

# CHIRP MARITIME FEEDBACK

Issue No: 41

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## EDITORIAL

Welcome to the latest edition of **CHIRP** Maritime FEEDBACK. Every company desires safe operations and whilst written rules, standards and procedures are important and necessary, they are not enough. Companies must develop a culture in which the value of safety is embedded at every level ashore and at sea. This commitment to safety should be a value that shapes decision making all of the time and embedded at every level in the organisation, at sea and ashore.

A company must not only learn from its mistakes and make changes as the result on an injury or damage to an asset, it should also be proactive and encourage near-miss and hazardous occurrence reporting. This should be a key part of the strong safety culture that seafarers work in and are encouraged to adopt by their ship managers. The learning from these reports and the analysis of data helps to create an informed safety culture. An established strong safety culture is a barrier against complacency, omissions and violations that are so often listed in incident reports as causal factors.

One area that appears to be difficult to address is seafarer's fatigue management. Malpractice is often seen and yet the reports we receive on this subject do not reflect the size of the problem. Safe manning on a ship should take into account the minimisation of fatigue. The Safe Manning Document establishes the minimum safe manning to ensure safe and efficient operations. The number is based on a transparent process based on a risk assessment, the minimum number as stated, is exactly that; therefore at times of high work load due to operational requirements, this number is not sufficient to manage the risks associated with fatigue in seafarers. When a seafarer does not get a response from managers, confidential reporting through **CHIRP** will assist. We review all correspondence received and agree the remedial action plan with the reporter before discussing with any other person or company representative.

**CHIRP** Maritime welcomes Charles Style CBE as their Maritime Advisor; this is a new position created by the Trustees and is in response to the increasing global interest in the maritime programme. We estimate 200,000 people have access to this publication. Charles provides a wealth of maritime experience and this will be used to good effect as he takes over as the editor of this 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.**

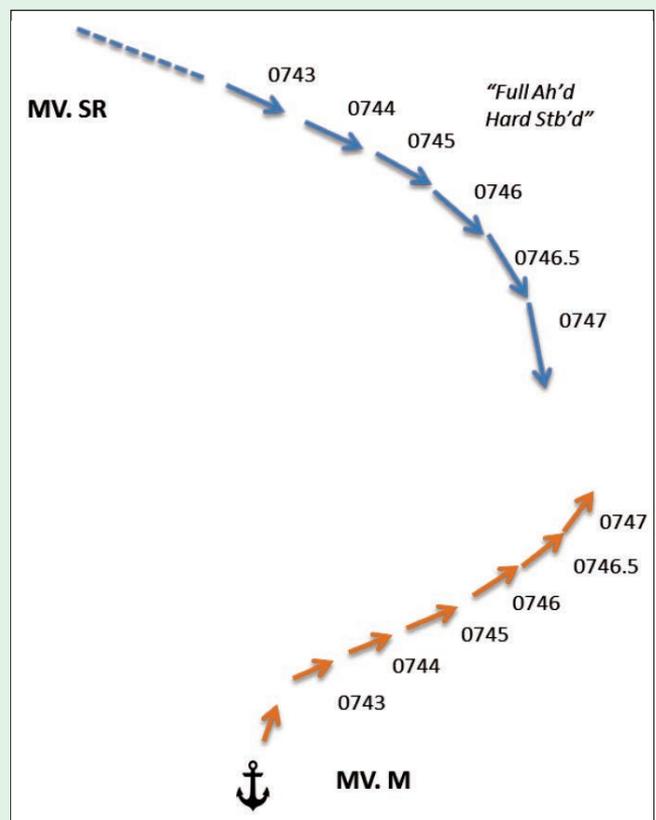
## REPORTS

### CLOSE QUARTERS AT LUANDA ROADS

**Report Text:** A vessel in transit in the Roads outside the port of Luanda, Angola. Vessel 'SR' was seen to transit the busy anchorage at high speed and when encountering a vessel in a close quarters situation, did not comply with the Collision Regulations. This non-compliance with the regulations required our ship to take immediate avoiding action by altering course to port and placing our engine astern in order for the MV SR to pass ahead and avoid a collision. Weather conditions were light airs with good visibility.

