http://www.chirp.co.uk), click on "Subscribe" on the home page and you will automatically receive an e-mail when the next issue of FEEDBACK is published. Please persuade your colleagues to do likewise. The service is free and gives you access to information which we believe is valuable in helping to prevent future accidents.

We have also set up a Maritime CHIRP Facebook page and a Twitter account. We will be encouraged if you become our electronic friend!

There is however another vital criterion for the success and continuation of this Programme; that is the number of reports that mariners send us. We all know that near-misses happen. Please be the person that reports such an incident. The phrase "I must do something about this" is much more powerful than saying "Something should be done."

### ENGINE ROOM - THE SAFEST PLACE ON THE SHIP?

Over the years, CHIRP has received a disproportionately low number of reports regarding near-misses or safety issues related to engineering. Is this because the engine room is the safest place on the ship? Unfortunately the statistics indicate otherwise. For example, the Annual Report for 2010 of the UK Marine Accident Investigation Branch (MAIB) records that there were 26 deaths and injuries in the rank of Engineering Officer, compared with 9 for the rank of Deck Officer. For any rank, officers and ratings, near-miss reporting provides a valuable tool for reducing the risk of accidents. The normal route for reporting a near-miss is to the ship's manager. If however for any reason you are unwilling to do this, please do contact CHIRP. All reports are treated in absolute confidence - we never disclose the identity of those who send a report. We would welcome receiving more reports from all ranks, including engineering staff!

We have read issue No 27 of 'Alert!', the International Maritime Human Element Bulletin, with interest. It focuses on the engineer's role in addressing human element issues that arise in operating technical systems of increasing complexity. The bulletin can be downloaded from [www.he-alert.org](http://www.he-alert.org).

### GROSS VIOLATIONS

A recent MAIB report on the grounding of a container vessel in the Mediterranean noted that, whilst the vessel was on passage, several officers had congregated on the bridge at midnight to celebrate an officer's birthday. No lookout was posted. Alcohol was consumed. The celebrations concluded at about 0200. Analysis of the data recording showed that at 0216, the autopilot had been altered from the planned course of 080 degrees to 305 degrees. At 0546, the vessel grounded on a gently shelving sandy shore in Spain. At 0606, the chief officer entered the bridge and found it unmanned, with the engine still at full ahead. The vessel was subsequently towed to safety.

Surprisingly, there was no damage to the ship. However, in slightly different circumstances, the lives of those on board could have been endangered. We would hope that in the shipping industry such gross violations are rare. However, if you are on a ship and are concerned that safety is being compromised, and do not feel that you can discuss the concern with the Master or the manager, do please contact CHIRP.

### SPORTS CLUB SAFETY

Another MAIB report on the death of an 11 year old girl at a water sports club in 2010 makes particularly sad reading. The report highlighted that the implementation and execution of the safety management system used at the club was flawed at every level and had not identified or controlled the risks to children taking part in its activities. Members of other clubs may find it useful to read this report and consider whether their own procedures are adequate. Sports should be fun, not tragic. (MAIB reports are available on [www.maib.gov.uk](http://www.maib.gov.uk))

CHIRP continues to receive and publish reports from the leisure sector, so please keep sending them in!

*Chris Rowsell*

### Our Sponsors

We are grateful to the sponsors of the CHIRP Maritime Programme. They are:

- The Corporation of Trinity House
- Lloyd's Register Educational Trust
- The Britannia Steam Ship Insurance Association Ltd

[www.chirp.co.uk](http://www.chirp.co.uk)

FREEPOST RSKS-KSCA-SSAT, CHIRP, 26 Hercules Way, Farnborough GU14 6UU (UK only)

[confidential@chirp.co.uk](mailto:confidential@chirp.co.uk)

Freefone (UK only): 0808 100 3237 or +44 (0) 1252 378947

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](http://www.chirp.co.uk).

## COMMERCIAL SECTOR REPORTS

### LIFEJACKET DESIGN

A mariner has reported concerns about the design of the lifejackets on his ship. His concerns are that:

1. The lifejacket is very tight around the neck. If jumping into the water wearing the lifejacket, there would be a high risk of injuring one's neck.
2. The lifejacket is cumbersome in which to work. It is difficult to work in a lifeboat or to climb down a boarding ladder whilst wearing the lifejacket.

In response to the concern, the ship's manager had advised that the lifejackets comply with regulations.



