

CHIRP MARITIME FEEDBACK

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EDITORIAL

Welcome to the latest edition of **CHIRP Maritime FEEDBACK**. Whilst we enjoy working on confidential near miss reporting and sharing the lessons learned, we always encourage ship owners and managers to realise the full potential value of their own company near miss and hazardous incident reporting system.

I read a recent report where the Bosun found four broken 'U' bolts on the cable pipe rack running along the main deck. The broken parts had been covered with paint indicating the 'U' bolts had been broken for a long time. The fixings have a purpose but those responsible for maintenance were more interested in the cosmetic appearance, rather than being concerned about what could have happened when heavy seas landed on the main deck, thereby creating uncontrolled movement and damage to the pipe and cables. Every day there are many eyes looking at the ship's equipment and yet many are blind to what is around them. Why is reporting these failures not considered important, or is it sadly considered to be just another paperwork chore?

Ship managers often remind the crew that it is of high importance to report defects, malfunctions, unsafe work practices, or substandard conditions of equipment. These can often be just words without commitment and encouragement, as there is already too much paperwork required to be sent from the ships. So let's stop pointing the finger at seafarers and saying they should do more. Instead, let's encourage them to report near misses, or 'learning events' and why not try the simplest of reward schemes onboard, such as a free phone card each month for the person that has the largest number of learning events recorded and accepted as valid? For those managers whose performance is driven by accountants, experience shows that up to 5% of learning events will result in saving the owner money! Also, and as a consequence, shipboard safety meetings will have more interesting and relevant subjects to discuss.

It is important to remember that every learning event deserves a reply. Very few people write a letter without expecting a response from the addressee, so safety managers need to look at their own performance!

CHIRP replies to all correspondence received, we hope you enjoy this latest edition of Maritime FEEDBACK.

John Rose Director (Maritime)

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.

REPORTS

SAFETY EQUIPMENT – WORKING OUTBOARD

Report Text: Upon departure from the port, whilst preparing the pilot ladder and working outside the ship's rails, an AB was observed to be not wearing his life jacket and safety belt. The company risk assessment states the crewmembers involved in this job should wear a life vest and safety harness, but the safety measures identified in the job hazard analysis had not been properly communicated onboard. The lack of adequate job instructions and supervision created a risk of death for the AB as a result of falling overboard.

Lessons Learned: Prior to commencing the work, neither the supervisor nor the personnel involved had effectively reviewed the activity using a job hazard analysis. Ship personnel were reminded that in 2010 a fatal accident occurred on a fleet vessel during the handling of the ship's gangway. They were asked to review the lessons learned in the report "Fatal accident to an AB who fell overboard during onboard work activities when securing the accommodation ladder". It should be noted that if the AB had been wearing a working life-vest this could have increased the chances of saving his life. Strict implementation of safe working practices, as per the provisions of the Company's SMS, is essential in order to prevent accidents.

CHIRP Comment: Whilst the company procedures were in place, the implementation of these was not. The supervisor and fellow seafarers did not stop the person when starting to work over the side of the ship: The effectiveness of the safety culture onboard should be reviewed. The report should consider the design of the equipment and the need for crewmembers to work over the side when rigging the pilot ladder. Also they should consider the effectiveness of wearing a life vest and a safety harness: It is good practice to use double clip-on harnesses, so there is always one attached line when relocating the other (See advice in Maritime FEEDBACK 39 page 5), then if worn correctly there should be no possibility of falling into the water.

USE OF NON-TESTED WIRE SLING

Report Text: During the lowering of an electrical motor from the poop deck to the engine room, the crew used a non-certified, handmade wire sling. As a result of this improper control of the lifting equipment, the potential risk was the failure of the wire sling resulting in damage to the motor and/or injury to the crew.

