

CHIRP MARITIME FEEDBACK

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EDITORIAL

Welcome to the latest edition of **CHIRP Maritime FEEDBACK**. A report we have received related to very serious concerns over the competency of an Officer of the Watch (OOW) Deck. Despite onboard coaching over a period of two days whilst in port, the individual made many serious errors during bridge watches; these on occasion put the ship at risk. We have also received concerns regarding the quality of officer training; this includes a reduction in the amount of qualifying bridge watchkeeping time in exchange for attendance on a bridge simulator course. Reports also challenge the quality of mandatory training and issuance of certificates; in one case certificates were issued prior to the completion of the course. We now question whether the current system of training and certification, in some countries, is in the best interests of the industry.

So what can a person do when encountering an OOW whose capability to perform a safe navigation watch is clearly in doubt? The reporter should use the Safety Management System (SMS) and report the hazardous occurrence to the ship managers. We believe any reluctance to use the SMS indicates a weakness in the safety culture onboard. It is also a lost opportunity to reveal weakness in the recruitment process, or the need for additional training in some circumstances or preparation for particular assignments. If the company does not react to the report, the details should be sent to the Flag state of the vessel that issued the certificate or endorsed the initial certificate of competence for service on that ship. Other options may be available; alternatively do not hesitate to contact **CHIRP**.

Reports of injury and near misses during mooring operations are still too frequent; we include a warning over the ill-advised use of painted 'snap back zones'.

In this edition we see more reports from enlightened ship managers. We extend the invitation to all ship managers to participate; our mission is to share the safety lessons learned for the benefit of all seafarers. Afterwards senior officers and managers need to take personal responsibility for ensuring the lessons learned from near misses are disseminated and discussed with personnel onboard, this way we can prevent the same mistakes repeating. In taking into consideration the number of seafarers around the globe we see very few reports. To make this easier, I include a copy of the **CHIRP** report form on the back page and invite any member of the crew to use this. So please report a near miss and you may help to save another person's life.

John Rose Director (Maritime)

REPORTS

MOORING LINE HAZARDS

Report Text: During mooring operations and whilst the aft tug boat was being cast off, an Able Seaman (AB) was holding the messenger attached to the tug line and did not let it go until it had almost reached the chock. There was potential risk of injury by the messenger, as caused by the AB's inattention and improper assessment of risks.

Corrective action from lessons learned: Crew should always exercise due diligence during mooring/unmooring operations to ensure that the job is carried out safely following good seamanship practices. Proper supervision during mooring operations is an important safety issue. Amongst other responsibilities the supervisor has the duty:

- a) To exercise full control of the working environment.
- b) To ensure through a toolbox talk the work is undertaken with safety instructions and good seamanship practices implemented at all times.
- c) To prevent potential injury or damage through unsafe acts or omissions by the crew.
- d) To ensure crew members are always at a safe position as far as is reasonably practicable, outside the dangerous/snap-back zones of the mooring lines.
- e) To maintain awareness, assess and react quickly and effectively to any new hazard that might occur.

Report Text: A crewmember injured his hand during mooring operations. The incident occurred when a bunker barge was beginning an approach to the port side of a Platform Supply Vessel (PSV) at anchor, for bunkering operations.

The crew of the bunker barge passed the "messenger line" to a crewman on the PSV, along with two mooring ropes. The crewman took the ropes and put the eyes of the two mooring ropes on each of the twin bollards aft and returned the messenger line to the bunker barge crew. The crewman on the PSV then considered that the mooring operation was over and started to walk away towards the accommodation. As he reached amidships the master of the bunker barge got his attention and indicated to him that he should go aft again and shift one of the mooring ropes to the other bollard. He returned to the aft bollard. The barge crew slackened the mooring rope a little and he tried to remove the rope. At that moment there was sudden tension on the rope, due to relative movement between the vessel and bunker barge.

