

# MARITIME FEEDBACK



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An independent and confidential reporting system for the maritime industry

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## The CHIRP editorial

# Safety remains our priority



**Capt. Jeff Parfitt**  
Director (Maritime)

This edition of Maritime FEEDBACK comes to you as the world is still in the grip of the COVID-19 pandemic, so we hope all our readers are keeping safe and well. At CHIRP Maritime we have been very active in recent weeks attempting to draw the world's attention to the plight of seafarers, particularly those who are trapped on board with no immediate prospect of relief. We have published three important new papers, all of which can be viewed on our website [www.chirpmaritime.org](http://www.chirpmaritime.org). The first draws attention to the crews trapped aboard their ships, while the second covers medical aspects of the pandemic and provides useful links to sites which offer further information on a variety of topics such as how to care for a shipmate who contracts the virus. The third paper has been specially written by our MAB member Dr. Claire Pekcan and covers all aspects of the mental health of seafarers who are trapped



Thousands of seafarers are trapped on board with no immediate prospect of relief ([image: Alamy](#))

on board and worrying about friends and family at home. This paper was considered so important that we secured funding from the Lloyd's Register Foundation to print it as a booklet for circulation throughout the industry. I can report that all the papers have been very well received and have been given excellent press coverage. They have also been forwarded to the Secretary General of the IMO and we hope they will help

CHIRP Maritime have been very active in recent weeks attempting to draw the world's attention to the plight of seafarers

draw the world's attention to the sacrifices being made by seafarers to keep the world's trade moving.

Turning to the contents of Maritime FEEDBACK, we have a varied selection of reports. We highlight some rules and regulations which may not be familiar to most of us, and once again consider problems with pilot ladders and rate of turn indicators. We consider poor communications between bridge and engine room and investigate a vessel which sailed through a Particularly Sensitive Sea Area (PSSA). We also have a report about ISM Code violations, where the company concerned at least launched an investigation when we were finally able to contact them, and an interesting account of encounters between ships and aircraft. We also consider a problem with broken wires, and safety violations on a bulk carrier. Finally, we have another excellent paper in our Pilot's Corner.

Safety must still be a priority, even when our minds are distracted by the pandemic so please, until next time, be careful out there!

## Learning opportunities from non-compliance reports

**Outline:** Two reports were received recently that contained references to unusual recommendations, rules and regulations. Following the adage 'take every opportunity to learn', *CHIRP* is publishing details in the belief that they need to be promulgated more widely to prevent ships' crews falling foul of them. Remember that other legal truism 'ignorance of the law is no defence'.

### What the reporter told us (1):

Prior to sailing, it was noticed by the pilot that the vessel had totally incorrect tracks on the ECDIS for departure. The master was requested to remove the incorrect tracks within the port limits and to monitor the vessels progress against the recommended tracks permanently displayed on both ENC and paper charts. Shortly after clearing the berth, one of the bridge team put the correct tracks into the ECDIS.

In a recent report, it was highlighted by an admiralty court that a ship was deemed unseaworthy if the correct passage plan to and from the berth was not on the ship's charts or in the ECDIS system.

(This refers to a ship which grounded whilst leaving a port in China in 2011 – however the admiralty court ruling was only made in March 2019)

<https://www.shipownersclub.com/robert-shearer-update-on-unseaworthiness-the-cma-cgm-libra/>

### CHIRP comment (1):

Once upon a time, course lines on a paper chart stopped on arrival at the pilot boarding station and commenced at the pilot station when sailing. With the advent of the

requirement for berth to berth passage plans, the course lines were extended, often vaguely up the middle of the buoyed channel, into the port. As the ship rarely knew which berth it was going to before the pilot boarded - by which time the vessel was already in manual steering following courses TMO/PA – that was considered perfectly adequate.

Not so nowadays when pilots often come onboard and connect their own PPU's. If the captain and the bridge team are to effectively monitor the ships progress, then the track lines loaded and displayed on the ships ECDIS need to match those already in the pilots PPU. Plotting waypoints and tracks takes time, so unless the Master/ Pilot exchange (MPX) is going to become a very lengthy affair, which is not desirable, then it is beholden on the port and pilot station to inform the ship in good time before arrival at the pilot station as to which berth the ship is going to utilise and the appropriate waypoints to input into the ships ECDIS to get them there. There is an argument that by utilising a port authority's waypoints the passage plan would no longer be the vessel's, but if the new section of the passage plan is auto-checked with the vessel's criteria of draft and required under keel clearance etc. by the ECDIS system, it seems to make little difference who instigated a waypoint co-ordinates.

