

Editorial

Since our last edition was published I have had the opportunity to visit the Seafarers Research Centre at Dalian Maritime University in China, whose excellent staff are responsible for translating Maritime FEEDBACK into Potunghua. It was a great pleasure to see the impressive campus and meet the staff and students, and reassuring to know that China's future seafarers are getting such an excellent maritime education.

Of course, these students will still face many risks and challenges when they go to sea, and this edition of Maritime FEEDBACK illustrates some of them. How do the staff on passenger ships ensure the safety of passengers with disabilities or special needs? What should you do when you experience a problem with the steering or manoeuvring of your vessel? What can you do if you think a port's approaches are unsafe?

As always, we include a number of useful lessons and we hope you will learn from them. Together we can make our industry safer, and together we form a powerful team – a fact that has been recognised by the Lloyd's Register Foundation, as described below.

In this issue we can also announce a new initiative with Witherby Publishing Group, which will ensure our message reaches an even wider audience.

PRESS RELEASE

Witherbys' and CHIRP Maritime to work together to improve the safety and welfare of seafarers

Leading maritime publisher, Witherby Publishing Group, and charitable organisation **CHIRP** Maritime, have announced that they will be working together to effectively

communicate lessons learned from maritime incidents within the industry worldwide.

CHIRP's reports and annual digests will now be developed into eBooks and distributed digitally by Witherbys'. Users will be able to download the reports for free via Witherbys' software, 'Seamanship Library'; the Witherbys' iPad App; and its weekly update email 'Shipping Regulations & Guidance'.

Witherbys' CEO, Iain Macneil said: 'The objective is to ensure that we have as wide a reach to the maritime industry as we can. We are delighted to team up with **CHIRP** to ensure that as many seafarers can access these reports as possible and offer a new route for reporting new incidents.

CHIRP Maritime commented: 'These are exciting times for **CHIRP** Maritime as the world's foremost confidential hazardous incident reporting programme, we continue to reach out across the globe. We are delighted to enter into this partnership with Witherbys' and we believe this initiative will significantly broaden our horizons by connecting with those who matter – the seafarers.'

CHIRP Maritime – Putting the Mariner FIRST

Finally, I draw your attention to a new Insight article about combination ladders for pilot boarding. There was too much information for it to be included in Maritime FEEDBACK, but it has been posted on our website and you will find a link in the Combination Ladder Issues article later in this issue.

WE WISH YOU ALL SAFE SAILING UNTIL NEXT TIME.



CHIRP Maritime awarded prestigious LRF "Team of the Year 2018"

CHIRP Maritime received the award at Lloyd's Register Foundation international conference in London on Wednesday 9th May. Former **CHIRP** Maritime Director John Rose accepted the award on our behalf, a fitting reward for John's successful tenure of our organisation.

The significance of this accolade, when put in to the wider context of the other competing candidates, should not be under-estimated.

So, from all of us here at **CHIRP** Maritime, we would like to take this opportunity to thank all of our team for their benevolence and generosity of spirit: our Trustees; members of the Maritime Advisory Board; Ambassadors; sponsors and individuals; companies and organisations who have given of their time and resources to support this project. Finally, we thank every reporter, and every seafarer who engages with us and sends us those vital reports. **YOU ARE MAKING A DIFFERENCE**

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 THAT ARE PUBLISHED IN FEEDBACK, PLEASE REMEMBER THAT CHIRP DOES NOT POSSESS ANY EXECUTIVE AUTHORITY.

SUBMIT A REPORT –

CHIRP always protects the identity of our reporters. We are a confidential programme and, as such, we only keep reporters personal details for as long as we need to keep in contact with them.

ONLINE

Reports can be submitted online, through our secure encrypted online form.

<https://www.chirpmaritime.org/submit-a-report/>

BY EMAIL

Reports can be submitted online, through our secure encrypted online form.

reports@chirp.co.uk

REPORTS ...

Emergency procedures for disabled passengers

OUTLINE: A report highlighting difficulties on cruise and passenger vessels that disabled persons may encounter when following standard emergency procedures.