**From 3rd Party Ship Manager:** *Thanks for your message, the Master of MV SR, would like to take this opportunity to explain the situation:*

"MV SR had permission from Luanda port control to proceed to the inner bay anchorage for port clearance: We passed through the inbound road proceeding to the inner bay with a speed of about 7 knots. At that time, MV M was anchored at West of Ilha do Cabo island. At about 0723, I observed MV M move in a direction NNE with speed about 2 knots and it appeared she wanted to cross the road to the North. After 5 minutes, I observed the compass bearing of MV M was increasing and at 0732, the compass bearing with MV M was still increasing: I thought she will passing across my stern. At 0740, our speed



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was 7.1 knots heading 120°, MV M's speed was 4.0kts heading 074° and on VHF we communicated with each other. I told MV M that: "I am inbound vessel proceeding inner bay to drop anchor, I want to pass across your bow then alter course to starboard, can you alter your course to port side to passing my stern?" MV M answered: "You want to pass my bow, OK, copy that." At 0743, I observed that MV M altered course to port side not obviously, her speed 4.0 knots heading 071°, so I called her again on VHF asking them to alter course to port side more quickly, she answered: "I am altering slowly."

In that situation, it is impossible for me to reduce speed or to alter course to port side, so I increase our main engine to full ahead, and at 0745, I ordered steer "hard to starboard" and alter course in order to pass the bow of MV M with Closest Point of Approach (CPA) 0.19 nm.

**In summary:** Before passing the bow of MV M, I had to get permission from MV M and she agreed. If she had not agreed to my passing her bow, I would reduce speed and alter course to pass her stern; but the Master of MV M agreed with my intention to pass her bow, but did not make substantial action in good time to alter course to port.

**In conclusion:** I should apologize that I was not fully compliant with the COLREGs and the cause for this close-quarters situation. First, I should proceed at safe speed. Second, I should take early action to avoid the risk of collision. Third, I should take action as the give-way vessel and avoid crossing ahead of the other vessel in a crossing situation, even if have a communication with other vessel in advance. And I promise that in the future, I will organize the OOW with me to study the COLREG and full comply with the COLREG."

**CHIRP** believes the captain of MV SR provided a very comprehensive reply to the report with a remedial action plan that was soon completed. **CHIRP** used the information taken from MV SR's Voyage Data Recorder to create a schematic view of the vessels' tracks.

**CHIRP Comment:** The greatest care needs to be exercised for collision avoidance between vessels moving within an anchorage. Visual bearings and Automatic Radar Plotting Aid (ARPA) derived CPA information will be based on inaccurate data and cannot be relied upon to avoid collision. This is due to the nature of the location and where both vessels will be either slowing down or speeding up. ARPA and visual bearing information will be immediately dated and cannot be safely used for reliably predicting future outcomes compared to open sea constant speed scenarios. It will be appreciated that ARPA derived CPA information is based upon two lots of continually changing triangulation information, where in this instance speeds are slower, more variable and have consequent larger constantly changing predictions. Radar ARPA is best effective on true vector outputs to monitor the status of all anchored vessels, which will show a nil vector and hence stopped. Radar "trails" should be set up so these will give the first indication of a vessel moving, or starting to move, within the anchorage. By such means stopped vessels will not become collision distractions provided that best practice of a longer route approach is followed to the anchorage, parallel to anchored vessels, in order to stem current/wind/tide. This will ensure close quarters situations are minimised and avoid suffering the effects of set.

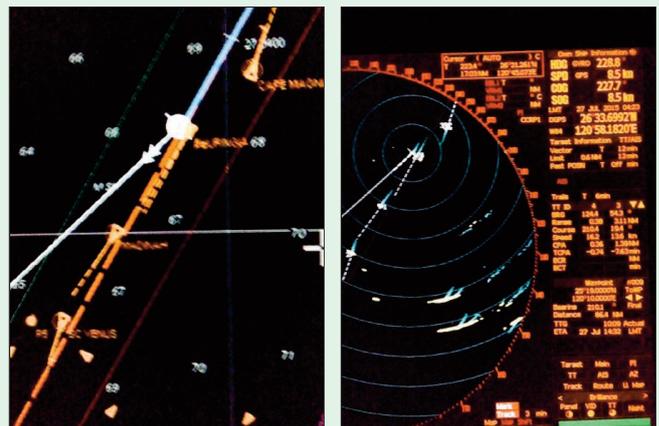
Exiting anchorages should always be done parallel to the vessels and ahead until well clear of the anchored vessels so as to avoid passing closely ahead and setting down. Vessels moving within the anchorage should therefore always be on parallel and not converging courses. Where this is unavoidable, set is difficult to manage, particularly at slow speeds: crossing the direction of anchored vessels will inevitably create collision scenarios with other vessels moving within an anchorage. The risk of collision is much greater within an anchorage than in open sea and more challenging to predict. Conventional means become less effective in the accuracy of predicting outcomes. Avoid the use of VHF to gain intent. This often creates more confusion than clarity.