**CHIRP Comment:** The lifejacket bears the Wheelmark symbol which denotes that it conforms to the European Marine Equipment Directive. CHIRP contacted the European organisation under whose authority the Wheelmark had been granted. They advised us to contact the manufacturer in Asia for details of the testing that had been carried out. This we did.

The manufacturer sent us details, including photographs, of the tests that had carried out in accordance with international regulations. These included thirteen persons jumping into the water from a height of 4.5 metres, with arms clasped over the lifejacket. None of the test subjects suffered adverse effect from the jump.

We have also obtained general advice from industry experts. They advise that a revised international standard for lifejackets came into effect in 2010. This requires the in-water performance to be measured against a "reference test device". This features a tight neck aperture, as a tight fit around the neck and body ensures that the lifejacket is less likely to move, thus minimising physical stress. The 2010 standard does have higher requirements in respect of clearance of the mouth from the sea surface and turning performance. These requirements have tended to increase the bulk of the lifejackets. This makes them really suitable only for abandonment situations, rather than for regular use whilst working.

We understand that the subject of the test standard is currently being reviewed by the IMO.

If you have comments regarding the lifejackets on your ship, please do let us know.

### ALRIGHT?

**Report Text:** Own ship is a large sailing ship. We were sailing in light winds, speed over ground 1.5-2 knots with the wind astern. A small fishing vessel, single handed, and displaying fishing shapes, had been picking up pots astern of me. He overtook me on my starboard side at approx 0.5 cable. Although unnecessarily close, there was nothing particularly unusual in that as we very frequently have vessels coming for a look pass just as close. When 20 degrees off my starboard bow, he stopped at approx 0.75 cable distance and proceeded to haul a pot. We started our main engines and were forced to manoeuvre to pass him. I was aware that I was the give-way vessel, as the other was engaged in fishing, though having come all the way down my side from right astern, he was the overtaking vessel. In any case, I cannot believe that the rules were intended to approve an act which displayed such blatant disregard for another vessel. Finally, the other vessel went astern and passed down my starboard side at approx 5 metres. The fisherman skipper looked up and inquired "Alright?" I resisted the temptation to respond.

Lessons Learned:

1. The value of keeping a good lookout - without someone keeping a close eye on other vessels in the vicinity, we might not have had time to avoid him.
2. The need to be even more wary than usual when the other vessel involved is a small fishing boat. Experience shows that own ship altering course to open the CPA simply leads to other vessel altering further towards! In this case, it may have been that the other vessel was concentrating on his pots and despite having just passed us, was not aware of our relative positions when he stopped to haul the pot. Either that or he was just deliberately ignoring us until he too was forced to take action.

**CHIRP Comment:** From the report, it appears that the fishing vessel was the overtaking vessel. We believe that the obligation of an overtaking vessel to keep out of the way of the vessel being overtaken continues until the vessels are well clear of each other. We do not believe that the Regulations can be construed to allow

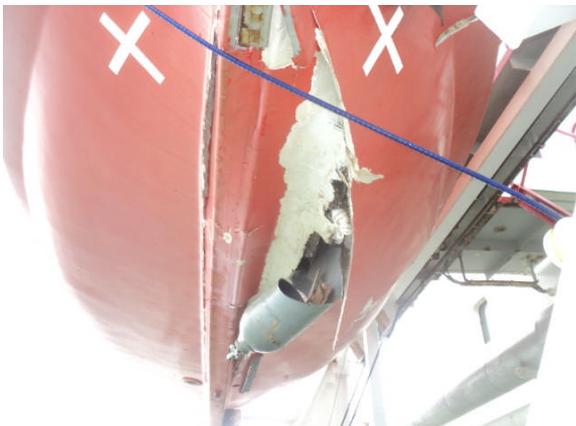
an overtaking vessel to acquire the rights of a "vessel engaged in fishing" whilst close ahead of the overtaken vessel.

We contacted the fisherman and discussed the incident with him. He recalled that the encounter had been too close for comfort and agreed that it highlighted the importance of allowing an adequate margin of safety.

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### AIR BOTTLE EXPLOSION

**Report Text:** Approximately one month after a survey and five-yearly overhaul of Life Saving Appliances, a fully charged air cylinder exploded just above the keel moulding of the TEMPSC (Totally Enclosed Motor Propelled Survival Craft), causing considerable damage. Fortunately, no personnel were injured. Once the vessel arrived in port, an independent lifeboat service company was requested to investigate the incident and assess the damage with a view to carrying out repairs.



