

Editorial

We have a full quota of reports in this edition of Maritime FEEDBACK, and we thank all our reporters for taking the time to contact us. Your efforts are appreciated by seafarers everywhere, and you really do make a significant contribution to improving safety at sea.

Our first report about the positioning of a pilot door may seem familiar, because we also dealt with it in MFB 48. This time we include a response from the classification society. Our Maritime Advisory Board were not entirely happy with this response, because it appears to rely upon the exact wording of the regulations rather than their spirit, which is disappointing.

We also include a number of cases involving the collision regulations, and highlight some of the themes which

emerge. There is still a long way to go before we can say that COLREGS are being observed by all ships, so please do your best to ensure you always adhere to them.

Readers will recall that some time ago we supported a campaign to retain a night watchman in a fishing port. The final article in this edition refers to that case, and describes another life saved as a result of keeping the night watchman. This is an excellent illustration of how **CHIRP** Maritime can help to save lives, but we can only do it with your support, so please keep sending us your reports.

Together, we are making a difference, and shipping is safer as a result.

REPORTS ...

Pilot door design

OUTLINE: Further to the article in MFB 48 concerning a vessel that was not constructed in compliance with SOLAS V 23, a second similar report has been received.

What the reporter told us:

This report concerns a new build vessel on her maiden voyage. The pilot boarded at the agreed pilot boarding area. On this occasion, the pilot access was via a "cat flap" which was positioned within the aft quarter length of the vessel. The stern camber profile started about 5m from the ladder's position making it difficult for the pilot cutter to land properly and risking the cutter being sucked under the counter.

On the outward-bound passage of the same vessel, with a draft of 10.4m, the pilot cutter was damaged whilst trying to disembark two pilots via the cat flap. The cat flap disembarkation option was aborted and the vessel rigged a combination ladder from amidships from which the pilots were able to safely disembark.

All of the vessel's other ladder equipment was observed to be in good order. The Owner should be informed of the difficulties this design caused, and pilot boarding arrangements reviewed before building any similar vessels.



Damage to pilot cutter

Further Dialogue:

Investigation revealed that the vessel was built at the same shipyard as the report in Maritime FEEDBACK Issue 48, and with the same classification society, but had different owners and different flag.

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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

CHIRP wrote to the managers of the vessel, the classification society, flag, and the shipyard. Whilst the letters to the ship managers and flag simply detailed the report, the letters to class and the shipyard highlighted the fact that the failings outlined in the previous report had not been rectified and that incidents were continuing. It was also highlighted that since both class and the yard had been involved in the modification to the previous vessels, as detailed in Maritime FEEDBACK Issue 48, it was unfortunate that lessons learned and acknowledged had not been taken forward for the new builds.

Although the managers of the vessel, the shipyard and the flag state all declined to respond, **CHIRP** did receive a response from the classification society. The salient points are highlighted below:

Our approval of the pilot boarding arrangements for this ship is based on a combination of two arrangements;

- *The pilot-ladder located aft, for drafts above 13m, and*
- *The combination accommodation ladder and pilot ladder arrangement located amidships, for drafts, less than 13m.*

With this combination, our approval is in conformance with the SOLAS requirements.

The choice of the correct arrangement to be deployed is, as you will surely appreciate, an operational matter to be decided by the ship's staff, depending upon the boarding conditions.

We assure you that we constantly strive to realise this Classification Society's purpose, which is "to safeguard life, property and the environment" in all our endeavours.

CHIRP Comment

The Maritime Advisory Board discussed this report in depth. Whilst thanking the classification society for their response, it was also noted that the approval was for this particular vessel and does not relate to the article published in Maritime FEEDBACK Issue 48.

The actual root cause of this incident and the one previously reported lies both in regulation and the initial approval at the design stage, (whilst noting that the classification society at the design stage may not necessarily be the same one as when the vessel is brought into service).

SOLAS Chapter V Regulation 23.3.1 states, "Arrangements shall be provided to enable the pilot to embark and disembark safely on either side of the ship." Sub-section 3.3.1.2 further states it should be within the parallel body of the ship and, **as far as practicable**, within the mid-ship half length of the ship. If the wording in red is removed, the regulation becomes a directive, rather than a choice.