Taking guidance from the above will minimise this risk. The golden rule of never passing ahead of an anchored vessel is aspirational in many instances as we know, however it not only avoids setting down onto vessels at anchor, it also excludes converging collision courses with ships in the anchorage area as we will all be going in the same direction either in or out of the anchorage!

Readers may also refer to the good practice advocated in The Nautical Institute's 'Navigator' magazine edition 02: Avoiding Collisions – Published February 2013.

## OVERTAKING VESSEL SMALL CPA BUT TAKING NO AVOIDING ACTION

**Report Text:** As Chief Officer I had taken over the 0400-0800 morning watch from the second officer. I had observed a vessel astern overtaking us showing a low CPA of 0.3nm, overtaking on the port side. As the overtaking vessel was still 2 miles astern I assumed he would alter to pass at a safer distance. As I continued monitoring the vessel he approached closer than 1nm, I signalled with Aldis lamp and called on VHF. There was no response or action from the other vessel. As the CPA was now still showing less than 0.3nm and range to the other vessel was now 0.5nm astern, it was clear the other vessel was not taking appropriate action under COLREGs Rule 13. I altered course 30 degrees to starboard to increase the CPA and reduce the risks from a close quarter's situation. The other vessel finally passed on my port side at a range of 0.36nm. The other vessel at no point altered its heading and ignored repeated attempts at VHF communication/warnings.



This is a perfect example of the increasing number (and size) of vessels who simply do not give way under any circumstances. It is frustrating to say the least that increasingly to pass other vessels in a safe manner you are ALWAYS the give way vessel. Although I am relating only this example, I have numerous similar experiences with large vessels approaching up to 400M in length, from large well-known companies who will overtake at 3 or 4 cables in open sea. When two such vessels meet each other in unfavourable circumstances an accident is inevitable sooner or later. Please see attached screen shots during the incident

### **Correspondence from 3rd party**

We conducted an investigation with regards to your feedback by engaging the present Master and bridge team on board. The Chief Officer on watch at the time of the incident has already disembarked.

As a lesson learnt we have taken the following steps:

1. Briefed the Master.
2. Asked him to conduct a bridge team meeting and discuss the feedback in detail.
3. Conduct a Navigation Audit and ensure compliance with procedures and Collision Regulations.

**CHIRP Comment:** COLREGs Rule 13 governs overtaking situations and states that, “any vessel overtaking any other shall keep out of the way of the vessel being overtaken.” This rule applies to all vessels and is unusual in that it firmly puts the onus on one vessel to take all necessary action, in order that a collision might be avoided. The third party ship managers have taken appropriate action by their work with the current officers to help to prevent reoccurrence.

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## **RIGID INFLATABLE BOAT – UNSAFE PRACTICES**

**Report Text:** Three Rigid inflatable boats (RIB's) were observed off Plas Newydd on the Menai Strait ‘show boating’ with a full load of passengers. Two boats were cutting across each other, the third boat was being used as a filming platform but was also joining in. One RIB turned into a standing wave and ‘hooked’ and two passengers were thrown out of the boat. The passengers were recovered and the three boats returned to the pier at Menai Bridge. A Paramedic attended the scene and one person was taken to hospital with a suspected dislocated shoulder.

As a result of this report, **CHIRP** made an investigation and established the RIBs do not fall under the MCA's jurisdiction but that of the local authority that being the Anglesey County Council. They confirmed the incident had been reported and the concerns discussed with the Harbour Master for Caernarvon. Also the Marine Accident Investigation Branch had received notification from the owners, as per Merchant Shipping Act 2012 (Accident Reporting and Investigation). The parent company was most forthcoming about the incident and the remedial work they have put in place. These include replacement RIB's, with each having improved securing measures on the aft seat and passengers now being issued with

automatic inflatable lifejackets, not the manually operated ones provided at the time of the incident.

**CHIRP** wrote to the film production company and advised that in the future, management should, as a duty of care for their employees, ensure all safety precautions are clearly understood before taking to the water.