What the reporter told us:

My husband and I have travelled with this company a couple of times, and on both occasions whilst we attended the emergency muster drill, nothing was said regarding people who were physically unable to walk down the vessel stairways. My husband is a wheelchair user, and last year I actually questioned what people in wheelchairs should do in an emergency since, quite understandably, we were told that wheelchair users should not use the lifts.

Last year we were told that there would be stewards available who would ensure that wheelchair users, etc., could get to their muster stations. This year we noticed that all the wheelchair users (or at least those who were assigned to our particular muster station) were gathered together slightly apart from the rest of the passengers at the muster station. This was done so that after the muster and briefing, we could leave before the able-bodied passengers filled all the lifts. We had mistakenly assumed, having been specifically segregated from able bodied passengers, that the muster instructions and briefing would have been specifically suited to those unable to use the stairways on their own. We were all told that in the event of the alarm sounding, we should return to our cabins, collect warm jackets, hats, any medication and our life jackets, and then proceed to our designated muster station. We were also told that if there was smoke involved, we should keep low and crawl, in order to get to the stairs and our muster station, but nothing was said about wheelchair users. I asked afterwards what people like my husband should do and I was told not to worry because they were aware of which cabins were occupied by wheelchair users and that these people would be collected and taken down the stairs in a stair chair by designated crew members.

My query is this. With our muster station being on Deck 7 and our cabin on Deck 12, if when the alarm sounds we were on another deck how would we get to our cabin in order to collect our life jackets, warm apparel, medication, etc. let alone be there ready for someone to get us down the stairs? If people are in a panic, I can't see how able-bodied people, let alone wheelchair users, are going to get to their own cabin to collect their things and then get to their muster station. From the point of view of wheelchair users, it would seem to me to make more sense if there was a designated gathering point on each deck. That way, when the alarm sounded, whichever deck one was on, crew members could guide those in wheelchairs to where they ultimately needed to be.

In addition, if lifejackets were already at the muster stations rather than being placed in individual cabins, they could be distributed at the muster station and assistance could be given with the donning of the lifejacket. In short, it may be fine for able bodied people who can use the stairs to go to their cabin, collect their things and then proceed to their muster point, but such an action could not be carried

out by someone in a wheelchair since they would not be able to use a lift.

I should also point out the fact that it is not uncommon for stewards' trolleys to be left outside cabins which makes it difficult at best to pass by with a wheelchair.

CHIRP Comment

The Maritime Advisory Board (MAB) spent a lot of time discussing this report and commented as follows:

So far as legislation regarding disabled passengers is concerned, there is an EU Directive (1177/2010) which requires international and domestic passenger vessels within European waters to allow disabled persons and persons with reduced mobility to have the same rights as other passengers. Similarly, the US market is governed by the Americans with Disabilities Act (ADA). The UK have gone further when enacting the EU Directive into UK Law by requiring companies to have procedures with respect to disabled passengers and access. The MAB discussed as to whether there was any standard best practice documentation that could be referred to with several of the more well-known cruise companies – apparently there is none.

In general terms with reference to passengers with disabilities, the Maritime Advisory Board highlighted the following;

- Everyone is different, and the range of disabilities varies from being wheelchair bound to those who may be:
 - visually impaired, with sight difficulties up to total blindness;
 - aurally impaired, with hearing difficulties up to total deafness;
 - frail, with difficulties in movement;
 - mute and unable to vocally respond; and
 - afflicted with any number of mental disabilities.

All of the above would require specialist care and attention in some shape or form.

- **CHIRP** understands that the procedures that most companies have in place assure that in the event of an emergency, a disabled passenger has a trained crew member or crew members assigned to assist. Perhaps a reasonable course of action might be for a ship representative to discuss with the passenger what assistance may be required in the event of an emergency. A disabled passenger knows for instance, what drugs might be needed in the short to medium term, how best he or she can be moved, and any specific requirements concerning the disability. Perhaps a “grab-bag” could be prepared in readiness for any potential emergency?
- With respect to the lifejackets being situated in cabins as opposed to being at the muster station, this point was queried with several cruise companies. Some have made a conscious decision to relocate all lifejackets close to the lifeboats. Others have not. It was mentioned that relocation of the lifejackets would be problematic on older vessels where there may not be sufficient space to allow for lifejackets to be situated in this position.
- Similarly, **CHIRP** understands that many new build cruise vessels have disabled cabins located close to the muster stations. This however, is not universal and there

are no regulatory requirements from IMO to ensure that the vessel design takes this into account.