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The AB's left palm got stuck between rope eye and bollard resulting in severe laceration to his left hand. First aid was given, before the AB was sent ashore to hospital for further treatment.

An investigation established the following: The incident occurred when the injured person agreed to shift the rope from one bollard to the other without insisting on the rope being sufficiently slackened. He failed to take into account the relative movement of the vessels, which led to his hand getting stuck between the eye of the rope and the bollard; VHF radio communication between the ship and barge was not established, there was no effective toolbox talk; the injured person was attending to the moorings alone, which was contrary to the job hazard analysis, which required attendance in pairs.

Lessons Learned:

- Vessel's bridge must establish VHF communication with another vessel before agreeing to start the mooring/unmooring operation;
- Both forward and aft station deck crew to be in VHF communication with duty officer on the bridge;
- Ship's crew to take instructions from the duty officer and not from the barge crew directly;
- Additional control measures during mooring and bunkering operations should include the importance of risk assessment taking place before work starts;
- Review the company Manual of Permitted Operations specifically with regard to weather conditions;
- To ensure Buddy System at workplace is in place, especially during night time operations, work as a team to spot dangers.

CHIRP Comment: The risks when handling mooring ropes of different types are well documented. The need for vigilance and diligent supervision at all times is essential. Appropriate Personal Protective Equipment (PPE) should be made available and worn.

See also The International Marine Contractors Association (IMCA) reports: SF 02/08 (Finger injury whilst casting off towing line) and IMCA SF 11/14 (LTI-Hand severed during mooring operations).

SNAP BACK ZONES

CHIRP also takes this opportunity to warn seafarers over the practice of marking on deck the 'snap back zones' for mooring lines on decks where a rope will recoil when parting. This practice is not supported by research and it is believed to create a false sense of security. The risk of injury can vary and will depend on (i) the lead of the rope, (ii) the type of rope used and (iii) the tension on the rope when parting.

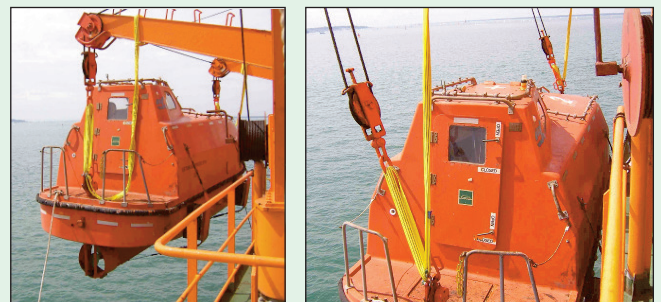
Attention is drawn to the Report RS 2014:03E by the Swedish Accident Investigation Authority into the incident resulting in death on the Netherlands vessel 'MORRABORG'. The UK Maritime Coastguard Agency have advised they will revise their guidance warning against the

use of painted 'snap back zones', in the next edition of the Code of Safe Working Practices for Merchant Seaman (COSWP). It is therefore prudent to remove the painted areas and post warning signs that the mooring area, when in use, is dangerous and caution should be exercised when handling ropes. In addition emphasis is required on training, a tool box talk prior to commencing operations and control through a supervisor dedicated to the oversight of safe operations. The supervisor needs to be alert to the potential risks as tension in the mooring lines and messengers increase and take timely action to avoid injury of personnel.

LIFEBOAT DRILLS – ENSURE THEY ARE SAFE

We noted the all too frequent reports on injuries and fatalities of seafarers whilst testing the launching and recovery of lifeboats. Industry misgivings have been brought before the International Maritime Organization (IMO) for several years; these are based on sound risk management principles, which understandably go in the direction of caution. The International Convention for the Safety of Life at Sea (SOLAS) however, primarily concerns itself with the emergency evacuation of a ship. It does not take account of drills other than to say they should be conducted as realistically as possible. More importantly, SOLAS does not cover recovery of lifeboats in any detail, yet this is when most accidents have occurred.