**Damage to the survival craft, showing the exploded air bottle.**

The remaining air cylinders were removed and a close scrutiny was undertaken. From evidence in the form of a date stamped into one of the cylinders, it was ascertained that a hydro-test of cylinders last took place more than five years ago. Further inspection of the remaining cylinders showed quite clearly material wastage through corrosion of approximately 50% of the cylinder walls' original thickness.



**The remaining air bottles, showing the corrosion in the area where the retaining strap had been fitted.**

As there was no more recent date stamp, it can be assumed that these particular cylinders were not hydro-

tested in the recent survey. Indeed, judging from the cylinder wall corrosion that can be observed, it appears possible that they were not removed from the boat during the survey.

After assessment, the TEMPSC was deemed to be beyond economical repair and was scrapped. A replacement lifeboat had to be obtained.

It is understood that the ship's manager has taken up the matter with the organisation that carried out the LSA survey.

**CHIRP Comment:** This report illustrates the importance of regular inspection and survey of all parts, including hidden areas, of bottles containing pressurised gas or air. Fortunately in this case, no-one was nearby or working in the lifeboat, otherwise there could have been serious harm. As it was, the lifeboat was clearly out of action for the remainder of the voyage.

There appears to be serious issues with this case regarding the survey and inspection regime which we understand the ship's manager has taken up.

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### SOLENT SAILING SITUATION

**Report Text:** My yacht was sailing in the Solent in wind force 2-3, speed over ground 4.5 knots. We became aware of a coaster 20-30 degrees on our starboard bow, approximately 5 miles away. We monitored progress and course for possible collision. The bearing remained steady throughout and we were sure vessel had ample opportunity to alter course and speed as appropriate for a sailing vessel on a port tack approaching.

We became very concerned that no alteration of course or speed was made by the approaching vessel and that a possible collision situation was fast becoming a reality. We maintained our course until we were sure that no corrective action would be made by the vessel. We then made a turn to starboard to avoid collision. The vessel passed very close, approximately 25 yards away, maintaining her course and speed.

At the time of the incident a large fleet of sailing dinghies were racing through this area accompanied by a RIB.

**CHIRP Comment:** We contacted the ship's manager who responded as follows:

*The officer on watch at the reported time of the incident does not recall the particular yacht in question and does not consider that an "incident" occurred. Consequently there is no formal record on board the vessel. The watch keeper's recollection of the passage on that day is that there was a very high degree of yacht activity in the area. A fleet of yachts was racing ahead of the vessel's track, accompanied by a control RIB. Additionally there was a ship approaching on our vessels' port bow. The density of yacht traffic and proximity of the other ship meant that it was not possible to treat each craft individually with early and substantial action and so our vessel's speed was reduced so that the regatta could cross ahead. The action of reducing speed was considered sufficient to alleviate the situation, both in terms of the regatta and the other recreational craft in the area and with consideration for the approaching ship.*

*It is of course the case that the collision regulations do apply in these circumstances, and the action taking by our vessel was considered appropriate and in accordance with those regulations (Rule 2b) given the special circumstances (proximity and density of traffic). If any anxiety was caused to the yachtsman in question this was not intentional and is regretted.*

We have included this report in the Commercial Section of this journal as we believe it useful to encourage mutual understanding between commercial mariners and yachtsmen. Our general advice is that if you are on the bridge of a ship in such circumstances, try to visualise the situation as it is being perceived from the cockpit of the yacht, and vice versa.

## WRONG WAY IN IRTC

The following report was received from a ship in the Gulf of Aden.

**Report Text:** The "eastbound" container vessel XXXXXX observed in the middle of the "westbound IRTC" (Internationally Recommended Transit Corridor) traffic lane. Course over Ground 070deg, Speed over Ground 22.5kts. MSCHOA (Maritime Security Centre Horn of Africa) and UKMTO (UK Maritime Trade Operations) have been informed.

*(The vessel details and position were provided.)*

**CHIRP Comment:** We alerted the manager of XXXX. He replied as follows:

Quote

*Thank you for bringing the incident to our notice. There was a deviation from the recommended track. We have asked the Master to strictly comply with recommendations and have sent a Fleet alert to all vessels.*

Unquote

The manager has thereby applied the learning from this incident across his fleet.

## 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.

## WOULD THIS HAPPEN IN AVIATION?

**Text:** I have just read the report entitled "Would This Happen in Aviation" in issue 29. While I agree there are many similarities in both jobs, there are many differences too.