With respect to the specific concerns of the reporter, this report would appear to demonstrate that there was a standard emergency lecture with no bias towards disabled passengers, albeit that they were separated from the main body of passengers. Whilst companies will have their own specific procedures, a more correct response to the concerns of the reporter would be to tell them to stay where they are and ask for assistance, at which point the personnel assigned to that passenger would be summoned to assist with the particular actions required.

CHIRP would like to hear from both passengers and the cruise industry on this subject. This may be in the form of reports detailing issues experienced, or from vessels and company management as to how they cope with such matters. We would be delighted to publish any comment in our "correspondence received" section of Maritime FEEDBACK. More and more people are taking cruises in their retirement and **CHIRP** believes that the whole subject is worthy of further discussion.

----- REPORT ENDS

Combination ladder issues

CHIRP continues to receive many reports from pilots who are faced with non-compliant pilot boarding arrangements. Further to the article in Maritime FEEDBACK 50, we have received a lot of reports relating to combination ladder arrangements. Some of these reports were very detailed and proved to be too big to be included in FEEDBACK. **CHIRP** has therefore compiled an Insight article on the subject. This insight article identifies some of the problematic areas, both with step over combination ladders and those rigged with a trapdoor within the accommodation ladder platform. The non-compliances are explained as are the requirements necessary to rectify the issues. In addition, **CHIRP** has included the full text of the IMO Resolutions governing the requirements for pilot ladders and accommodation ladders, plus the IMPA Pilot Boarding Poster.

The Insight Article may be found on our publications page at <https://www.chirpmaritime.org/wp-content/uploads/2018/04/20180424-Rigging-of-Combination-Ladders.pdf> and is aimed at mariners and company management alike.

----- REPORT ENDS

Rudder angle discrepancies

OUTLINE: A report describing a vessel which was apparently experiencing excessive port helm.

What the Reporter told us:

As part of my duties as a pilot, I was required to shift a vessel from one berth to another. During the operation, I noticed that she was carrying an excessive amount of port helm, which I estimated to be in the region of 5 to 10 degrees. I pointed this out to the bridge team and on berthing, advised the master to compare the steering gear rudder angle against the corresponding rudder angle indicator display. However, when

the vessel sailed outbound, the attending pilot observed that the situation had not much improved.

Recently, the same vessel returned to our port. Whilst inbound, the attending pilot again observed the same phenomenon. This made handling the vessel challenging, and as a result this discrepancy was formally reported to the local authorities.

Last night I sailed the vessel. Prior to departure, I discussed the issue with the master, and I insisted on witnessing the testing of the steering gear. An officer conducted the appropriate tests, and all was found to be in order.

However, the outward passage required a tug to be made fast on the centre-lead aft, and so I briefed the tug master that I would be conducting checks between the bridge rudder angle indicator and the actual angle of rudder observed by the tug master. Throughout the passage, about 50mm of rudder was visible above the waterline and any apparent discrepancies could be observed by the tug master.

On leaving the berth, it was immediately apparent that the vessel still carried a considerable amount of port helm. At various points during the passage, I was able to compare the vessel's rudder angle indicator with corresponding observations from the tug master. These comparisons led me to conclude that the ship was carrying 8 to 9 degrees of port helm beyond what was indicated on the bridge.

The vessel is relatively new having been built in 2017, and there is no evidence of excessive vibration or load on the steering gear. The handling characteristics are however, outside the parameters that would be considered normal by the average ship handler and could be considered unsafe in certain circumstances. I feel the matter probably needs further investigation.