The Industry Lifeboat Group (ILG) continues to apply pressure where it can promoting good practice such as the use of Fall Preventer Devices (FPD) and hanging off pennants used to by-pass the hook. Photographs below show FPDs (between hanging-off lug and fall) and Hanging-off pennants (between hanging-off lug and davit arm) rigged for use.



It is important that FPDs are made of resilient material that can absorb shock. In the photo the same principle has also been applied to the hanging-off pennant. This ensures any failure of the hooks would not induce a large shock loading, which in a wire or chain could cause the latter to sequentially fail as the materials have limited resilience. Furthermore, as can often be found in incident reports, corrosion in wires can be present and could cause weakening of wire strops.

The master is the supreme authority responsible for the safety of his crew (See ISM Code). So it is in the master's interests (and indeed the ship manager's) to go further than the stated capabilities of the boats and davits and conduct a proper risk assessment to determine the consequences of a failure. Beware though; falls still remain a single point of failure. In the initial swinging-out operation, when many

disruptive loads can occur they too can be by-passed by hanging-off or maintenance pennants that attach the boat directly to the davits (see photo). There have been some notable accidents recently in which falls parted and many seafarers paid with their lives (7 lives in 3 accidents!). We will discuss this in more detail in a future edition of Maritime FEEDBACK.

DISREGARDS FOR COLREGS SAILING VESSEL

Report Text: We were sailing from Cherbourg to Southampton via the Needles on a 10 metres sailing yacht equipped with an AIS (Automatic Identification System) transponder and active radar reflector. Visibility was about 4 miles, our speed about 8 knots. As we crossed the eastbound shipping lane, several AIS targets were approaching on the port side and eventually became visible. One was of concern because the closest position of approach (CPA) was almost zero. The speed of this ship, the xxxxxx, was about 18 Knots. After monitoring the situation for some time, I called up on VHF radio and informed the crew who answered, that according to our AIS our CPA was near zero. The response was 'I agree'. I then asked if he planned to alter course to avoid risk of collision and he replied in the negative.

I politely pointed out that we were a sailing vessel and the stand on vessel under the Collision Regulations and asked once again if he would alter course. The reply was 'I could do but I'm not going to'. I decided at this point that further discussion was unlikely to be productive, ended the conversation and instructed the helm to turn 20 degrees to port and harden up the sails. This allowed us to pass behind the ship by a safe distance.



Lessons Learned: Do not assume that another vessel will take avoiding action even if it is aware that a risk of collision exists.

CHIRP contacted the ship's manager who forwarded the information to the ship and subsequently discussed the report when the superintendent visited the ship.

Unfortunately the crew had changed before the report had been received by the ship. The master appreciates **CHIRP** publications and the in depth analysis of dangerous situations but after several months it was difficult to reconstruct a specific situation. The master stated the use of VHF unfortunately causes confusion a lot of the time.

The superintendent visited the ship whilst in Europe to discuss the report but the relevant person was no longer on board. However, they found that the ship had been at the mentioned position at the time stated in the report but the model of the Voyage data recorder on the ship does not record VHF conversations.

CHIRP Comment: The use of AIS is useful for the identification of a ship, but is not recommended for collision avoidance. AIS measures speed and course over the ground and not through the water.

The refresh rates for AIS also need to be considered. For AIS class A, between 2 and 10 seconds depending on vessel speed and for AIS class B every 3 minutes where speed over ground is less than 2 knots, or every 30 seconds for greater speeds.

The Yacht skipper is complemented for the actions taken and the ship manager for investigating the report onboard.

DP WATCHKEEPING AND THE ROLE OF CHARTERER'S REPRESENTATIVE

CHIRP received a report requesting clarification on two aspects of offshore vessel operations (a) the roles and responsibilities of officers when working on ships in dynamic positioning or more commonly known as in DP mode and (b) the authority of an appointed charterers representative.