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Lessons Learned: Only portable lifting appliances that have been inspected, tested and then confirmed as suitable for use are to be made available to the crew. Appliances that have not been tested should be separated from those in good condition, while the crew should provide a warning tag to prevent accidental use. Safety Management System (SMS) instructions state that all portable lifting appliances/equipment should be tested by a competent person every five years and thoroughly inspected every year. Lifting appliances/equipment that have not been tested/inspected as above, must not be used. An inventory of all portable lifting appliances, as well as records and details of testing and inspection details, should be maintained. All portable lifting appliances must have stamped on, or attached to it, a permanent identification mark through which it can be identified as suitable for use for the intended job. All crewmembers involved must be fully aware of these procedures.

CHIRP Comment: A useful overview by the reporter. In addition, ensure the toolbox talk includes the checking of the identification marks and that there are test dates on all portable lifting equipment. See also the Code of Safe Working Practices for Merchant Seaman (COSWP) Chapter 21 Provision and Care of Lifting Plant and Carrying out of Lifting Operations.

WATER UNDER THE FLOOR OF A LIFEBOAT

Report Text: Water was observed under the floor in the freefall lifeboat when it was lowered to the waterborne position. This accumulated water had slight corrosion on the high-pressure air bottles.

Causal factors: Substandard working practices not followed and poor housekeeping.

Preventative action: All flooring was removed; the inside bottom was cleaned and dried out; air bottles were disconnected and removed from the lifeboat then carefully chipped and painted over with two layers of paint. The matter was discussed with the safety and deputy safety officers and the necessity of inspecting the freefall lifeboat for the presence of water was recognised as being important. The ship managers confirmed the above actions were appropriate. The master advised everyone that during each weekly inspection of the lifeboat, any water accumulation is to be checked and, if found, removed immediately.

CHIRP Comment: The source of the water under the deck flooring was not mentioned: It was most probably due to the failure of the hatch seal. A weekly visual inspection of survival craft, rescue boats and launching appliances is required under SOLAS III/20.6.1. Chipping air bottles is not recommended. If there is that level of corrosion, the bottles should be landed for overhaul/testing and if light scale is observed, then use of a wire brush and painting may be appropriate.

FREE FALL LIFEBOAT RELEASE JAMMED

Report Text: During an abandon ship drill we encountered difficulty in releasing the free fall lifeboat from its stowed position due to the moveable parts being stuck in the stowed position. The procedure for performing the simulation test was missing on board the vessel.

Causal factors: Failure to follow planned maintenance inspections resulted in inadequate maintenance due to guidelines not being followed.

Preventative action: The matter was discussed on board. The frequency of testing the release mechanism is important as it clearly detected a fault at the time of the simulation test. The ship managers agreed with the vessel's comments that the release mechanism should be tried out frequently, i.e. checked once a month and the parts well greased to prevent corrosion of any touching parts that can cause the jamming of the release system.

CHIRP Comment: This incident is a failing of the preventative maintenance system and it is surmised that the practice of not correctly maintaining the equipment may be due to adverse weather, or the trading pattern.

More controversially the "simulated launch" training has been at the centre of concern within the industry, causing some to question the value of the exercise. Furthermore, CHIRP has been made aware of a relaxation of the requirement to launch freefall lifeboats by some Classification Society surveyors, acting on behalf of flag states, but it is understood that this is not universal.



Picture shows the stowage of a shipboard Freefall lifeboat.

"When designing and certifying equipment such as on-load release systems for lifeboats, all facets of the equipment's possible operation, use and environment must be taken into account and allowed for. Only then can fully comprehensive instructions be documented, enabling seafarers and others to safely use and maintain the equipment under all conditions."

CHIRP will welcome comments on a suggestion that shoreside training for freefall launching could be a suitable and prudent alternative to shipboard exercises. It has been suggested that it would not expose strops, often of wire; to repeated shock loads and it would not rely on the careful monitoring of the condition of the exposed equipment and accurate resetting of on-load release gear,

all of which could influence the success or failure of the exercise. The training would not be unlike that used to train offshore workers in helicopter ditching. It is also accepted that gear should remain subject to some system of testing as is conventional with lifting gear but it should not involve such regular human exposure.

LIFERAFT PAINTERS NOT SECURED TO SHIP

Report Text: No painters from any liferaft were attached to any part of the ship construction for automatic activation in case of the vessel sinking. The liferafts were sent ashore for annual service and upon return the chief officer did not ensure the correct securing of the liferaft painters.