What the company told us:

CHIRP wrote to the company concerned, which conducted a full investigation. This investigation also included a detailed review of the VDR. This, along with the company analysis of the situation, did not suggest that there was any external force such as a grounding which might have caused the problem. The company requested the attendance of Class, and the following is an extract of the Class report detailing their findings and subsequent repair in drydock. This included damage to the hydraulic rams of the steering gear and the rudder stock. The company concluded that the damage to the steering system was most likely due to workmanship and/or material failure at the new building stage.

A bottom inspection of the vessel was carried out in drydock and there was no indication of any damage to the hull bottom paintwork. In addition, an inspection of the propeller blades and rudder revealed no deficiencies.

Inspection of the steering gear, rudder stock and the rudder blade were carried out in dry dock. Damage was noted as follows;

- *Securing bolts for the guide bar bearing of the steering gear were found to be broken and the guide bar was found to be 20mm out of alignment.*
- *Cracks were found in the port side hydraulic cylinder ram, several foundation bolts were loose, and the ram was found to be slightly out of alignment.*
- *Several port side steering gear cylinder ram foundation bolts were loose.*
- *The upper rudder stock keyway was found to be slightly deformed, there was an offset of 25mm between the*

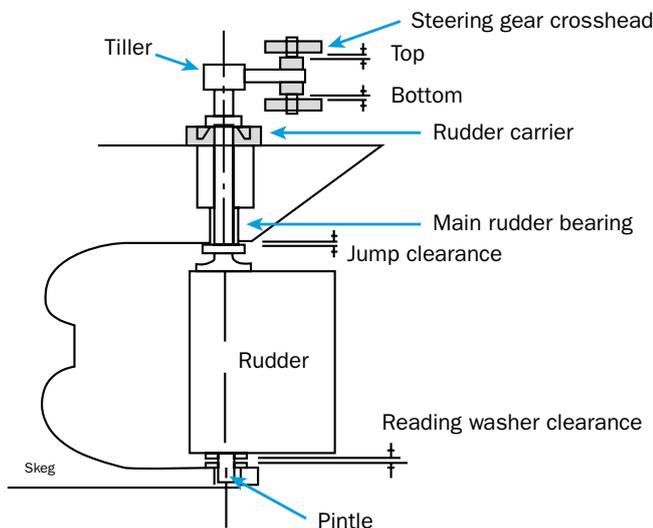
upper and lower bearings of the upper rudder stock when compared with the true centre line.

- A twist of the keyway amounting to approximately nine degrees was found between the upper and lower keyway when comparing this with the original centre line.

The Class report additionally gives full details of the repair that was carried out which included a thorough overhaul of the rudder carrier, repairs to the hydraulic rams and the steering gear foundations, heat treatment and straightening of the rudder stock, and machining out the deformations. The tiller keyway and carrier to the rudder stock were renewed. All of the work was carried out as per Class technical specifications.

The repairs were followed by magnetic particle testing, penetrant testing and ultrasonic testing of welding and machined repairs.

Upon completion of the repairs the rudder blade was given a swing test, and the steering gear with associated alarms were fully tested with satisfactory results. In addition, the attending surveyor witnessed sea trials of the steering gear whilst manoeuvring and these also were satisfactory.



Typical Ship's Steering Gear, Rudder Stock and Rudder

Notes:

- The steering gear guide bar is a structure that guides the lateral movement of the hydraulic ram rods, such that the tiller movements correctly reflect the desired rudder angle of steering. The guide bar can run parallel to the steering gear crosshead or be fitted in place of the crosshead shown above. The guide bar bearing is the moving part of the mechanism that takes movement of the steering rams and transfers it to the tiller, while moving on the guide bar.
- The securing bolts for the guide bar bearing effectively connect the steering rams to the tiller.
- The rudder stock is the cylindrical steel bar (or tube) which connects the tiller to the rudder. It is of sufficient strength and moves in azimuth, to ensure that steering gear movements cause the corresponding direct movement of the rudder.
- The upper rudder stock keyway lies within the joint of the tiller to the rudder stock, with the key ensuring (if aligned correctly, and not damaged) that the tiller arm is correctly located, relative to rudder position, when the tiller arm is tightened down correctly onto the upper taper fit of the rudder stock.

- A typical steering gear has two hydraulic rams: one on the port side and one on the starboard side of the rudder stock, to provide power for the full range of rudder movement starboard to port.