CHIRP has consulted oil industry organisations when composing this reply, which includes background information for the benefit of those readers not conversant with offshore dynamic positioning (DP) operations.

(i) There are frequent occasions in the offshore industry when the Ship owner/operator's regular officers, whilst qualified as DP Operators, may not have sufficient time to qualify for a full DP Certificate. If the project requires such certification in order to meet either internal and/or external (industry) standards, a Senior Dynamic Positioning Operator (S.D.P.O.) will be appointed. This position should be defined in the charter party and the person is then employed by the vessel's operator to supplement the existing crew.

During DP operations there are normally two watch keepers on the bridge at any one time; the shifts are normally 12 hours on and 12 hours off. During the watch, the rotation at the DP desk is an hour about, one hour on the desk the other hour doing a safe navigational watch. In most situations the 'off desk' DPO maintains the lookout and 'traditional' watch-keeping role whilst the 'on desk' DPO focuses on the DP operation.

CHIRP Comment: Full certificates are required on DP Class 2 & 3 ships and a limited certificate can only be used on DP Class 1 ships. Clarity over the respective roles of the DPO on the desk and OOW is a bridge resource management (BRM) issue and should be set out clearly in the Safety Management System (SMS). Under The International Convention on Standards of Training, Certification and Watchkeeping for Seafarers (STCW), SOLAS et al, there is a requirement to maintain a safe

navigational watch; by default it is the master/OOW that must retain full responsibility for the actions taken. An OOW should not feel his/her responsibility on the bridge is compromised as the result of the S.D.P.O.'s actions whilst in DP mode.

(ii) Offshore industry vessels often have a charterer's representative placed on board to oversee the client's needs and ensure these are carried out in the terms of the charter party. Note also that these representatives may not necessarily be from a marine background or discipline.

Oil companies rely on charterer's (client) representatives primarily as their eyes and ears onboard a vessel and they are expected to advise and monitor operations to ensure that they are followed in accordance with company expectations. Any representative should be there to advise and not to directly instruct how an operation is carried out (as this should remain within the respective contractor's safety management system and the project procedures). The master can expect a bridging document to be in place for all significant projects and term period charters, this document is primarily designed to bridge the respective management systems and ensure that there is clear allocation of responsibilities between stakeholders.

However CHIRP has been advised there are an increasing number of instances where the presence of such persons on the bridge has become intimidating and overpowering to the point at which the bridge operations can become potentially hazardous. This has led to reports of dangerous occurrences, including:

- (i) Charterer's representative without the knowledge and agreement of the O.O.W., transmitting a radio message to another vessel on a private U.H.F. radio channel, instructing the vessel to come alongside and transfer materials This was without the permission or knowledge of the O.O.W.
- (ii) Charterer's representative instructing the DP operator to speed up the operations and
- (iii) Insisting the bridge house lights are switched on whilst vessel is under way, despite the OOW expressing concern over the potential navigational risk.

CHIRP Comment: The master always retains overall responsibility for the vessel and for the safety of persons on board. The charterer's representative does not normally sign on the vessel articles but every OOW should have high expectations of the charterer's personnel placed on board. The operations for a project, on a day-to-day and watch basis, should be agreed beforehand. Any unsanctioned vessel/cargo operations are considered to be a reportable hazardous occurrence. The combined goal is always to achieve the mission safely and in accordance with procedures. The only time the client representatives are advised to directly intervene is when they witness an unsafe operation or act.

Some vessels will have an Offshore Construction Manager or a Diving Supervisor who can also be employed by the

Operator. Again those roles play no part in the vessel technical operation/navigation but do have responsibilities for the completion of the vessel's industrial mission and these should be clearly stated in the bridging document.

A charterer's representative should not be asking anything that is not part of the standard operating procedures for the vessel; this in turn should be supported by a risk assessment for the work to be undertaken. If a charterer's representative asks for work outside the parameters of the risk assessment, the controls in place should prevent the work until the ship manager has reviewed the proposals.