It is essential that classification societies work in conjunction with shipyards to ensure not only compliance with the letter of regulations, but also within their spirit to avoid hazardous situations and potential loss of life. Flag states have a duty to ensure compliance with regulations either directly or by oversight of designated bodies, i.e. classification societies. Ship owners should also take an active interest in the vessels that they purchase so that they are fit for purpose and do not unnecessarily endanger life.

Whilst an alternative option for a combination of an accommodation ladder and pilot ladder may exist, the

temptation to use an alternative pilot door requiring less rigging, located in the aft quarter length of a ship in proximity to the propellers should not be an option. The danger to both the pilot cutter and pilot when such a location exists needs to be fully appreciated.

It is preferable to 'design out' rather than 'design in' a potential hazard resulting from an interpretation of imprecise wording in regulations, especially when the wording is intended for exceptional cases.

The following link may be helpful: [IMPA Guidance for Naval Architects & Shipyards – Provision of Pilot Boarding Arrangements 2012](#)

----- REPORT ENDS

Ship shore interface – shore gangway

OUTLINE: A report highlighting poor practice by shore workers whilst removing a gangway from the ship.

What the Reporter told us:

Recently, whilst in port on a cruise, the gangway was installed and removed by a road crane managed by the port. Just before the ship sailed, three personnel (a crane driver and two stevedores), removed the gangway using the crane. I was on a balcony about four decks above the quay and alongside the crane. I have no professional maritime experience, but in the past I have managed heavy mechanical engineering operations, including crane operations. There was no apparent haste, but the two stevedores took a number of chances that I thought were avoidable:

- They were not wearing hard hats, and their heads were at times very close to the crane's heavy metal hook.
- The stevedore gave hand signals to the crane driver with very slight finger movements. I am unsure whether he was using a local system of signals, but the system that I am familiar with involves unambiguous signals using the whole arm.
- One of the stevedores walked under the load and briefly placed his hands under the load when positioning timbers, putting himself at risk if the load were to descend unexpectedly.

These were easily avoidable risks that could have been eliminated by the use of hard hats, clearer signals and staying out of reach of the suspended load. The risks were very small, but the consequences, if an accident did occur, could be serious.

Further dialogue:

CHIRP wrote to the shipping company concerned highlighting the report – the company are in the luxury area of the cruise sector. Means of access to the vessel is generally the responsibility of the master (and company management by association), but this report falls squarely on the port. It was queried as to whether "poor practice by association" was acceptable? The Company responded, welcoming the report and passed it to their QHSE department for information. They also gave a port

contact and **CHIRP** wrote to the port manager but received no response.

CHIRP Comment

The Maritime Advisory Board commented upon two aspects of this report. Firstly, everybody is responsible for the safety of all personnel whether they are ship or shore based. The stevedores have a duty of care to look after one another and to intervene if somebody is doing something in an unsafe manner. This is sometimes termed Stop Work Authority and encouraging this promotes a higher safety culture. Similarly, anybody who observes an unsafe practice can intervene.

In this particular case, it was commented that the cruise industry generally does not subcontract this type of job and that responsibility usually lies with the port. It was also noted that some ports operate at lower safety standards. However, remedial action in these cases could be encouraged if perhaps the master were to “note protest”. Alternatively a letter from the company to the port may encourage safer behaviour.

It was finally noted that the Reporter’s comments are equally applicable to all lifting operations and that the Code of Safe Working Practices contains signalling procedures.

----- REPORT ENDS

Collision Regulations – several near misses

INTRODUCTION: **CHIRP** has received several accounts of navigational near misses from both the leisure and commercial sectors. Some of these have a common theme and thus, to avoid repetition, **CHIRP** comments may be found at the end of the section rather than on an individual basis.

Report No 1: A report describing a near miss between a yacht and vessel under pilotage highlighting differing perceptions of the same event.

What the Reporter told us (1):

Whilst participating in a local yacht race we were running downwind with the incoming tide toward our next mark. We were flying a large and very brightly coloured cruising chute and doing approximately 6.5 knots over the ground. Visibility was hazy but about 2.5 miles. We suddenly became aware of a large vessel approaching rapidly from our port side. This was unusual as the ship was crossing from South to North outside of the usual shipping channels. Normally the only commercial vessels in this area are the local tugs and pilot boats. It was immediately apparent that we were on a potential collision course and with the wind and tide pushing us, we were closing rapidly. As the relative bearing was not changing and there was no sign of the ship (the give way vessel) taking any action, I called them on VHF Channel 16. I called them three times, asking them to acknowledge and make their intentions

clear, but received no answer to any of my calls. We were on the point of doing a crash gybe when one of my crew said the ship’s aspect was changing, that she was turning to port.