### What the reporter told us (2):

After boarding the vessel, which had a well-worn pilot ladder, the master was asked for the certificates for his ladder. He produced a surveyor's certificate dated 6 days after the vessel's launch date (9 years earlier). The captain was asked if he had any test certificates as required by ISO799, but he was unable to provide these. Without any available verification, it had to be assumed that the

**10.4** Each ladder shall be subjected to the ladder and step attachment strength test in Table 2 at not more than 30-month intervals. Each ladder which fails the test shall be rebuilt according to 10.3 or scrapped. The ladder shall be marked with the date of the test and the identification of the person or company performing the test. This marking shall be placed on the same steps as marking required by 8.1 of this document

#### The appropriate section of Table 2

Test	Item to be tested	Test Procedure	Acceptance Criteria
Ladder and step attachment strength	Fully assembled ladder of longest length to be approved	Suspend the ladder vertically hanging to its full length or extend the ladder to its full length on a horizontal surface, with the top end of the ladder secured using its own attachments. Apply a static load of 8,8kN widely distributed over the bottom step for a period of at least 1 min, so that the load is applied evenly between the side ropes through the step attachment fittings. Repeat the procedure at five different steps, except that the ladder is not required to be hanging at full length and only the step under test, its side rope attachments, and the side ropes immediately above the step attachment fittings are required to be subjected to the load.	Steps shall not break or crack.  Attachments between any step and a side rope shall not loosen or break.  Side ropes shall not sustain any observable damage, elongation, or deformation that remains after the test load is removed.

pilot ladder had not been load tested for over 9 years rather than “at not more than 30 months intervals” as required by ISO799.

#### CHIRP comment (2):

Like many seafarers, CHIRP is aware of the requirements of IMO and SOLAS concerning pilot ladders and refers to the appropriate publications. For those who are not familiar with the requirements of ISO799 (2019/2020) the appropriate section 10.4 is reproduced. (see box).

#### Final thought:

It is quite possible that the cost of load testing a pilot ladder every 30 months is going to exceed the price of a new ladder. A simple notation in the planned maintenance schedule to renew each pilot ladder every 30 months would be simple and probably cost-effective.

## Communication is essential

**Outline:** CHIRP received the following report from a vessel's captain

#### What the reporter told us:

At the end of a long river pilotage, the ship was about a mile from the berth and proceeding upstream at slow ahead whilst awaiting tugs. The pilot ordered 'half astern', but the engine failed to kick astern. After waiting a few seconds, the telegraph was moved to 'stop'. The air pressure in the starting air cylinders decreased to 12bar. After waiting a few seconds, a further attempt was made, but again the engine failed to start. The pressure in the starting air cylinders dropped to 7bar. Attempts to call the engine control room were unsuccessful, as nobody answered the telephone. After a further short period, the pressure in the air start cylinders was seen to increase to 22bar, the telegraph was moved to 'half astern' and the main engine responded and started to run astern. After this, there were no further issues.

During the subsequent onboard investigation, it was discovered that the new chief engineer had closed the valve between the two start air cylinders but had not told anyone about his action. According to his explanation, he wanted to have one start air cylinder full and ready for use.

#### Further dialogue:

CHIRP suggested that a chief engineer on a vessel is at liberty to run the engine room in whatever configuration he believes to be the best and safest, assuming the setup is not contrary to any statutory regulations, SMS requirements or pre-existing standing orders. However, in changing an existing arrangement, it is the chief engineer's responsibility to ensure that all members of the engine room team are made aware of the change. CHIRP would suggest a written instruction for all engineers to sign, acknowledging the change, should be standard practice. Sadly, on this occasion, that did not happen.

Another worrying aspect of this report is the fact that the engine control station was left unattended during manoeuvring / pilotage operations. Yes, there was an issue in the engine room which needed to be addressed, but good practice would suggest that someone should have remained at the control station if only to answer the telephone. If the engine room were short-handed, a call to advise the bridge that the control station would

be unmanned for a few minutes would be preferable to leaving the bridge team guessing.