Firstly this is not meant to be any kind of excuse for bad practice, however the life of a pilot and a ships officer are very different work schedule wise. Fatigue and rest hours are I suspect far less of an issue in the regulated world of aviation.

The airline pilot isn't living breathing and sleeping in his cockpit. He isn't doing his job over and over for typically weeks if not months in many cases. He isn't distracted by the worry over pirate attack, whether his family are fit

and well since last seen weeks ago, about whether he has actually been paid for his trouble over the last couple of months, and he certainly won't be getting the same sort of money an airline pilot receives.

There are still human errors made in aviation, and when they are they typically have much higher cost in human tragedy. I was myself on a flight once where I had to remind the cabin crew the seat belt signs weren't on as the plane throttled up at the end of the runway.

**CHIRP Comment:** We agree that the working lives of mariners and airline pilots are very different. However, human factors issues are very important in both professions. One of these is how to prevent errors in routine operations. The point we were endeavouring to make in our comment in Issue 29 is that check lists can provide a valuable tool, provided of course that they are used properly and not treated as a "tick the box" exercise.

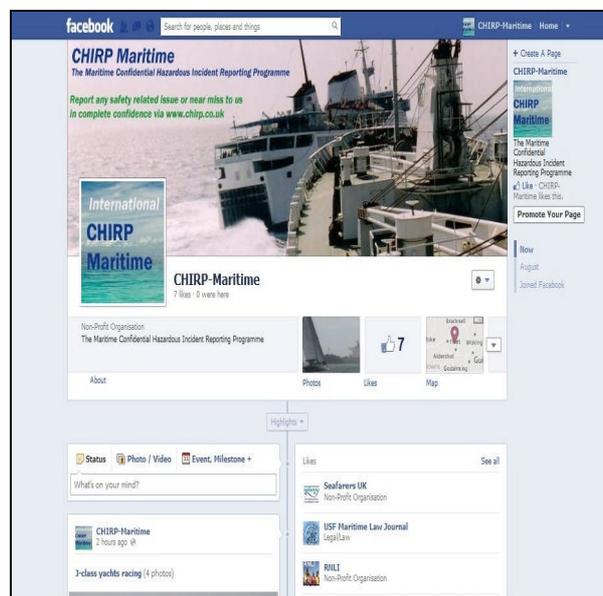
## REPORTS FROM THE LEISURE SECTOR

Reports of primary interest to the leisure sector are published in the full edition of MARITIME FEEDBACK; this is available on our website: [www.chirp.co.uk](http://www.chirp.co.uk), but not in the hard copy of this Issue 31 distributed to ships.

## PLEASE JOIN US ON FACEBOOK

Click on the link from our website [www.CHIRP.co.uk](http://www.CHIRP.co.uk) to the Maritime CHIRP Facebook page.

<http://www.facebook.com/pages/Maritime-CHIRP/388066931253279>



## LEISURE SECTOR REPORTS

### LESSONS LEARNED FROM CAPSIZE

**Report Text:** An entrapment incident took place during a training session for single-handed dinghies at our sailing club. Weather conditions were good, wind estimated force 3 to 4.

A sailor capsized when going about. The duty safety boat immediately responded, and observed the boat partially inverted and suspected that its mast head had become stuck in the mud (water depth is shallow estimated approx 2 - 3 metres). The sailor was trapped at the front of the cockpit, with his head above the water.

The safety team was concerned that the boat was inverting further. Recognising the danger, they took immediate action to prevent this by putting pressure on the boat's dagger-board.

It was noticed that a strong string used to retain the sailor's hat to his buoyancy aid had become caught up on the boat. After several minutes the sailor managed to free himself by breaking the attachment point on his buoyancy aid.

During discussions after the incident it was recognised the sailor was carrying a knife and there was one available in the safety boat snatch bag. However, neither was given any consideration to effect a quick release. No injuries or breakages were sustained during this event, and it has been categorised as 'a near miss'. Fortunately the mast did not break otherwise the boat may have fully inverted, trapping the sailor.

Lessons Learned: A club briefing was issued to all members noting the following: Preferable to attach hats with clip-on retainers rather than string or cord. Clothing and equipment should be tucked away and 'snag free'. Sailors should carry a safety knife for such an occurrence. A reminder was given to all safety boat crews that safety knives are packed in all the club's safety-boat grab bags.

**CHIRP Comment:** It is encouraging that this sailing club has an established process for reviewing incidents, discussing the lessons learned and applying them. We commend the club for this. Does your club have a similar process?

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