The ship passed about 100 yards ahead of us and as we crossed her stern I noticed she was flying a pilot flag.

Lessons Learned:

- Never assume that the give way vessel will in fact give way. With some 35 years of sailing this is a lesson I have already learnt.
- Appreciate that VHF is a very poor method of communication because:
 - There is no guarantee that you are transmitting – in fact we were, because I checked with another vessel in the race.
 - There is no guarantee that anyone is listening, or that their VHF is on/working.
 - In the case of ships versus small sailing vessels, sometimes calls may be ignored.
- That even a vessel carrying a local pilot, who should be well aware that sailing vessels are regularly in this area, may not obey the COLREGS.

Further dialogue:

CHIRP wrote to the Pilot Authority who responded as follows:

We have discussed this report with the pilot who was onboard the vessel, and he has offered the following comments;

- While approaching three yachts on our starboard bow, bearings were monitored for some time and the vessels tracked on ARPA radar. Two yachts passed well ahead of us and a third passed astern. The bearing of the third yacht was noted to be always opening.
- We had been steering a steady course since departing port and had a maximum speed of 8 knots. Why the reporter should state that the vessel appeared “suddenly” is difficult to understand. The visibility was actually in excess of 4 nautical miles that day, so we would have been visible to anyone keeping a lookout from the moment that it left port.
- We were monitoring VHF Channel 71, which is appropriate as it is the VTS channel for that area. Had the reporter been monitoring that channel as per local General Directions, and made his call on that channel, he would have received an immediate response.

The reporter commented as follows;

- From my position (third yacht) the bearing appeared fairly steady, enough to concern me. All I wanted from the VHF call was confirmation of the vessels intentions and to know that he knew we were there.
- The vessel appeared “suddenly” to me because it appeared on a most unexpected course for commercial shipping in that area. Not a mistake I will make again.
- With my eyes about 6 feet above sea level, visibility for me, was indeed only about two miles. I did not have the benefit of a view from 30 feet above the water.
- The local General Directions specifically exempt pleasure vessels, and therefore they are extremely unlikely to use VHF Channel 71. It is however, one of the channels we scan, so that we have an idea of what is happening in the

area. If they had called us on Channel 71 we would have heard them. I never thought of calling on Channel 71. To me, Channel 16 was the logical channel to call on. I am concerned that the vessel was not apparently monitoring Channel 16. This has come as a real eye opener to me and calls into question the very point of Channel 16 as a safety channel.

I have learnt a few lessons from this, especially regarding expectations from VHF radio and how different views of the same situation may result in totally different perceptions.

Report No 2: Differing perceptions as to a safe passing distance between an overtaking vessel and a vessel being overtaken.

What the Reporter told us (2):

My vessel was departing from the port of Rotterdam heading for the Dover Strait. Our speed was about 8.2 knots with a course of 270°. After we passed the pilot cutter I noticed two ships behind me which were both faster than us. Both ships were on my port quarter.

First, I called the larger vessel to let them know that we would keep to the south side of the traffic lane. She confirmed and altered course to starboard to overtake us on our starboard side. Then I noticed that the second vessel (a container feeder with a speed of about 14 knots) was about 1.8 miles away and was on a collision course. She was ahead of and faster than the first vessel. I tried to contact her on VHF Channel 16 without receiving any answer. Then I tried to contact her on VHF Channel 02 (the working channel of Pilot Maas as we were inside their working area). As I still did not receive an answer I contacted Pilot Maas and advised them that the vessel was on collision course and that I was unable to reach them. Also, I requested Pilot Maas to advise them to pass on my starboard side as I was heading for the south side of the traffic lane. Pilot Maas replied that the ship had heard and that they would be altering their course to port (to pass us on our port side).

At 1.2 miles I saw she was altering to port but after a short time it became clear that she was trying to overtake me at 1.5 to 2 cables of distance. At that time, we were north of the Maas-Center light buoy at a distance of about 1.6 miles from the buoy. On the port side of the other vessel there was no other traffic.