#### CHIRP comment:

For clarity, the isolation of engine room starting air receivers should not be encouraged as this potentially minimises the 'consecutive' starts of the main engine and may prevent compliance with the IACS rules which state the following:

M611.5: The total capacity of air receivers is to be sufficient to provide, without their being replenished, not less than 12 consecutive starts alternating between Ahead and Astern of each main engine of the reversible type, and not less than six starts of each main non-reversible type engine connected to a controllable pitch propeller or other device enabling the start without opposite torque. The number of starts refers to engine in cold and ready to start conditions. There must be at least two starting air receivers, the total capacity of which will give 12 consecutive starts for a reversing engine or 6 consecutive starts for a non-reversing engine with CPP.

Further to the communication issue, the chief engineer and engine room duty staff must keep in very close contact with the captain and the bridge team – especially when manoeuvring or during pilotage. Sadly, ship operators / owners will often invest in Bridge Team Management training but not Engine Room Team training.

## Defective rate of turn indicator

**Outline:** Failure to highlight a defective rate of turn indicator at the MPX.

#### What the reporter told us:

The ship's digital rate of turn indicator at the bridge front was lagging considerably behind the ship's true rate of turn. Once the ordered rate of turn had been held steady for a period, the digital rate of turn indicator would then catch up and show the correct rate of turn. However, the rate of turn indicator at the helmsman's position showed the correct rate of turn throughout.

#### Further dialogue:

The ship's own bridge team were aware that the digital rate of turn indicator was lagging but it was not highlighted at the time of the MPX. The amount it lagged even appeared to surprise the crew when the ship started the first major turn.

On a positive note, when the helmsman was ordered to put the ordered rate of turn on immediately – whilst it was not showing on the bridge front rate of turn indicator – the Master was quick to point out that the helmsman's RoT indicator was working correctly and the required rate of turn was already on.

At the debriefing after the ship was berthed, the Staff Captain raised the topic that at future MPX's, the bridge team must highlight that the digital RoT indicator was experiencing significant lag, but that the helmsman's indicator was functioning correctly.

#### CHIRP comment:

Failure to highlight the defective rate of turn indicator not only caused the pilot a brief period of consternation but

also raised the question whether there were any other deficiencies which had not been mentioned? Suspicions like that could trigger the pilot to request a Port State inspection. Malfunctions do occur at times, but they must be brought to the attention of the pilot at the MPX and repairs must be arranged as soon as possible.

## Violation of PSSA restricted area

**Outline: Navigation through a PSSA (Particularly Sensitive Sea Area) is prohibited for vessels over 50m in length. However, not everybody obeys the rules.**

### What the reporter told us:

While on watch, I noticed another large cruise ship clearly enter and sail for over an hour through the PSSA we were passing. The other ship's AIS was on and identified the ship and showed her port of destination.

The reporter included a screen shot of the Radar/AIS clearly showing the reported ship transiting within the adjacent PSSA.

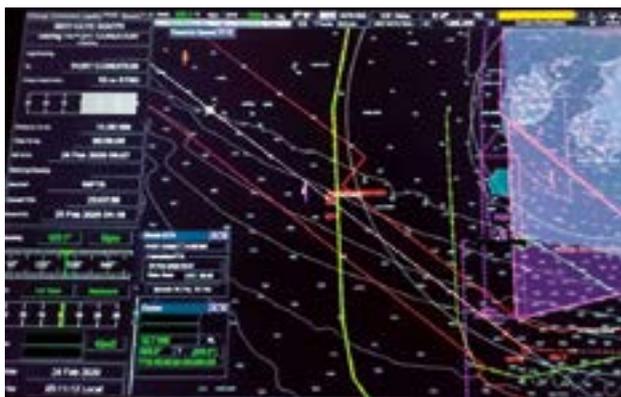


Figure 1 – screen shot of the Radar/AIS showing the reported ship transiting within the adjacent PSSA.

### Further Dialogue:

The reporter confirmed that he had not reported the matter to the local maritime authorities due to poor internet access. The reported vessel was nearly 300m long and it is possible that it was cutting a large corner off the transit to make an ETA, or to make up some earlier lost time. At the very least, it is poor attention to passage planning. Contravening the PSSA restrictions for commercial interests would seem particularly cynical. There is a reason for the restrictions on navigating within a PSSA.