Preventative action: Master discussed the issue with all crewmembers during a boat drill briefing and also advised that the liferafts should be checked during weekly routine inspections.

CHIRP Comment: The end of the painter of every liferaft should be secured to a suitable strong point so that on being launched the raft is held to the ship and thereby inflates the liferaft. See MCA's Marine Guidance Note M343.

INFORMATION OVERLOAD

Report Text: A recent incident occurred whilst docking a new large car-carrier vessel into a lock, with a professional bridge team management in place. Whilst the vessel was approaching the lock, the amount of verbal reports from the officers fore and aft and on the bridge became so detailed and relentless that the master became overwhelmed by the information he was receiving. This was in addition to him taking in visual observations during the manoeuvre and the instructions from the pilot.

The point at which this occurred was the most critical position during the manoeuvre. The bow thruster had to be stopped and reversed, also the helm put to amidships, in addition the tug had to be stopped and its direction of pull changed in order to lift off if required. This is a relatively common manoeuvre when entering a large modern lock and is often done under strong wind and tidal conditions, which require a fast changing stream of clear and concise instructions from the pilot to the Master, bridge team and the tugs.

I was concerned that the master appeared to freeze at this point and seemed unable to act on my instructions to stop the thruster and order the helm amidships. Needless to say I repeated my orders forcefully, and the required actions occurred.

This situation seems to be becoming more common, especially on vessels where there is a more defined bridge team in place that have obviously undergone some formal training.

I feel that the pendulum has swung too far in requiring reporting distances, headings, engine settings, helm orders, as well as wind speed and direction and other spurious information, all to be relentlessly chanted out in what are already challenging conditions.

The vessel involved was less than one year old and was fitted with a docking display giving fore and aft speed, athwartship speed, wind speed and direction.

As the pilot on this sensitive vessel, I was also using a personal pilot unit (PPU) that gave me an indication of position, track vectors and speed and was assisted by a second pilot positioned on the starboard shoulder giving me distances off & approach tendency.

To improve this, I would recommend that officers tasked with giving distances off merely give the distance without any further commentary and should not expect this to be acknowledged over the radio.

In the case of the officer and helmsman repeating orders, this should be done positively and quietly without three repetitions of the same order.

Having spoken to my colleagues, this is an issue we all have to deal with. Usually it is only an unwelcome distraction that annoys, but it has the very real possibility of causing information overload to both the pilot and master with consequent damage.

CHIRP Comment: The quality of the leadership of the master is very important and should include a full briefing of the bridge team when the pilot arrives, prior to arrival and departure from a port and be followed up with a debrief on completion. See The Nautical Institute (NI) Publications: *Bridge Team Management 2nd edition*; 'Navigator' Issue 7, October 2014 – *Bridge Resource Management*.

CLEANING OF MOVING MACHINERY

Report Text: After completing repairs, the engine crew were cleaning the booster pump of a generator. Rags that were used for cleaning were caught and then stuck in the pump's shaft bearing. The pump was running throughout the cleaning work.

Lesson Learned: This incident highlights the hazards involved in moving machinery. The movement of machinery parts – if not properly guarded – may have the potential to cause injury, for example by entanglement, friction or abrasion, cutting, shearing, stabbing, or puncture, impact, crushing, or drawing a person into a position where injury can occur.

As such, this hazard must be identified during the relevant safety "toolbox" meeting prior to the work, where the job-specific Risk Assessment/Job Hazard Analysis will be carried out and appropriate measures taken, with the aim of minimizing risk. In this particular case the cleaning work should not have been carried out with the pump running (Hazard Elimination) and in addition, as a second safety barrier, appropriate power isolation/lock out should have been made prior to the cleaning work commencing.

CHIRP Comment: The reporter has provided an appropriate list of lessons learned. However, the company should apply a Permit to Work system for this type of work, together with a 'Lock out'/'Tag out' system. This should be combined with checking the effectiveness of the SMS and any related training provided.