Much depends on a personal rapport established between the master and the charterer's representative from the outset. The charterer's representative needs to keep the master continuously well informed of intent so the master may fully appraise the situation and plan accordingly. The charterer's representative needs the master to feel comfortable so that at any time he feels the intent, situation and plan are compromising the safety of the vessel he can veto such action and stop the operation without question. Such a veto needs to be immediately supported by the charterer's representative without appearing critical. Such a relationship based on communication, preparedness and ultimate veto authority being encouraged will lead to a good working relationship between the two parties.

If the O.O.W. is concerned over hazardous incidents, these should be reported and the master should be empowered to ensure the bridging document is complied with.

If it is not possible to achieve such action through the company SMS, truly confidential reporting to capture the learning from incidents is available through **CHIRP**.

Industry documents to refer to for guidance can be found in the IMCA Information Note TCPC 12/04 Competence of Client Representatives. Also roles are summarised in the International Association of Oil & Gas Producers: OGP431 Diving Worksite representative roles, responsibilities & training.

INJURY DUE TO ADVERSE WEATHER

Report Text: The vessel encountered a heavy swell, which caused green seas on the bow deck, but the following day the swell reduced, there were no seas on deck, only sea spray. The master had a meeting with the chief officer, they discussed the improvement in the sea conditions and they decided that it was a good opportunity to inspect the forward part of the vessel to verify if there was any damage. At that moment in time the weather conditions wind NW 5 with N'ly swell. The chief officer together with the Bosun and one AB, wearing all necessary PPE and having established communication with the Bridge, were ready to go forward. The master was on the bridge. The team arrived at the forward of the vessel and entered into the Bosun Store to inspect the area. The chief officer reported to

the master that the store was dry and that he and the other crewmembers intended to approach the windlasses in order to check the condition of anchors' lashings. At that moment the vessel started to increase her rolling due to synchronization with the swell. The team was close to the starboard windlass when a wave came on deck and dragged the three seamen away, they in turn collided with deck fittings. When the bow deck was clear of water, the team returned back to the accommodation where the chief officer was transferred to the ship's hospital in order to be examined for possible injuries.

Lessons Learned:

- (i) Despite the weather conditions not being prohibitive for the team, there wasn't any strong evidence for the need to inspect the forecastle. The reasons for undertaking such tasks should be properly evaluated. A risk assessment should be performed and all the precautions should be taken (even a major alteration of the course). The period of exposure should be continuously evaluated and restricted to only important tasks.
- (ii) If the crew should be exposed to high adverse weather condition to perform tasks crucial for the safety of the vessel/ the crew/ the environment, the alteration of the course and adjustment of the speed should be taken into consideration in order to minimize the risk. In addition, the crew should be fastened to strong points and backup personnel to be close to them and provide all the required support.
- (iii) The master should establish watches to monitor not only the exposed personnel but also the surrounding area for abnormal sea condition.
- (iv) In addition to portable communication, establish backup communication ready for immediate use (such as public address). Ensure all of the crew on deck are aware of it.

Action by the company: The report was circulated to the Fleet reminding them that when members of the crew are exposed on deck during adverse weather conditions, the Company's SMS provides procedures for such situations and a relative risk assessment scenario is provided for the use of each vessel through company's risk assessment library.

CHIRP Comment: During heavy weather, and particularly with seas breaking over the deck, there must be a presumption of damage to the vessel until proved to the contrary by visual inspection. The fitting of remote bilge sensors to forecastle stores cannot be relied upon to indicate flooding and in any case condensation/rolling drainage into bilge wells often gives false positive flooding warning. Once these have been activated, even if a false alarm they then give no further warning of continuous flooding. Recommended practice on prolonged voyages into heavy weather is to daily turn the vessel away from the sea and muster a forward inspection party to sound forward spaces, check the security of anchors, lashings, closed forward space ventilators and inspect the forecastle

store. Only when personally and visually proved, there is no damage to the ship can the voyage be continued, in the knowledge the vessel is being operated within safe parameters with condition and speed matched to the prevailing weather conditions.