CHIRP Comment

The Maritime Advisory Board agreed that this incident was a good example of a company following up and acting upon receipt of a report. Quite apart from the technicalities of the actual repair, the main focus of the Advisory Board comment, was that there was potential for a hazardous situation to develop, such as a grounding. In hindsight, it is easy to see that there was a problem even though the standard steering gear tests did not reveal any issues. It is also easy to note that for many defects (not specifically this report but in general), if the problem is not detected immediately it can become the norm – “That’s the way it’s always been”. So the main lesson to come out of this report is: if something doesn’t feel right, then there may well be an issue – so REPORT IT! This lesson does not only apply to this vessel’s manoeuvring characteristics, but to any piece of equipment or any operation which does not appear to be functioning as you might expect it to.

-----REPORT ENDS

New build vessel – poor steerage

OUTLINE: A report describing a new build vessel with poor handling characteristics when in the loaded condition.

What the Reporter told us:

Description of Event: A pilot reported that when berthing a specific vessel, a considerable amount of port helm was required to stop a tendency of the vessel to go to starboard. The vessel was in the loaded condition and the speed varied between six and nine knots. The weather and water depth were considered not to be a contributing factor.

The vessel is a new generation bulk carrier with a very rounded bluff bow and is the third vessel of this hull form where I have encountered this tendency. The first couple of times, I thought perhaps it was the weather, but now I believe it is a quirk of the design. When the vessel is in a light condition, there has been no issue.

Further dialogue:

CHIRP wrote to the designers of this particular class in order to seek any clarification of the reported manoeuvring issues but received no response. Similarly, a letter was sent to the Quality Assurance department of the vessel’s ISM Managers – likewise, no response was received.

CHIRP Comment

The Maritime Advisory Board discussed this report in depth. Some members had historical first-hand experience of other new build vessels where poor handling was attributable to the design of the rudder. Regarding one such class in

particular, a change of rudder design was required and the installation of a “high lift” rudder rectified the problem.

In general, sea trials for new building vessels are conducted in the ballast condition only, with the laden condition being extrapolated from the results.

It was pointed out that the lessons are similar to those of the rudder angle indicator report above. If the handling of the vessel does not feel right, then report this to your managers for further investigation. Poor manoeuvring characteristics, if unrecognised, present a danger to safe navigation and the potential for grounding or collision in restricted waters.

In addition, **CHIRP** will be writing to the relevant Classification Society, primarily as an awareness raising exercise, but also to try to determine whether this is a known common problem. Any feedback will be promulgated in a future issue of Maritime FEEDBACK.

In order to widen the debate, **CHIRP** would like to hear from anyone else who has experienced similar problems.

----- REPORT ENDS

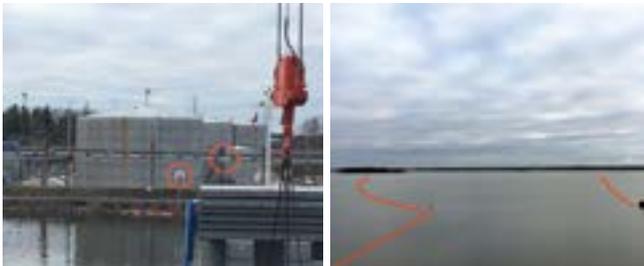
Navigational aids

OUTLINE: A report detailing difficulties approaching a berth due to issues with navigational aids.

What the Reporter told us:

Currently I am trading on a liner route between two ports. In Port A, we load pipes for discharge in Port B. The berth in Port A is located on the island of xxx. It is not a busy berth and it is now mostly used for the transportation of pipes.

There are two problems with this berth. The main leading line is mostly useless because the upper light is obstructed by a pipeline. According to a pilot, this issue was reported to the authorities six years ago, but it still has not been rectified. Another problem is the position of one of the buoys. The location of this buoy makes for a challenging approach in a strong northerly or southerly wind. I have already experienced several close encounters with this buoy and it is not helped that the buoy is unlit. Re-positioning of the buoy would help a lot. (See pictures below).