SELF-CLOSING VALVES WIRED OPEN

Report Text: During a morning inspection of the engine room it was noticed that a self-closing cup valve on the Heavy Fuel Oil overflow tank was in the 'open' position and tightened in position with wire. This was an improper attempt to save time/effort.

Lesson Learned: Self-closing cup valves for the engine room tanks must never be inhibited but must be able to operate freely at all times.



The observed practice is totally unacceptable as it could have serious consequences for the vessel and is contrary to Company's instructions and SOLAS requirements. There are a number of risks associated with this bad practice including the following:

- (a) Overflow of the tanks into the engine room.
- (b) Fire hazards in case of oil overflow.
- (c) Release of dangerous vapours in the engine room.
- (d) Flooding of the engine room in case of an emergency (e.g. grounding) etc.

Chief engineers should ensure that all self-closing devices operate properly and then instruct the engine crew to ensure/verify free operation of the devices whenever they use them.

Ensure that a warning note is provided next to the closing devices stating the following: "Self-closing devices should NEVER be inhibited".

CHIRP Comment: The lessons learned and preventative actions are appropriate. The value of routine inspections is clearly demonstrated.

NO WARNING NOTICE ON ELECTRIC PANEL

Report Text: During the overhauling of the Heavy Fuel Oil (HFO) transfer pump, the 2nd Engineer instructed the Electrician to isolate the power of the pump and display the "warning notice" on the electrical panel, "Do not touch under repair". However, later when he inspected the panel, the 2nd Engineer realized that the electrician failed to implement his instructions. There was a risk of an accidental start of the motor, resulting in an injury of the personnel working on the pump.

The SMS states in the section "Execution of maintenance work, based on the PMS" that all mechanical and electrical power connections must be isolated prior to work commencement and relevant "DO NOT OPERATE" tags must be posted at the control positions. The relevant work permits must be issued in this respect. There is also allowance for the fact that prior to work commencement and depending on the nature/type of the inspection/repair/maintenance work, there might be the need, to isolate/lock out and tag vessel's equipment, valves, mechanical or electrical power connections, breakers, switches etc. In that case, a "DO NOT OPERATE" tag has to be posted so as to prevent unauthorized use.

With a view to facilitate the uniform implementation of the above requirement onboard the fleet vessels, the Company issued a standard format for the "DO NOT OPERATE" tags. Laminated reusable tags (in A5 size) have been prepared and will be forwarded to all fleet vessels (8 pieces per vessel).

Lesson Learned: It is important that the above procedures have been communicated effectively to all crewmembers and are implemented strictly at all times onboard.

CHIRP Comment: The qualification of the electrician was questioned (ETO certification). The 2nd Engineer appreciated the high risk associated with electrical equipment and did well to check but it is unclear if the work had started before he checked. It appears this was an ad hoc check and not driven by the SMS procedures. CHIRP is concerned the preventative action of an A5 size notice was short term and inadequate. A better approach would be to amend the design of the electrical panel casing and install a multi lock system, or 'Lock out for life' system, that creates a physical barrier, before operating the related electrical system.

IN PUMP ROOM WITHOUT ENTRY PERMIT

Report Text: During the work meeting on the daily work activities, between the Chief Officer, Bosun and Pumpman, it was agreed no work was to commence in the pump room without first issuing the entry permit. However, an AB was found in the pump room during checks on the atmosphere. The incident occurred because the person involved failed to apply the relevant company safety instructions, either because he was not aware of these, or due to inadequate diligence to comply with them.

Lesson Learned: The "toolbox" work meeting was ineffective because it did not include all of the people involved. A "Toolbox" safety meeting should be carried out at the work site prior to every work activity and include all personnel involved, thereby ensuring the agreed procedures are communicated to all personnel involved.

Ship's personnel were reminded that any entry into the cargo pump room includes a number of hazards. The Company's SMS provides specific safety measures that should be followed prior/during every entry, in order to ensure that risks associated with identified hazards are reduced, so far as reasonably practicable and ensure safe pump room operations are in place.