**CHIRP Comment:** The response by the third party RIB owner was complete: the causal factors were identified and a remedial action plan put in place. Readers are advised to read the MAIB report on ‘RIB Milly’ resulting in 2 fatalities. Also the Norwegian report on the accident with a chartered RIB in Olden, Stryn Norway, where one person died.

**MAIB report on the RIB ‘Milly’ can be found at:**

<https://www.gov.uk/maib-reports/ejection-of-6-people-from-rigid-inflatable-boat-milly-in-the-camel-estuary-corn-wall-england-resulting-in-3-of-the-people-injured-2-seriously-and-the-loss-of-2-lives>

**CHIRP** wishes to bring attention to a quote in the report of the trials taken to reenact the incident: *During the runs it was noticed that the boat took up a high angle of inward heel when it was turned. It was also noted that when turned tightly at certain speeds the RIB's heel angle would increase until the aft end of the hull lost grip in the water and slid sideways, leading to a ‘hook’.*

*The hook rapidly took the boat from its original course as the hull executed a sideways slide across the water, until the boat's keel gripped and the sideways motion was suddenly stopped, causing the craft to roll violently upright from its banked attitude.*

*The driver and co-driver reported that they needed to be well prepared for this hooking action by being seated, braced and holding on to handholds, as the forces generated were considerable. The driver suggested after one test turn that an increase in RIB speed of 5 knots would have been sufficient to result in his ejection from the boat, despite being prepared.*

**CHIRP** noted in the short video accompanying the MAIB report, “when the RIB ‘hooked’ it returned 30 degrees to the upright in less than 0.5 second”.

Modern RIB's are getting bigger and faster, with very fast action engine controls. The risk when operating these craft is much greater than in the past and an operator mishandling the craft can result in catastrophic consequences.

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## **CLOSE ENCOUNTER WITH A FERRY**

**Report Text:** We were proceeding under engine power on a clear sunny day in the final stages of a voyage from the N coast of Mallorca to the S coast of Menorca when I spotted just forward of the beam a ferry leaving the coast as it cleared Ciutadella in Menorca travelling towards Mallorca. The vessel was also identified on Automatic Identification System. Our yacht can receive but not transmit AIS. The weather was clear with excellent visibility on a smooth sea and I was able to watch the

vessel from the time it left the coast and I tracked it visually and on AIS. The AIS indicated a CPA of about 0.2 miles. Our yacht was heading 104° true at 5.5 knots. The ferry was heading approximately 240° true on my port quarter.

As it came closer the CPA decreased and the ship's speed was around 20 knots (AIS) (maybe a little more). From my log I altered to starboard initially but was not clearing the ferry. We had crossed on 086T from an anchorage at Cala S. Vincent in Mallorca and our destination was Cala Santa Galdana in Menorca.

As the ferry continued to close at speed it became obvious that the ferry would pass very close so I tried to contact it on VHF Channel 16 but received no reply. The ferry had plenty of room to pass either ahead or astern but seemed to head straight for the yacht. Due to its speed a close quarters situation rapidly developed and as the ferry was heading directly for the yacht I had few options as I can only make 6knots. An alteration to port would leave me close on its port side with a danger of it altering to starboard, an alteration to starboard would leave me in the ferries path. In the end I applied full throttle, cleared across the bow of the ferry and altered to port once passed. The ferry passed approximately 100m up my port side. Again I tried to contact via VHF Channel 16 but received no reply. The ferry made no course alterations despite being the give-way vessel. I also got the impression that a watch was not being kept on the ferry though I could not see onto the bridge to be sure.

**CHIRP Comment:** The Maritime Advisory Board when reviewing this hazardous incident report, had sympathy with the reporter's predicament in taking early and substantial action to avoid a small CPA to a fast moving vessel. They believe there could be similarities between this report and that addressing the sinking of the yacht Ouzo, see UK's MAIB report 7/2007. As a result of the ferry company's failure to respond to the report, and due to the severity of the report, the Flag State authority was informed of the failure to maintain a proper lookout and listening watch on VHF Channel 16.