There are many considerations to be taken into account when mitigating the exposure to risk. When slowing the ship down to gain access, give sufficient time for the vessel to settle at the new speed and assess the new rolling motion. When turning the ship around at a set time every day, allow the ship to settle in the new rolling motion for 10 minutes before anyone goes on deck.

On a ship with no Flying Bridge walkway, under the Loadline rules, the ship must have lifeline wires through stanchions on each side of the ship, it is good practice to use double clip-on harnesses, allowing the seafarers to clip ahead of the strong point before disconnecting (just as the good practice when mountaineering).

UNSECURED WATERTIGHT DOOR

Report Text: A watertight door left open and unsecured on main deck. This created potential injury to limbs. Causal factors: Failure to follow procedures and an inadequate securing system.



Lessons Learned:

There is a need to improve safety awareness onboard; hazards can be encountered in all onboard activities including the routine ones. Hazards are controlled through the implementation of the Company Safety Procedures, onboard training and good seamanship practices. A moment of inattention could result in injury.

CHIRP Comment: Leaving these doors permanently open at sea increases the risk of progressive flooding and loss of stability. International Convention for the Safety of Life at Sea (SOLAS) describes how watertight doors should be used, including how and when these doors can be left open and when they need to be closed. Vessel management teams are encouraged to ensure that all personnel are aware of the risks and that watertight doors are kept closed and to use all of the dogs.

IMCA advised in 2001, there are a few safety basics for protecting your hands and body when walking through watertight doors.

In rough sea conditions, use both hands to control heavy passage doors – When entering through a doorway look up and look down to avoid striking head and feet on doorframe – Always face the door when both opening and closing the door – Never attempt to open or close a watertight door while holding an object in your hands – Never lose contact with door. Always grasp door with at least one hand – Never grasp a door by its edge. Always hold the door by an inside or outside handle.

If regulations will allow, consider installing a door closure device designed to aid door control and stability.

MACHINE GUARD NOT CORRECTLY ALIGNED

Report Text: 2nd Engineer noticed the 3rd Engineer was using the grinding machine for cleaning bolts whilst the distance between the safety beam and the wheel brush was more than 10 mm. Potential hazard – injury to operator.

Causal Factors: Inadequate tool for the job, Inadequate training/supervision.

Corrective Action: This incident underlines the need for effective inspection of the equipment and tools prior to their use. Defective tools or equipment is a cause of accident onboard, hence it is necessary and important that the tools and equipment are thoroughly inspected and tested by the supervisor and the user prior to use.

CHIRP Comment: A good example of the senior engineer looking after the safety of his ‘buddy’ in the workshop. Good practice should include a senior engineer confirming the level of competence of each individual through situation awareness training in the use of wire brushes, abrasive wheels and grinding machines.

A useful reference for such equipment is the UK Code of Safe Working Practices for merchant seamen (COSWP). This can be downloaded at no cost from:

[https:// www.gov.uk/government/publications/code-of-safe-working-practices-for-merchant-seamen-coswp](https://www.gov.uk/government/publications/code-of-safe-working-practices-for-merchant-seamen-coswp).

Chapter 20 USE OF WORK EQUIPMENT provides guidance on Workshop and Bench Machines (Fixed installations) (section 20.5) and on Abrasive wheels (Section 20.6).

THE MASTER’S INSPECTION

Report Text: During an inspection of the accommodation, the plastic light cover of a cabin toilet light was missing and posed a potential risk of electrocution of the occupant. On another occasion it was observed that the filters on the driers in the crew laundry were very dirty with clothes flocks creating a potential fire risk. A good practice is to post a warning notice, “Clean filters before use” and place this adjacent to the driers.