Leading lights obscured by a pipeline, and a view of the approach to the berth – looking west.

Lessons learned

- Approach to the berth is difficult in some conditions.
- The position of one (unlit) buoy is not logical given the layout of the berth.
- Obstructed navigational aid has not been recognized and corrected, thus making navigation dangerous.

Further Dialogue:

CHIRP wrote directly to the port Operations Manager but received no response. We then wrote to the Chief Hydrographer for the relevant country, who immediately responded. **CHIRP** was thanked for the report and the email was passed to the proper department that supervises local port authorities and those responsible for fairways and nautical aids within their waterfront. No further comment from that particular department was forthcoming.

CHIRP Comment

The Maritime Advisory Board commented that all information printed on a chart should always be up to date. In this case, the information relating to the leading lights was incorrect. Although the issue was stated to have been reported to the local authorities some years ago, it would appear that no action had been taken. It is irrelevant that the berth is now infrequently used – the point is that all information that is published on any chart should always be correct.

CHIRP has sighted the relevant chart and it is clear that the buoy mentioned in the report does appear to obstruct the approach, particularly when leeway sets you towards the buoy. Whilst the charted information is correct in this case, **CHIRP** can only agree that the approach does seem to be problematic.

As a general comment, there is always the option of reporting inaccurately charted navigational aids to the Hydrographic Office. In the case of British Admiralty Charts, the process is described in the link below and can be used by all mariners to report any updated information they may have. In addition, further information may be found in *The Mariners Handbook – Chapter 8 (NP100)*

<https://www.gov.uk/guidance/use-of-third-party-data-and-h-notes#hydrographic-notes>

----- REPORT ENDS

Unauthorised modification

OUTLINE: A report detailing a dangerous modification of an aluminium step ladder.

What the Reporter told us:

During a routine safety inspection of the Steering Gear Room, the Shipboard Safety Officer spotted an unauthorised modification to a portable aluminium ladder. The ladder had been crudely extended by bolting two pieces of wood into the sides of the ladder. Attached to the end of this was a wooden spreader/step. The full distance from the aluminium steps to the wooden spreader/step was nearly an additional one metre.

The pieces of wood had visible evidence of cracks, sharp edges, and two long nails with 2cm protruding from the wood. In addition, the arrangement resulted in the ladder becoming unstable as it was uneven when placed upright on the deck.

The Safety Officer advised that equipment such as portable ladders should never be modified as this is outside their design parameters and would render them unsafe for use. In addition, the manufacturer’s certificate for the safe load of the

ladder would become null and void. If this type of modification were noted during a Third Party inspection, such as Port State Control, the inspectors would not be impressed.

CHIRP Comment

The Maritime Advisory Board commented that this is a classic case of not using “the right tool for the right job” and agreed with the comments of the Shipboard Safety Officer. Unauthorised modification could lead to equipment failure and potential injury. From a human element perspective, the person who modified the ladder was clearly not aware of, nor concerned with, the dangers that could arise from this practice. Furthermore, looking at the “Deadly Dozen” reveals the following:

- **Local Practices** – Don’t cut corners, and beware of the local “norms” becoming the new standard.
- **Culture** – Do you really have a good safety culture – does everyone on board and in shore management really care about safety?
- **Situational Awareness** – Ask yourself “What have I missed?”
- **Complacency** – When considering any job, follow procedures – they work.

The Code of Safe Working Practices has a lot to say regarding portable ladders. Sections 11.8.4–11.8.5, 17.3, A17.2/3–A17.2/4, 22.2.9, 22.6, 28.6.3 refer.

----- REPORT ENDS

Expiry dates of provisions and safety equipment

OUTLINE: A report detailing the supply of out of date provisions. Similar lessons learned can be applied to safety gear with a shelf life or expiry date.

What the Reporter told us:

Upon loading provisions at Port A, the ship’s crew discovered that a number of items had surpassed their expiry date.

The company conducted their own investigation and stated that expired provisions could lead to health problems, food poisoning and the risk of illness. They stated the resultant cause was improper control and/or standards of the supplier.