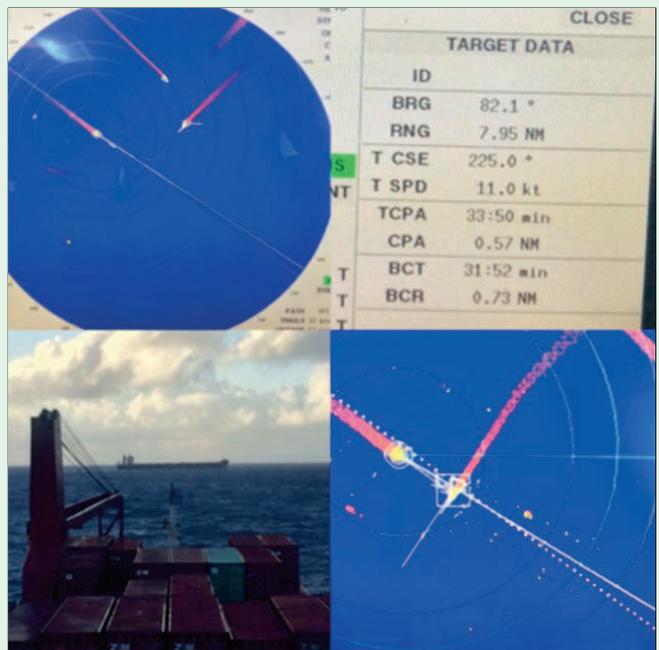
The Maritime Advisory Board also brings to the attention of all leisure users, the following advice:

- (a) Yachts often do not show up on a radar screen beyond about 5 miles, the radar wave passes through the GRP structure and reflects off the far side of the depression made in the water by the hull, then beyond that distance they do not show up on a radar screen due to a combination of too shallow an angle between the radar beam and the sea surface, interceptions from waves in front of the target and a reduction in signal strength according to the inverse square rule. When closer to the vessel, the yacht may be difficult to detect on the radar screen due to wave clutter.
- (b) Radar reflectors have limited effect in improving the ability to enhance identification (RYA web site, MCA Marine Guidance Note M394 Carriage and Use of Radar Reflectors on Small Vessels paragraph 4.3).

- (c) These issues will be detrimental to automated radar plotting aids and alerts and also to human observers, who may genuinely be having difficulty in detecting a yacht in the very large area of sea to the horizon.
- (d) It would be prudent to incur an additional cost and install an AIS transponder additional to, or incorporating an AIS receiver. If there is concern over sufficient battery power, the yacht owner should turn on the engine and thereby power the batteries.

## NON-COMPLIANCE WITH COLREGS RULE 15

**Report Text:** Container ship 'A', on passage from Kingston Jamaica was heading towards Willemstad Curacao on a course 127° at 7.7 Knots. The Master was monitoring traffic and observed Vessel 'B' from far away. With a small CPA and with the intention of not to cross the bow of Vessel 'B', the Master of the container ship 'A' reduced the ship's speed a small amount, believing to be acting under Rule 8(e) and giving himself more time to assess the situation, he then contacted the Officer of the Watch (OOW) on Vessel 'B'. When asked about the intentions of Vessel 'B', their OOW replied that container ship 'A' should pass his stern and B' would alter course more to his port side. The Master of container ship 'A' did not agree and replied that Vessel 'B' should follow COLREGS Rule 15, Unfortunately the OOW on 'B' just said 'thank you' and changed VHF channel without acknowledgement. The Master on container ship 'A' tried to call Vessel 'B' again on VHF but got no reply.



The pictures of the Automatic Radar Plotting Aid (ARPA) screen show 2 miles range rings showing the crossing ahead was 1.7 miles with CPA 0.57 miles.

Reply from Ship manager: The OOW of Vessel 'B' reported to the Master that he was in contact with the OOW of Containership 'A' and in order to avoid the close quarter situation of initial CPA 0.57 nm that could have developed, altered course to port that resulted in a crossing of about 1.8 nm, with CPA of about 1.6 nm. He also stated that the

situation was at all times monitored as were VHF channels 6 and 16 and there was not any other call from Container ship 'A' after the initial call.

However this action was in breach of Rule 15 as the Vessel 'A' course should have altered to starboard in order to comply with COLREGs Rule 15.

As corrective and preventive action, the Master was instructed to and has carried out to all Deck officers:

- a) Refresh training on COLREGs and Rule 15 in particular.
- b) Extraordinary Navigational audit..
- c) In addition the case was discussed during an extraordinary Safety Committee meeting with all Deck officers participating.

Furthermore, Company Port captain shall attend the vessel at next port and we will discuss this case and during the debriefing after he signs-off.

**CHIRP Comment:** The honesty of the reporter and the response from the third party ship manager is much appreciated as it maximizes the opportunity to raise awareness of any safety lessons learned.