Prior to any entry into the pump room, a number of safety checks should be carried out and an entry permit should be issued. It should be noted that a notice warning the crew about the safe entry procedures should be provided at the entrance to the pump room. Failure to implement the requirements of the Company's "work permit system" may cause serious accidents or death.

CHIRP Comment: The reason why the AB was in the pump room was most likely due to the failure to communicate the potential risks involved and the precautionary procedures to be applied to all crewmembers. The concern here is no matter how many deaths and accident reports, training and warning notices, we still see deaths in enclosed spaces with alarming regularity.

WHAT IS AN ENCLOSED SPACE?

Report Text: During the master's inspection it was observed that the bow thruster entry procedure was incorrect, the bow thruster entry log was missing and the enclosed spaces were not identified on board the vessel. Crew members were not complying with the bow thruster space entry procedure and a job risk assessment was missing.

Causal factors: Failure to follow rules and regulations; inadequate warning system; inappropriate knowledge and training.

Preventative action: A new procedure for the entry into enclosed spaces was produced and all enclosed spaces identified. The Job Risk Assessment for entry into the bow thruster was produced and the crew passed the onboard training.

CHIRP Comment: The clarity of what is an enclosed space onboard should be determined and then controlled through a permit to work system with an entry permit issued on every occasion.

INCINERATOR DOOR SECURITY SYSTEM

Report Text: During a Port State Control visit to the ship, it was noted the security system of the incinerator door was disconnected.

Causal factors: Failure to follow planned repair/maintenance instructions on defective equipment. Inadequate guidelines listed in manuals.

Preventative action: All waste oil incinerator alarms and trip devices were tested as per the monthly checklist and all were in operational condition, without remarks. The main cause of the problem was two small securing bolts, which keep an interlock plate connected to the door. They were not found during the investigation and probably fell down into the incinerator furnace. This in turn was caused by a wrong size or a bad thread condition that allowed them to unscrew due to vibration or heat effect.

The repair was put in place immediately and additionally LOCTITE glue used for better securing of these small bolts. The officer in charge and the incinerator operator were instructed to check all safety devices on the incinerator every time before operation.

CHIRP Comment: A useful reminder on the importance of safety checks before use of an incinerator.

MAIN ENGINE NOT STARTED

Report Text: Whilst the vessel was making an approach to the berth, the main engine did not start when requiring an astern movement. Eventually after a couple of attempts the main engine was successfully started. After investigation it was revealed that one of the two starter air bottles was closed, and the air pressure in the single bottle was not enough to start the main engine. Moreover, engine staff had not monitored the air pressure at all times and therefore had not opened the second bottle in a timely manner.

Causal factors: Incorrect use of equipment or machinery; lack of knowledge and leadership with requirements/guidelines not followed.

Preventative action: The matter was discussed with attention focused on the proper preparation of the main engine. If a bottle valve is kept shut then the duty engineer must monitor the pressure at all times and be ready to open the second bottle in a timely manner. The master should receive proper information from the chief engineer about the position of the interconnection of the air bottle valve. In addition, the master was advised to be more careful when manoeuvring in those waters. The vessel was maintaining a speed of 4.5 knots, with a strong current favouring the vessel, when the pilot gave an astern movement instruction. As the engine speed was higher than the minimum revolutions (rpm) required for the engine to be started, the air brake system was used. In this process the air bottle pressure quickly reduced. When the spare bottle was opened, the astern kick was effective and there were no further problems.

Lesson Learned: The engine staff should be very watchful and either keep both bottles 'open' or be in a position to quickly open the balancing valve.

CHIRP Comment: Best practice is to test the engine astern before entry into port. The Bridge should ensure the Engine Room pre-arrival /pre-departure checks are complete. The key issue is to know the volume of the air tanks and the capacity of the compressors. Engineers should know the number of starts remaining. Consideration on the adequacy of the available starter air must be made during the design phase of the ship.

MAIN STARTING AIR RESERVOIR SAFETY VALVE

Report Text: During a routine inspection of the engine room compartment, it was noticed that the main starting air reservoir safety valves lifting levers were hardly painted and also not operational by hand in case of an emergency.

Causal factors: Lack of knowledge, inadequate work standards and guidelines.