Expired or improperly maintained foods are a potential cause for health problems onboard. During delivery, strict preventive measures should be implemented at all times. The handling, storage, preparation and serving of provisions and food must be in accordance with the company’s procedures and instructions.

Upon delivery and prior to storage in the provision rooms, the expiration dates of the provisions should be verified. Expired provisions and those that expire within a short period must be returned to the supplier. If the ship has already sailed from the port, the company should be notified with necessary evidence (photos) as soon as possible.

Cooks and galley personnel must ensure that no expired foods are consumed. The consumption of foods should be arranged so as to prioritise items that have the earliest

expiration date. The ‘first in – first out’ principle of stock rotation should be observed in the storage of all provisions.

CHIRP Comment

The CHIRP Maritime Advisory Board discussed this report and expanded upon some of the comments from the company. Some companies have procedures in place where the master is provided with cash to pay for provisions and in this case the master often has a free rein to determine which chandler is utilised. The danger with this is that, inevitably, there is a cost versus quality argument – cheaper is not always better.

Other companies may well have their own list of preferred chandlers for various ports. If this is the case, those chandlers can be audited by the company to ensure that standards and expectations are maintained. Similarly, any complaints about expired provisions being delivered, can immediately be addressed by the company and acted upon by the chandler.

Expired provisions can, as the report states, lead to health issues. Items labelled “use by” refer to products which may perish fairly quickly – dairy products, salads, fruit, fresh fish and meats are all examples. Best before dates may often be found on frozen products, dry and canned goods. Ordering in sensible quantities, and utilisation of good stock rotation can all help in ensuring that standards are maintained and that all foodstuffs are kept in date. In addition, it should be noted that the temperature at which provisions are loaded is equally important from a health and safety perspective. Frozen provisions should not be accepted if the product is not frozen, and chilled products should be delivered between 0°C and +5°C. Finally, cross contamination between out of date or defrosted frozen and chilled products should be avoided.

A well fed and healthy crew is, in general, a happy crew.

As a general lesson, the Board also mentioned that the delivery of expired goods or those close to expiry is not confined to provisions. It may be equally applicable to medical stores, pyrotechnics, or indeed any safety equipment with an expiry date. It is worth noting that grinding discs may also have a use by date.

----- REPORT ENDS

Safe working practices – working aloft and in cargo holds

OUTLINE: CHIRP has received several reports concerning unsafe working practices whilst engaged in cargo hold preparations and also when working aloft using ships cranes.

What the Reporter told us (1):

A crewmember reported that whilst anchored on a bulk carrier waiting to load grain, the vessel’s management instructed them to repaint the cargo hold. The crew were not provided with basic personal protective equipment such as gloves, dust masks, and eye protection. The holds were being treated with chemicals and painting was conducted

from dusk until dawn – which also meant the crew incurred non-paid overtime.

In this particular port, there is a general prohibition on all painting.



Ladder not secured and crew in a precarious location with a risk of falling

CHIRP Comment

CHIRP highlights that notwithstanding the poor standard of safety employed by the vessel's management and the lack of basic safety protection to do the job, the most common requirement for cleanliness when loading grain in bulk carriers is termed "grain clean". This involves fresh water washing and the removal of all of the previous cargo residues. The hold must be free of any infestation and any loose paint flakes removed, and the hold must be odour free. In this particular case, with these practices being employed, there existed an inherent danger that the holds would not be odour free at all. Holds would generally be inspected prior to loading grain and any failure of the inspection would mean time off hire until any deficiency was rectified.

What the Reporter told us (2):

A vessel reported unsafe working conditions whilst engaged in rust removal and painting of the cargo holds from the hatch coaming to the tank top. This involved using the ship's crane with a cage, or sometimes a bosun's chair, suspended from the crane.



Unsafe work practices and crane riding

CHIRP Comment

Whilst some of the work practices regarding unsecured equipment bear remarkable similarities to the previous report, CHIRP highlights the picture where crew members are riding in a cage painting the upper sections of the hold. Any crane and associated equipment used for the transfer of personnel should be designated as "man-riding" for that purpose, and in general this means that a crane must be fitted with a failsafe brake. It should also be Class approved for use in transferring personnel. In the above example, the crane is almost certainly not designated for this purpose.