The Maritime Advisory Board raised concern over the actions of the OOW on both vessels. The Master of containership 'A' was correct when advising the OOW on Vessel 'B' that his actions did not comply with COLREGs Rule 15. However the Master of containership 'A', by making only a small alteration in speed, took action which was unlikely to be detected by the other ship and therefore was at risk of not being in compliance with Rule 17 (a)(i). Rule 17 has three stages and you must identify and assess each of them:

Rule 17(a) (i): when you are the 'stand-on vessel', you must keep your course and speed. You must not do anything unexpected.

Rule 17(a) (ii): 'as soon as it becomes apparent' that the give-way vessel is not taking appropriate action, you may take your own action to avoid a collision.

Rule 17(b): when a collision cannot be avoided by the give-way vessel alone, then you must take the best action you can to avoid colliding.

Action under Rule 17(b) must still be in time to avoid a collision so do not leave it too late and do not go to port in a crossing situation under Rule 17(c). If the other ship goes to starboard, as it should, then both ships will turn towards each other. The most prudent action would be to alter course with a round turn to starboard and by turning away would avoid the risk of collision.

The situation appears complex – there appears to be a third and fourth vessel in close proximity to and on the starboard side of vessel 'B'. OOWs must always "look at the big picture" and assess the possibilities at an early stage, placing their mind in the position of the other vessel(s) to determine if there are complications that will influence and possibly restrict the available actions of any of the ships involved.

Finally do not forget Rule 34(d) manoeuvring and warning signals – the 'wake up' signal. Sound your horn and flash your lights at the other vessel. Also think twice before calling

on VHF, as that always takes valuable time during which the risk of collision will increase and this has in many instances, resulted in mistaken identity due to incomplete positional referencing.

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## INLAND WATERWAYS BOAT HIRER TRAINING

**Report Text:** I've hired a 38' motor cruiser on the inland waterways on many occasions (and have plenty of other experience of cruisers, narrow boats and sailing dinghies. I also hold the necessary Certificate of Competence etc. for VHF radio). This summer there were occasions when other hire boats tried to overtake between me and the nearside bank. I also observed hire boats hugging so close to their right hand bank as to brush through tree branches. Another was so close in that this moving boat brushed against all of a line of moored craft. Each occasion was on a wide river with no difficulty posed by opposite-direction traffic.

As to the inside-overtakes, one was at a river junction where I was about to turn right onto the main branch (so the overtaking craft would have been confronted with a view of my starboard beam directly ahead) and the other was where I was pulling more centrally into the river to pass the stems of craft that were moored stern-on to my right (so the overtaking craft would have gone straight into the port beam-end of the nearest of these).

**CHIRP Comment:** The Broads Authority was invited to comment on the report and in so doing CHIRP was pleased to note good practices which we believe are worth sharing with a wider audience, This should include boat hirers and the regulators of inland waterways.

It is also useful guidance for hirers, explaining the level of safety training they can expect when hiring from a responsible leisure boat operator.

The Broads Authority Act 2009 has provisions to licence boats let for hire to the public. Formerly the Authority had no control over operators or their boats other than the general Navigation, Speed and Registration Byelaws.

<http://www.broads-authority.gov.uk/boating/navigating-the-broads/byelaws-and-speed-limits>

Through consultation with the local trade body the Authority developed a number of conditions for their new hire boat licensing scheme. Introduced in 2010, the scheme was well received by the industry as they had actively been involved with the development of the conditions. One specific condition was that operators were to give a handover to hirers, which was in accordance with the "Hire Boat Code" and the Authority also gave advice to operators regarding the minimum level of content of the handover, which was to include navigation restrictions, etc. such as notice to mariners. Operators, handover paperwork and systems are audited initially annually, although since the operators are "all up to standard" now we have taken a view that a three yearly routine audit is reasonable. However the Authority will react to complaints and incidents to ensure that standards are maintained.

Our hire boat licensing officers also spot check yards to ensure that adequate handovers are being delivered to hirers and occasionally we will carry out a 'secret shopper' visit so that some independence can be factored in, although this can be difficult to facilitate.

The Broads Authority staff regularly meet with the Broads Hire Boat Federation and the private boat owners' user group to identify issues and resolve them to everyone's satisfaction. A DVD on safety and the Broads is also available, which most of the hire boat operators either stream from their website or refer to the Authority's site. Some operators include a copy of the DVD on board.