Under the circumstances, a passing distance of 1.5 to 2 cables was, in my eyes, not a safe passing distance (if either vessel were to lose steerage there would not be enough time for the other ship to react).

In accordance with Article 2 of COLREGs I altered my course to starboard to make a passing distance of 2 to 3 cables. Still short, but I had the first vessel overtaking on my starboard side. I called the ship on my starboard side to advise them, and they confirmed that they would keep a safe distance.

After the vessel on our port side passed us at 2.4 cables, I turned back on course to give way for the vessel on our starboard side. The xx crossed our bow at about 1.2 nm and proceeded on a track about 1 mile north of ours.

CHIRP contacted the company of the vessel involved and spoke directly with the master concerned. The perception

of the master was that he needed to make for the traffic separation scheme and avoid the third vessel. He also knew of the reporter's intentions. A desired safe passing distance of xx cables/miles is sometimes just not possible in high density traffic areas.

Report No 3: Disregard for COLREGS approaching a pilot station in the Bungo Suido - Japan

What the Reporter told us (3):

On 10 Apr 2018, we were in the Bungo Suido leaving Seki Saki pilot station outbound, whilst an inbound car carrier was north-west of us and heading to pick up a pilot.

We initially monitored the target at about 10 miles on our port bow, and then called them by VHF when they were 6 miles on our port bow showing a clear green sidelight. We assumed she had seen us as well showing our red since visibility was good that night. Her distance to the pilot station was around 8 miles. Our OOW asked the inbound vessels' intentions? The OOW of the car carrier replied that they were approaching the pilot station to pick-up a pilot and requested starboard to starboard. My OOW responded that they, being the "give way" vessel, should keep clear of us and not cross our bow and alter their course to starboard so that we pass port to port. He added that there was another ship on our port bow outbound and that we could not alter course to port. There was no reply to this.

We continued to closely monitor them, and we were amazed that they blatantly disregarded the collision regulations. They continued their course, started slowing down and we found ourselves in a collision situation. Just before they were 2 miles distant on our port bow, we requested their intentions again and when they replied they were maintaining course, we immediately went hard-over to port to pass clear.

The unsafe behaviour they displayed was both disgraceful and irritating. Heated exchanges ensued with the master of the car carrier. He was obviously incorrect in disregarding the COLREGS just because he was approaching a pilot station, especially since he was still 8 miles away from the pilot boarding ground. The actual pilot boarding ground was located about 5.0 miles west of the normal traffic lane.

Can you pass this to the company concerned as the vessel exercised exceedingly bad seamanship and blatant disregard of the COLREGS? He is a navigational hazard.

CHIRP wrote to the company involved but they did not respond.

Report No 4: A blatant disregard of COLREGS in the Aegean Sea – superyacht under power and a general cargo ship.

What the Reporter told us (4):

M/V xx was detected at an approximate range of 8 miles on our port bow with a CPA of less than 0.35nm. The TCPA was approximately 40 minutes. We monitored her movements until her TCPA was approximately 25 minutes. We attempted to establish radio communication through both voice and DSC on a regular basis, but no response

was received. Both our vessel and xx were travelling at about 9 knots, so I maintained my course and speed and continued to try to obtain radio contact. When the range reached 1 mile I began sounding my horn and prepared to take avoiding action. The range closed to around 0.5nm and I continued sounding my horn. We were observing through binoculars and in their deck lights a crew member was visible leaving the crew accommodation and rushing to the bridge. At this point the vessel made a bold alteration of course to port, put her stern towards us, steamed away from our track and slowed down. We maintained course and speed and passed with a CPA of around 0.5nm. I tried to raise the vessel on VHF again but still received no response. We continued on our passage safely, maintaining a proper look out with engines and steering at the ready.

Lessons Learned:

My experience of transiting this part of the Mediterranean has taught me that the standards of watchkeeping on many of the smaller merchant vessels in this area is very poor. They regularly ignore the rules of the road and rarely respond to the VHF when called if a close quarter situation is developing, as they do not wish to have to change course or speed to comply. There seems to be an apparent attitude that yachts should always give way regardless of the circumstances. My vessel is 50 metres and 530GT and so not a small craft, but we regularly find ourselves in circumstances such as last night's events. We had some other traffic around us last night and would have created another close quarters' situation with other vessels had we slowed down or changed course. M/V xx had unrestricted sea room to pass by our stern, but it appears she had no one on watch in the bridge if our observations through the binoculars of a crew member rushing to the bridge were correct.