CHIRP Comment: These observations help demonstrate the value of vigilant routine inspections, over and above planned maintenance inspections. The safety culture onboard these ships can be improved by ensuring each individual is aware of their personal responsibility to report the hazardous occurrences around them and not just wait for the master to find deficiencies.

CORRESPONDENCE

INCINERATORS – TOO HOT TO HANDLE?

CHIRP has received reports from a ship manager relating to serious incidents involving incinerators

Report 1: An engineer was carrying out incineration of garbage assisted by an oiler. After loading several bags containing either rags or filters into the incinerator, one of the bags containing a filter jammed. The interlock that should have prevented the engineer from opening the external door failed, he opened the external door of the loading chamber and attempted to use a stick to free the filter. When this was not successful he then attempted to push the filter with his hand. The filter became free causing the sluice door to close suddenly, trapping the hand until another engineer freed him a few minutes later. The engineer sustained 3rd degree burns and subsequently had to have an amputation of his fingers and thumb on the right hand.

Investigation into the incident revealed, direct causes:

- Unsafe Condition: Interlock failed allowing the external door of the feed chamber to open.
- Unsafe Act: The 4th Engineer opened the external door and put his arm into the incinerator instead of stepping back.
- The oiler did not intervene in this incident.

Root causes:

- The safety device (interlock) was inoperative after a modification had been carried out on the system.
- Ships staff were unaware that a contractor had made the modification.
- The sluice door did not fully open when an impulse was given on the sluice door button.
- The Engine Information Book had four documents related to the operation of the incinerator, which gave conflicting information.
- The burning of garbage was not on the daily work plan. Garbage had been previously burnt on board without being on the daily work plan. No Risk assessment was used on this occasion.

Report 2: While operating the incinerator, a bag of oil soaked sawdust was put into the loading chamber and within seconds a fireball was ejected from the chamber causing second-degree burns to the operator.

Investigation into the incident revealed, direct causes:

- Modifications to the incinerator were not documented correctly (internal refractory wall had been removed).
- Incinerator was not being operated as designed and did not allow the combustion chamber to reach its optimum temperature of 850°C before loading garbage. It had become common practice onboard to run the incinerator at much lower temperatures; there was evidence of incomplete combustion. Debris was evident in the sluice door hinges; this prevented full closing of the sluice door.
- The quantity of sawdust in each bag was not strictly controlled; the manufacturer's instructions state a maximum of 12 litres to be loaded however 14–16 litres of sawdust was removed from the incinerator after the incident.
- Correct requirements for PPE should have been reviewed prior to the commencement of the task. The provision for a full-face visor and flash hood/neck protection is now mandatory for persons involved in or observing incinerator operations onboard.
- Failure of the door interlocks allowed the loading door to be open even though the sluice door wasn't fully closed. The limit switch on the sluice door was not operational; this went unreported.
- Inner sluice door was not properly maintained, this contributed to the door not being fully closed during operation.
- There was an inherent lack of comprehensive and effective training onboard pertaining to the correct and safe operation of the incinerator.
- A comprehensive toolbox talk never took place prior to incineration commencing.

The ship managers also advised that over a period of 6 years their fleet received 61 non-conformances reports with 15 having the potential to cause injury or damage.

The main causal factors were the failure to follow rules, failure to secure the unit before use, improper handling of waste, inadequate preparation/planning and equipment failure.

A deeper look for the root causes identified error enforcing conditions, hardware and inadequate hardware design/construction/installation and inadequate procedures.

FOLLOW US ON FACEBOOK

We are encouraged by the enthusiastic response to our Facebook page; we have support from over 1500 followers from all around the world. You are all helping us to make CHIRP more accessible to the global community of seafarers. We encourage more seafarers to join us. Enter “**Facebook CHIRP Maritime**” into your search engine, you will easily find us; or use the link from our website www.chirp.co.uk

In recent months we have published short articles on:

- 166 lifeboat and rescue boat accidents were reported to the Marine Accident Investigation Branch (MAIB) between 2002 and 2012.
- Reports of collisions, allisions and groundings either in or near designated pilot embarkation and disembarkation areas, reveal the underlying cause was the members of the bridge team becoming distracted and losing their situational awareness.
- Best Practice mooring observed in the Port of Stavanger. Mooring lines were dipped and bollards tested to 50T SWL, the date of last test stamped on a metal plate fixed to each bollard.
- It is timely to remind ourselves of the Maritime & Coastguard Agency guidance on the marking of Fishing Gear.