<http://www.broads-authority.gov.uk/boating/owning-a-boat/boating-beginners>

The Broads Authority publishes a yearly Broadcaster magazine, which is placed on every hire boat at the commencement of hire and within this publication are many tips and hints regarding boating safety.

On the water, eight launches patrol across the Broads system, their primary role being one of offering advice and guidance but they do police byelaws and the provisions of the 2009 Act. They regularly help out hirers and any trends are referred to the hire boat licensing officer, who can specifically target these areas when auditing. The Rangers are their eyes and ears on the ground. There are also quay attendants at strategic locations throughout the Broads; their observations are key to addressing issues, such as poor access to deck areas and short mooring lines.

The Port Marine Safety Code has set up a framework of safety management for the Broads Authority and they regularly review the marine hazard log with their stakeholders to ensure that hazards are managed to an ALARP state. The Broads Hire Boat Federation and the private boaters are represented on that group, as with many other liaison groups. More recently they have been working nationally with the Association of Navigation Authorities, the MCA and the British Marine Federation, on a Hirer Safety Review and an update to the Hire Boat Code, which is still in final development.

<http://www.boatsafetyscheme.org/media/231417/navigation-authority-hsr-initial-recommendations-nov-13.pdf>

## CORRESPONDENCE

### INCIDENTS UNDER PILOTAGE

A major charterer has observed that the maritime industry continues to experience an increasing number of incidents whilst vessels are berthing, un-berthing, or navigating under pilotage. Typically these incidents include collision, contact with fixed objects and grounding. The following failures of communication between the pilot and the bridge team management contributed to such incidents:

- Ineffective master-pilot exchange: Though vessel information is provided to the pilot by means of pilot card, pilotage plans are not fully reviewed and agreed by the master and/or not communicated to, or understood by, the bridge team.

- Failure to intervene: The bridge team failed to raise concerns, or challenge the decision of the pilot.
- Failure of bridge team to anticipate developing dangers to navigation.
- Insufficient manning of the bridge, resulting in reduced focus on pilot's activities.
- Failure to discuss and plan the mooring arrangement during the master-pilot exchange.
- Pilot communicating with tugs and shore mooring teams in a local language not understood by the vessel's bridge team.
- Communication failure between the pilot and the bridge team caused through premature issuing of instructions by the pilot before the master/pilot exchange has taken place.

### Good Practice:

- A thorough master-pilot exchange should include:
  - (a) Providing vessel's information to the pilot as required by the pilot card,
  - (b) Pilot's plan of maneuvering the vessel at different stages, communicated to the master, and
  - (c) Details of mooring/unmooring plan and tug arrangements.
- The language of internal and external communication should be agreed and documented during the initial master-pilot information exchange. The bridge team should get the pilot's attention if there is a deviation from the above agreement.
- Vessel operators are encouraged to develop a proforma to assist masters in receiving and documenting the pertinent information and for easy communication with the bridge team.
- Appropriate bridge manning and delegation of duties are key to the success of the bridge team. Pre-arrival and pre-departure bridge team briefings are an essential step to discuss the final plans for vessel's safe navigation.
- Vessel operators may wish to reiterate the master's overriding authority when under pilotage and take steps to instill confidence in them to intervene when necessary.
- The bridge team should not hesitate to seek clarification from pilots regarding any aspect of their plans or communication.

Good interaction between the pilot and the bridge team, using an agreed communication protocol and supported by clearly understood plans, is essential for the safe and effective navigation of the vessel.

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

### CONTACT INCIDENTS IN ANCHORAGES

A major charterer noticed an increase in the number of incidents involving contact between vessels at congested anchorage locations. They issued a Safety Alert Bulletin to draw the attention to this issue and share good practices/lessons learnt from various incidents.

### Causal Factors:

- Bridge team's failure to correctly assess the strength and direction of the local tidal current & wind prior to arriving at, and during departure from, the anchorage.
- Manoeuvring own vessel too close to vessel(s) already at anchor.
- Lack of proper navigational watchkeeping practices whilst at anchor.
- Swinging circle not plotted, or used as a monitoring tool, especially during the swinging of anchored vessels in different directions.
- Lack of monitoring clearances from adjacent anchored vessels during change of tide.
- Inadequate monitoring of prevailing weather and weather forecasts, such as local seasonal winds, thunderstorms, passing squalls, etc., leading to the dragging of the anchor.
- Unavailability of vessel's main propulsion for immediate use, when required.