Corrective and Preventative action: This is a common problem. Avoid blindly painting the fulcrum of levers and handles that are supposed to be lubricated and avoid getting paint into the sliding/rolling surfaces that ensure free operation.

CHIRP Comment: Care must be taken when painting such items and ensure that after completion the levers are checked for smooth operation.

UNIDENTIFIED OIL/CHEMICAL IN BOTTLE

Report Text: Some chemical/oil in a bottle was kept on the spare cylinder head for the auxiliary engine and this should have been removed and kept in an appropriate location.

Causal factors: Failure to follow rules; poor house-keeping and guidelines were not followed.

Preventative action: The matter has been discussed in a safety meeting. All were advised that no unidentified items are to be kept, especially with chemicals. All chemical/oil should be properly stored in their respective locations with information provided by the Material Safety Data Sheet (MSDS), with safety and protective items available for immediate use.

CHIRP Comment: A timely reminder of good house-keeping practice. If the contents of the bottle have an MSDS sheet, ensure it is dated.

HAND PUMP FOR CARGO CONTROL VALVES

Report Text: The hand pump for the emergency opening of remote control valves for use during cargo operations was not located near the manifold valves. The procedure for checking this pump before cargo operation was not in the company safety system.

Corrective and Preventative action: The Chief Officer was instructed to ensure the hand pump be kept near the manifold during the cargo operations, with the oil level checked and crew trained in its operation.

CHIRP Comment: Experience has shown this is an important piece of equipment and the reporter was correct in making sure the deck officers are familiar with its operation and trained in its use. Maintenance of the hand pump should be included in the Planned Maintenance System, with regular practice in the use of this hand pump to be added to the ship's drills programme to ensure familiarization with the pump operation.

TALES FROM THE GALLEY

Report Text 1: The relay box switch for the wet chemical fire suppression system in the galley was found in the 'off' position and immediately returned to the 'On' position. The chief cook and electrical engineer were re-instructed to avoid any future recurrences.

Preventative action: Electrical officer to ensure that during his daily rounds of the vessel the above switch is checked and if it is switched 'off' then enquire as to why and by whom it was done. This should be ascertained prior to 'blindly' switching it on and bring the matter to the attention of the master and chief engineer.

CHIRP Comment: A wet chemical fire suppression system that meets SOLAS regulations is designed to suppress fires in high risk equipment, such as deep fat fryers and produces a rapid fire knockdown effect. Switching off this safety feature has been highlighted as a concern and correctly addressed by the master.

Report Text 2: During a routine inspection of the galley and on the threshold of entering a restricted area for the disposal of garbage, it was revealed the galley personnel were not fully aware of the procedure and some distinctive features of using the waste grinder.

Causal factors: Incorrect use of machinery due to a lack of knowledge, inadequate supervision, and guidelines not being followed.

CHIRP Comment: The report has identified a lack of fundamental training of relevant crewmembers in these requirements/regulations.

MARPOL SPILL DRILLS

Report Text 1: During a drill using the scenario of an oil spill at the starboard side manifold, 200 litres of water was to be transferred to the drain tank. The crew were not able to do the job because two valves were open and this produced no suction at the Wilden pump. The correct line up of the Wilden pump was not carried out before loading and discharging and with no allowance for the different types of cargo (Annex 1 or Annex 2). The information on the remaining space in the drain tank was not considered when planning cargo operations.

Causal factors: Failure to follow rules and regulations due to a lack of knowledge, inadequate supervision and an inadequate warning system.

Preventative action: The Chief Officer carried out familiarization training of the crew on the arrangement of the MARPOL drain lines and the setting of the valves. For easy identification, all MARPOL drain valves are marked with their own number. Posters are sited on each side of the manifold near the Wilden pump, on the bridge and in the cargo control room. Cargo planning now includes the line-up of the Wilden pump and information on the remaining space in the drain tank.

Report Text 2: During a pollution drill, a quantity of seawater was flushed on deck to symbolize a spillage of cargo. All scuppers were plugged and water collected near the suction well of the permanently installed pump for transfer to the drain tank. The Wilden pump was started successfully, but no suction was created. Investigation revealed the well was clogged with debris.