BULLYING & HARASSMENT

Eliminating workplace harassment and bullying is still a challenge at sea and must be stopped, we are losing good people through this unacceptable behaviour. The Swedish Merchant Navy recently conducted a survey and identified 45% of women and 22% men (48% deck, 58% machinery, 34% catering) had experienced harassment at work within the previous 12 months. The deck department and the engine department had more experienced abuse or harassment in lower job levels compared to higher. There was no difference between the various occupational categories, vessel types, the sea areas or marital status.

In 2010 a Nautilus International survey revealed nearly half had personally experienced bullying, harassment or discrimination in their workplace.

If you experience this intimidating behaviour onboard, there is support material you can reference. The European Community Shipowners Associations and European Transport Workers Federation have provided ‘Guidelines to shipping companies’.



Available through the **CHIRP** website www.chirp.co.uk

Also a short video accompanies this work:

https://www.youtube.com/watch?v=sqA_JuE32cc&feature=youtu.be

*Please note all reports received by **CHIRP** are accepted in good faith. Whilst every effort is made to ensure the accuracy of any editorials, analyses and comments published in **FEEDBACK**, please remember that **CHIRP** does not possess any executive authority.*

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CHIRP MARITIME REPORT FORM

CHIRP is totally independent of any organisation in the maritime sector

Name: ▲
 Address: ▲

 Post Code: ▲ Tel:
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▲ Indicates mandatory field

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.

If your report relates to non-compliance by another vessel with regulations, CHIRP generally endeavours, to follow this up with the owner or manager of that vessel, unless you advise otherwise. The identity of the reporter is never disclosed.

NO. You do not have my permission to contact a third party

If your report relates to safety issues that may apply generally to seafarers, it may be considered for publication in Maritime Feedback unless you advise otherwise. Reports may be summarised. The name of the reporter, the names of vessels and/or other identifying information are not disclosed.

NO. Please do not publish in MARITIME FEEDBACK

YOUR POSITION ONBOARD OR IN ORGANISATION	THE INCIDENT	THE WEATHER
<input type="checkbox"/> Master/Skipper <input type="checkbox"/> Chief Engineer <input type="checkbox"/> Deck <input type="checkbox"/> Engine/ETO <input type="checkbox"/> Catering <input type="checkbox"/> Officer <input type="checkbox"/> Manager <input type="checkbox"/> Rating Other:	Date of Incident:	Wind force:
	Time: Local/GMT	Direction:
	Vessel Location:	Visibility (miles):
	TYPE OF OPERATION	YOUR VESSEL
	<input type="checkbox"/> Commercial Transport <input type="checkbox"/> Offshore <input type="checkbox"/> Fishing <input type="checkbox"/> Leisure	Name:
		Type: (Tanker, Bulk Carrier, Fishing, Yacht, etc)
		Flag:

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. Please bear in mind the following topics when preparing your

narrative: Chain of events; Communication; Decision Making; Equipment; Training; Situational Awareness; Weather; Task Allocation; Teamwork; Sleep Patterns.

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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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Please place the completed report form, with additional pages if required, in a sealed envelope to: **FREEPOST RSKS-KSCA-SSAT, The CHIRP Charitable Trust, 26 Hercules Way, Farnborough, GU14 6UU, UK** (no stamp required if posted in the UK).

Confidential Tel (24 hrs): +44 (0) 1252 378947
or Freephone (UK only) 0800 772 3243

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