Report No 5: A near miss in the English Channel between a yacht and a power-driven vessel. The actions or inactions of one impact upon the actions of the other.

What the Reporter told us (5):

My sailing vessel was crossing the English Channel, sailing northwards hard on the wind. The vessel xx was heading WSW. Our CPA varied between a couple of hundred feet and zero. This ship failed to respond to three VHF calls on Channel 16 and two DSC calls.

Following a short VHF communication with another ship (which would otherwise have passed behind us) to inform him, we turned to starboard. We were then called by a third vessel asking us to confirm our intentions and explained that we would turn to port after passing the two ships so as not cause him to take action to avoid us.

Lessons Learned:

Do not assume that a ship has anyone on watch or willing to respond on VHF even when in close proximity with other vessels. Ships wishing not to be inconvenienced by having to change course and thus not answering VHF calls, be aware that in so doing you may cause inconvenience not just to one other vessel but to many.

CHIRP wrote to the managers of the vessel which failed to comply with the COLREGS, but they did not respond.

Report No 6: A report from a yacht outlining a near miss with a dredger followed by an official complaint where the follow up was considered to be less than satisfactory.

What the Reporter told us (6):

My husband and I were sailing west in our yacht when we saw a dredger astern of us in the main channel. Further back was an inbound tanker. We were just inside the channel, so we immediately changed our heading and moved outside the channel to let both vessels pass - we were under sail and goose-winged. My husband then noticed the dredger was changing direction and was heading toward us, out of the main channel. At this point, we were a little confused and quite concerned. There was no communication from the dredger in any way via radio or by sounding of horn and he was approaching very fast. At this point we started our engine and went full throttle to steer hard to port (into the main channel) to get out of his way, which resulted in us gybing the boat. The dredger proceeded past us at full steam and crossed our bow, seemingly completely oblivious to us and then it re-joined the main channel.

As you can appreciate this was a very worrying situation that could quite easily have ended in disaster for us if we had assumed he was going to try to avoid us. It was as though there was no one on watch.

We officially reported this to the local Port Authority as a dangerous near miss, asking them to acknowledge this and advise what further action would be taken and if there was anyone else I should be informing. They responded to say that they had opened an investigation with the vessel concerned (and its company) to establish the facts using their own vessel tracking replay facilities.

We were quite encouraged by this response and iterated that the dredger made no attempt whatsoever to warn or contact us about their intentions. Just before we had to helm to port we were on a downward sail with sails goose-winged and had we not turned to port, we would have been in the direct path of the dredger (they were the overtaking vessel).

The following is a precis of the response from the Port Authority;

The Master of the dredger came in for interview last week and we ran through the events as he recalled them.

- It was established that the bridge team of two were aware of yourselves and all the other yachts in the area and tried to carry out the difficult passage through you all as safely as possible, however, things didn't go as planned, which resulted in your report being raised. It was also confirmed by the Master that they were monitoring VHF Ch.12 and 16 throughout their transit but did not hear your calls.
- The Master was on the bridge with the Second Officer at the time you report the incident occurred, both were fully qualified with the appropriate certificates.
- The Master recalled there were quite a few yachts in the area but stated that he was maintaining a safe speed at the time and tried to carry out the difficult passage through the yachts as safely as possible.

- In the Masters’ opinion there were no yachts that he passed in the area that he considered to be a near-miss situation.
- Unfortunately, we were unable to obtain a replay of the radar and AIS data from our own Vessel Traffic Services (VTS) system due to a technical issue and therefore did not have the opportunity to see for ourselves what actually happened that day.

We are satisfied that the matter has now been thoroughly analysed with the Master and also raised with the owners, therefore no further action will be taken by ourselves.

Further comment from Reporter 6:

This was quite nearly a disaster and could have resulted in loss of life and boat and it was through our actions alone that this was averted. In fact it was so close that if for any reason our engine had not started we would have been in serious trouble. It is bad enough when leisure boats disregard or don’t know the COLREGS, but when those supposedly “trained professionals” in charge of vessels that could cause devastation flout the COLREGS, it just makes an absolute farce of them.