What the Reporter told us (3):

During a personnel transfer operation from our vessel to the bunker barge, a surveyor was to be transferred from our vessel to the barge using a "Billy Pugh" basket.

The bunker surveyor who was to be transferred, positioned himself in the centre of the "Billy Pugh". This area is solely for baggage stowage and the correct method for transferring personnel is for the person to be positioned on the outside of the basket, standing on the base ring with arms engaged through the netting.

This incident was disappointing since the surveyor had participated in the safety meeting before the task's commencement. The operation was reviewed, and the transfer procedure was fully discussed with the surveyor. The transfer then proceeded without incident.

CHIRP Comment

CHIRP highlights that, in addition to the comments of the reporter, any personnel involved in personnel transfer should be wearing full PPE including life vests.

Whilst the following link from the Standard P+I Club is mainly directed at transfer of personnel during ship to ship transfers, there are many aspects which are relevant to these reports and there are useful guidelines for all to be aware of. The article also shows pictures of the Billy Pugh arrangement for personnel transfer.

<http://www.standard-club.com/media/23827/StandardSafetyPersonnelTransferJuly2010.pdf>

Further guidance may be found in the MCA Marine Guidance Note MGN332 (M+F) Lifting Operations and Lifting Equipment Regulations 2006. In particular, the attention of readers is drawn to Regulation 7 of the Annex which states that the employer shall ensure that no

lifting equipment shall be used for lifting persons unless it is designed for the purpose. It also states that lifting equipment designed for lifting persons must have suitable devices to prevent it from falling.

The Code of Safe Working Practices mentions the following;

- 19.11.4 No person should be lifted except where the equipment is designed or specially adapted and equipped for that purpose, or for rescue or in emergencies.
- There is a full section relating to personnel transfer in section 31.13.

-----REPORT ENDS

Overheating of light fittings

OUTLINE: A report detailing a repeat of a known hazard that had previously been identified and actioned by the Company.

What the Reporter told us:

During a night time routine safety fire patrol, a watchman reported to the OOW that he smelled melting cable coming from a light fixture in the accommodation spaces. The Electrician was immediately called to investigate the causes of this incident. It was found that a fluorescent light capacitor had overheated. This in turn resulted in nearby cables becoming burnt. The Electrician replaced the capacitor and additionally renewed the burnt cables. Normal operation of the light fitting was restored without further incident.

Using the internal near miss reporting system, the company management were notified, and the safety department duly followed up. The following points were highlighted:

Within the previous twelve months, two similar incidents had occurred on company vessels and both were specific to this particular capacitor that had originated from a single manufacturer. These two failures led the company to take the following action;

- All fleet vessels fitted with this particular light-fitting were to replace the capacitors with an updated product.

- The Planned Maintenance System for all vessels with this fitting were modified to provide instructions for inspection every six months, and to renew the capacitors every four years.
- 500 capacitors were delivered to the affected vessels by the manufacturer.

In this particular case, and prior to the incident, the replacement capacitors had been received on board but not fitted. Further, the vessel's last routine report to the company management indicated that inspection and maintenance on the accommodation lights had recently been carried out with no problems being reported.

After examining the defective capacitor, it was found that this type of capacitor was still fitted on board. The company instructed that all of the old capacitors be replaced, with appropriate spares ordered.

Overheating and failure of capacitors in fluorescent lights constitute a fire risk. It is important to use capacitors made from flame retardant materials fitted with an appropriate thermal fuse. The lighting fixtures in the engine room and in the accommodation should be subject to regular inspections to confirm their good condition.

Proper implementation of PMS requirements and implementation of instructions from the company, especially those deriving from hazardous incidents, should be promptly arranged.

CHIRP Comment

This report highlights the value of companies having an effective near miss reporting system. It also shows that even with a reporting system, things can go wrong. If a hazard has been identified and actions taken to rectify the problem (which may take a certain amount of time to implement), then these should form part of the handover notes for onboard personnel. In addition, a company could request positive confirmation of remedial action. If this had been done, then it would effectively ensure that a closed loop instruction had been properly implemented.

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