### Good Practice:

- Pre arrival/departure planning in detail (i.e. appraisal, planning, execution & monitoring) including contingency, and site-specific risk assessments.
- Evaluation of the prevailing congestion status at the port's designated anchorages. Identifying a suitable anchorage position, in consultation with Port Authorities/ VTS, prior to entering the anchorage area. Whilst approaching an anchorage, avoid passing close ahead of other anchored vessels.
- Evaluation of adequate length of anchor cable to pay out, with due consideration to the prevailing conditions, holding ground and sea depth. Plotting of vessel's swinging circle on GPS, paper chart and ECDIS, if available, to ensure that the vessel has adequate clearance to swing about the anchor. Once anchored, the actual swing pattern to be ascertained and ECDIS/Radar/GPS alarm limits adjusted if available. Swing tendencies of other vessels in immediate vicinity should also be monitored, especially at change of tidal streams.
- Calculation and marking of tidal streams where applicable and in known areas for strong tidal effects.
- Maintaining a robust anchor watch at all times, checking of vessel's position at regular intervals.
- Echo sounder and anemometer limit alarms, where fitted, to be re-adjusted after anchoring.
- Monitoring of weather at all times and having an action plan available, in case of expected adverse weather, or finding that anchored vessel's are swinging in different directions.
- Inserting a visual marker on the windlass to indicate any instances of the brake slipping.
- Maintaining vessel's main engine in an appropriate state of readiness.
- Use of BNWAS, if available whilst at anchor.
- Clear standing instructions on calling the Master well in time, based on situations specific to that anchorage location.
- Emergency contact list of local support services (such as pilot, tugs, etc.) to be available at all times.
- Bridge Team Simulator training provided to deck officers and Masters that includes scenarios with weather changes, such as but not limited to:

- Approaching & anchoring in congested anchorages
- Dragging own anchor in congested anchorages.
- Other anchored vessels dragging their anchor, or a maneuvering vessel drifting towards own vessel at anchor, which could result in a contact incident.
- Vessel operator's internal navigation audit to include an evaluation of best practices, whenever possible.

## FOLLOW US ON FACEBOOK

The most popular recent FACEBOOK posting are:

### Try this 15 minutes test at your next safety meeting:

The feedback to management will be useful and they can compare their results across their fleet. The Diagnostic Tool can be found at:

<http://www.hse.gov.uk/construction/lwit/step1.htm>

### If you are on a ferry, or on a regular route between two ports:

We suggest you read the U.K. Marine Accident Investigation Branch's report on the grounding and flooding of the ro-ro ferry Commodore Clipper, citing passage planning problems and ineffective use of ECDIS as contributing factors.

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/451374/MAIInvReport-18\\_2015.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/451374/MAIInvReport-18_2015.pdf)

### Two crew members from the Norwegian Cruise Lines 'Pride of America' were seriously injured during the recovery of the rescue boat:

The wire falls parted and the rescue boat dropped a reported distance of 45-feet. The injured men fell into the boat and then into the sea. For a short overview see:

<http://maritimeaccident.org/2013/02/corrosion-dropped-thomson-majesty-lifeboat-malta/>

### BBC Radio 4 programme regarding the effects on body and mind due to lack of sleep:

The story is available on BBC iPlayer. The lack of sleep can cause high blood pressure and an increased risk of a stroke.

<http://www.bbc.co.uk/programmes/b0639jpl>

*The Maritime Advisory Board is interested to learn from readers of this publication, Maritime FEEDBACK, what information has been used to make changes on board.*

*Is the information used in safety committees or just read by individuals in their spare time at sea?*

*Please email us at [reports@chirp.co.uk](mailto:reports@chirp.co.uk). The information will be most useful and will be considered when we look for the best methods of reporting the safety lessons learned from your near miss and hazardous incident reports. Thank you.*

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

- The Corporation of Trinity House
- Lloyd's Register Foundation
- Britannia Steam Ship Insurance Association Ltd
- International Foundation for Aids to Navigation (IFAN)
- Cammell Laird

# CHIRP MARITIME REPORT FORM

CHIRP is totally independent of any organisation in the maritime sector

Name: ▲ .....  
 Address: ▲ .....  
 .....  
 Post Code: ▲ ..... Tel: .....  
 e-mail: .....

▲ 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](http://www.chirp.co.uk)