We wanted to bring this to your attention as we really feel this should be brought out into the open as we are sure we are not the only ones who have had to take evasive action. We all understand that the locality is a very busy area with lots of hidden dangers which makes it quite fraught at times. We all need to respect each other, after all it is supposed to be pleasurable and we enjoy being on our boats on the water.

CHIRP Comment

The Maritime Advisory Board discussed each report in turn and noted that there were several themes running through some of the reports.

Firstly, VHF. It was highlighted that the collision regulations are specifically designed to operate without the need for any VHF intervention. If you are the stand-on vessel then as soon as you think you are in doubt, then you actually are in doubt, and that is the time to take your own avoiding action or to reduce speed. It was also noted that a VHF conversation “requesting intentions” gives the other vessel the chance to say “No!”. With respect to the third report, whilst “heated discussion” might make you feel better, it is certainly not advisable and concentrating upon the collision regulations rather than the VHF is by far the better option.

With the advent of GMDSS there is no legal requirement to monitor VHF Channel 16, although it remains a safety and distress frequency. It is important to note any specific working channel you should monitor in your operational area, and also to appreciate whether it is on a Simplex or Duplex frequency – for the latter, other vessels can hear you, but you can only communicate with the transmitting station. The MCA MGN324(M+F) Navigation – Watchkeeping Safety notice provides useful information.

Several of the reports allude to situational awareness. The perception of a safe passing distance has been described, and CHIRP highlights the need to always put

yourself in the position of the other vessel(s). Any action taken should be early and substantial – full situational awareness would ensure that in the fifth report it would not be necessary to check the intentions of the other vessel. The perceptions of one person may not be the same as another, as illustrated in the visibility and risk of collision comments of the first report.

CHIRP notes that in an overtaking situation, where practicable, it is good practice to overtake to starboard keeping your own starboard side open.

In all of the reports, it is easy to simply look at the actions or inactions of the parties involved and apportion blame, but this does not identify the root cause(s) - which may lie in the qualifications and experience of personnel. In the case of the unmanned bridge, somebody had a certificate of competency, but that does not mean he was competent. Who went to the bridge in the fourth report? A deck officer or somebody less qualified? Hours worked in the past 24 hours, week, or month may also be factors as could commercial or time pressures, whether perceived or otherwise. Finally, several of the reports demonstrate a complete failing in human element aspects and safety culture.

CHIRP encourages reports of this nature – they come from many areas of the world and amply demonstrate that, in terms of best or good practice, we still have a lot to do.

----- *REPORT ENDS*

Fishing vessels – housekeeping

OUTLINE: A report outlining significant housekeeping issues in a fishing port which appear to have become a “standard” of normal operation.

What the Reporter told us:

When walking from the ferry landing point, I was aware of the large amount of fishing equipment left discarded around the harbour. I attach photographs showing a mass of fishing equipment on both sides of the access route for passengers using the ferry.





The notice highlighted on the picture above states that fishing gear left here will be removed

The picture on page six shows a large amount of discarded / old equipment close to the dock edge and the access ladder for crew. Fishing gear is permitted to be stowed there but the manner in which it has been done in this case generates plenty of safety hazards. Fishing gear is not permitted to be stowed in the vicinity of the area shown in the the photograph above. The Harbour Authority notice was clearly not obeyed by fishermen or enforced by the Harbour Master.

A fishing vessel under repair, shown below, had an LPG canister and what appears to be gas cutting equipment discarded on deck and not stowed safely. There were no crew members onboard.



Plenty of housekeeping hazards here – how many can you spot?

The large number of hazards can clearly be seen. Perhaps with **CHIRP**'s guidance and encouragement the port authority can be encouraged to improve their risk management and reduce the likelihood of injury to third parties using their facilities.

CHIRP wrote to the Harbour Authority but did not receive a response.

CHIRP Comment

The Maritime Advisory Board commented that the report indeed shows significant housekeeping issues. There is a duty of care to protect everybody within the port and the fishermen. It was mentioned that the costs involved in simple housekeeping were far less than the costs associated with an accident, prosecution, or indeed litigation from a third party.