Causal factors: Planned inspections and maintenance not followed.

Preventative action: This matter was discussed at the after drill meeting in order to avoid a repeat. Before entering the port all meshes are to be removed and wells cleaned.

CHIRP Comment: These two reports demonstrate the value of using realistic drills with water; both are examples of good practice by the master.

ANTI-SLIP AREAS

Report Text: During the Master's inspection it was observed that the first and last step of the ladder did not have any anti-slip material and some anti-slip areas on board were not marked and identified with a contrasting colour.

Causal factors: Poor housekeeping, inadequate planned inspections and maintenance.

Preventative action: Master carried out an additional inspection with the bosun and chief officer. All anti-slip areas were identified and how they should be marked and painted was explained.

CHIRP Comment: The listed preventative action is good practice. All steps should have a non-slip material top covering with top and bottom steps highlighted in yellow/white.

WHO CAN UNDERTAKE RESUSCITATION?

Report Text: During a drill with a topic of "Rescue operation from an enclosed space", it was discovered that apart from the Master, not one crew member was able to carry out resuscitation.

Causal factors: Lack of knowledge and training; inappropriate work standards and guidelines.

Corrective and Preventative action: The issue was discussed with crew members on completion of the drill. Training on how to carry out resuscitation was carried out. A new poster regarding resuscitation was posted.

CHIRP Comment: Preventative action is good practice but ship managers should be concerned over the lack of training/refresher training, officers are required to have training as part of STCW Certification of Competence.

aware of closing speeds between their own vessel and other vessels. Please read the recent MAIB flyer/report https://www.gov.uk/.../at.../file/428440/ShorewayOrca_Flyer.pdf



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Mooring lines dipped and bollards tested: Best Practice mooring in the Port of Stavanger. Mooring lines dipped and bollards tested to 50T SWL with the date of last test stamped on a metal plate on each bollard. Other port authorities should demonstrate a similar level of safety management at the interface between ship and shore. It is not a difficult task to do but despite the equipment being safety critical, it is rarely checked!

Vessels' heaving lines: Should be constructed with a monkey's fist at one end. To prevent personal injury the fist should be made only with rope and should not contain added weighted material C.O.S.W.P. 25.3.2. Please think of the person on the receiving end of the line – no weights!

Freefall lifeboat: If you are on a ship with freefall lifeboats you should read this Australian Transport Safety Bureau Report. Whilst under way at sea there was an unintentional release of the boat with one person inside! <http://www.atsb.gov.au/media/5299888/MO-2014-002-Final.pdf>

Keeping a proper lookout at all times is essential. The four pictures, taken from a stationary vessel, give an indication of how rapidly a vessel, in this case a dredger, can approach. Leisure sailors need to be particularly

CORRESPONDENCE

OPERATING AND MAINTENANCE MANUALS

In the past, **CHIRP** has expressed growing concerns that absent and inadequately prepared procedural instructions are contributing to human errors in shipboard operations and maintenance tasks. We were pleased to note on the IMO World Maritime University's Springer web site, details of a paper on the effects that the style and structured headings used in shipboard operating and maintenance manuals can have. Material from **CHIRP** publications is used in the study.

In summary: Where the seafarer is reliant upon operating and maintenance manuals as a pathway to safe and successful completion of tasks, manuals should be structured to support ease of access and inference. The application of rule-based design principles, supported by research and theory, reduces the potential for error in operation and maintenance tasks. Furthermore, in the absence of such a regime, procedures may in fact open the pathway towards unsafe behaviour, leaving both user and equipment vulnerable to the consequences of human error.

CHIRP Comment: There is little doubt that procedures and checklists will NEVER work efficiently until and unless they have ownership by the END USER.

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- Lloyd's Register Foundation
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CHIRP MARITIME REPORT FORM

CHIRP is totally independent of any organisation in the maritime sector

Name: ▲
 Address: ▲

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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: **The CHIRP Charitable Trust, Ancells Business Park, Ancells Road, Fleet, GU51 2UJ, 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