In the United Kingdom, the HSE document [Approved Code of Practice and guidance \(ACOP\)](#) covers safety in dock operations and is aimed at those who have a duty to comply with provisions of the Health and Safety at Work Act 1974. This includes people who control dock premises, suppliers of plant and equipment, dock employers, managers, safety officers, safety representatives and workers. It also advises upon the use of risk assessment and establishment of controls. In addition there is the [MCA/DfT Port Marine Safety Code](#). Internationally, other countries will have their own legislation covering safety in ports.

----- *REPORT ENDS*

A Complete Lack of Safety Awareness

OUTLINE: A short report which details two areas where there was a breakdown in safety awareness.

What the Reporter told us:

During the arrival manoeuvre of a general cargo ship, I noticed that most of the crew members on the fore and aft mooring stations were not wearing any PPE at all (no safety shoes, helmets, or gloves). A few of them, including an officer positioned by the mooring winch control panel, were wearing flip-flops! Furthermore, upon completion of the docking, as they opened the cargo hatches using the ship's old-style derricks, I could clearly see crew members climbing up the vertical ladders leading to the derrick controls and securing arrangements bare-chested, wearing flip-flops, but not any PPE! It was appalling to witness the complete lack of safety culture, whilst everywhere around them were ship safety notices, posters, IMO signs etc. SAFETY FIRST? Well, maybe not on that ship!

In addition, whilst the ship was on the final approach to the pier, the port anchor was dropped from the hawse pipe without being walked back to the water level first. It just missed the line handler's boat which was literally a few metres away. As a result, the line handler's boat rolled heavily and moved quickly away.

The anchor was dropped to slow down the approach. However, this was not clearly communicated by the pilot to all parties involved by VHF. We were all surprised by the unannounced action. The weather was fine at the time (NE winds 10/15 knots), with negligible current and tide, and no abnormalities occurred during the manoeuvre. All the crew in the forward mooring station were standing on the starboard side ready to lower the ropes to the boat. When the anchor was dropped, no one checked the port side prior to letting go.

Lessons Learned:

This is a spiral to disaster – a total lack of awareness of any danger, poor safety culture and no communication.

CHIRP Comment

Having discussed this report, the Maritime Advisory Board agreed with the reporter that the lack of any safety equipment (PPE) is indicative of a scant respect for safety, leading to a poor safety culture both on board and from the company.

With respect to the anchor, it is not uncommon to control the speed of approach by “dredging” an anchor in small ports with restricted room. It is, however, to be expected that proper communication between the bridge team (both pilot and master) and the forward mooring station is maintained throughout. In this case the lack of communication could have been fatal to the line boat.

CHIRP agrees with the reporter that prior to dropping an anchor the area should be checked over-side to ensure that it is clear. It is also noted that if the dropping of the anchor is regularly conducted then the line handling boat should not have been in the vicinity until this operation was completed. Finally, it is always good practice to lower the anchor to the waterline prior to letting go – anchors can get jammed in the hawse pipe

----- REPORT ENDS

CORRESPONDENCE RECEIVED

Night Watchman

What the Reporter told us:

A year after a local authority abandoned cost-cutting plans to remove the night watchman at this harbour, an

intoxicated man decided to go for a dip at about 1am but got into difficulty. The night watchman spotted him in the water and threw a lifebelt to him whilst raising the alarm to the Coastguard. The RNLI subsequently attended. They located the casualty who was using the life ring deployed by the night watchman. The casualty was brought aboard the lifeboat and transported the short distance to the shore where he was assisted by our crew members and passed into the care of the ambulance crew.

This incident illustrates the importance of having someone on hand at the quayside. It was only last year that the post was close to being scrapped, and given the increasing activity at the port, the role of the night watchman is vital. Another life saved by the night watchman - that's two this year. I think we all know alcohol and vessels just do not mix, and alcohol has no place on vessels or around harbours. I'm told by the RNLI that if it wasn't for the actions of the night watchman this guy would have lost his life.

Again, you and **CHIRP** were vital in keeping the night watchmen in their jobs and this shows the work you do has saved lives.

CHIRP Comment

CHIRP was happy to have been of assistance in ensuring that this important role was continued, and the value of the role has been categorically proven with the saving of lives. We would also reinforce the fact that alcohol and swimming are an extremely dangerous combination.

----- REPORT ENDS

CHIRP Maritime – Putting the Mariner FIRST

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