### CHIRP Comment:

According to the IMO website: **A Particularly Sensitive Sea Area (PSSA)** is an area that needs special protection through action by IMO because of its significance for recognized ecological or socio-economic or scientific reasons, and which may be vulnerable to damage by international maritime activities...

There are 17 PSSAs in the world – including 3 extensions to the original Great Barrier Reef PSSA.

We would also add that, although by the time we received this report it was very much a historic event, we considered it important enough to forward the report to the appropriate maritime authorities for future reference.

## Poor safety culture on board

**Outline: A report received from a crew member concerned about the safety culture on board his ship and the poor example set by senior crew members.**

### What the reporter told us:

I have been working on board an LPG carrier for almost three months and I notice the lack of safety here is common. I want to report about the work permit system. The responsible officer is issuing the work permit after the job is done or whilst the job is ongoing. I tried to ask the bosun but he said, 'it has always been like this'. When I started to argue about this matter, instead of stopping the job until the permit was received, the bosun told the chief officer that I am complaining about the job and the chief officer started to get angry with me. The bosun usually does working aloft jobs without a harness or safety line and it is common for the officer to get mad with you if you question the safety.

### Further dialogue:

CHIRP responded and entered a correspondence with the reporter who, from the start, was apprehensive about losing his job if his identity became known. CHIRP was able to allay his concerns and the correspondence continued.

The reporter had been working in this company for 10 years and there were similar situations on other vessels, but a lot depended on the bosun.

The reporter advised that the vessel did carry the required PPE and there was even a matrix posted listing all the PPE required for each specific job which suggested a previous good safety culture. However, the present casual approach towards issuing permits and the bosun's poor example and reluctance to insist on having permits in hand before starting a job suggested that, currently, the safety culture onboard was poor.

On one occasion, the reporter had by-passed the bosun and approached the chief officer directly regarding the issue of work permits. The meeting had not gone well, with the reporter saying he could always ask the DPA which was apparently perceived as a threat because the chief officer informed the reporter that he would contact the DPA and inform him that the reporter was a troublemaker. After that, the reporter decided not to contact the DPA.

The issue had started a month previously when a ballast tank inspection was being carried out by an IACS surveyor. Crew members were sent into the tank with the surveyor, but the permit was not signed until the crew came out of the tank on completion of the inspection.

Initial attempts by CHIRP to contact the DPA were unsuccessful on two occasions.

### CHIRP comment:

At the most recent Maritime Advisory Board meeting, the members of the MAB felt that this report reflected a serious breach of the ISM code and should be pursued further. In addition to putting the crew at risk, the IACS surveyor, who should have made his / her own checks regarding the presence of a valid permit, was also put at risk.

There are tremendous costs, both financial and personal, associated with a poor safety culture and it is not a coincidence that the most safety-conscious companies and ships are invariably the most financially successful.

It was also pointed out that a safety culture can only ever be created and then reinforced from the top

of the organisation. It is up to the senior managers to create a good safety culture, both ashore and on board ship. A good safety culture is a constant battle against complacency and indifference.

#### Final thought:

Following the MAB meeting, efforts were made to contact both the IACS member involved and the relevant flag state administration. The flag state's response was immediate and positive and full details of the report were passed to the administration. Furthermore, a few days later the vessel manager contacted *CHIRP* after being alerted by the relevant IACS authority. A full and frank engagement between *CHIRP* and the vessel manager followed, and appropriate details of the report were passed to the vessel managers to enable an investigation to be carried out.

## Conflict between aircraft and ships

**Outline:** This unusual report was received from *CHIRP Aviation*.

#### What the reporter told us:

While flying by ILS (instrument landing system) inbound to runway 35 at an island airport, we broke out of low cloud conditions several miles out, on final approach. I saw a very large cruise ship steaming from left to right out of the harbour with a course that would cross the short final in front of Runway 35.

It appeared that the ship's vector would cross ours on a very short final 1 mile. I directed the First Officer to query the tower if this ship was going to be a problem with our final. The tower's answer was something like "... they (the ships) don't coordinate with us." I elected to fly high on the final glide path, approximately one dot high, to ensure adequate clearance over the cruise ship but was also considering a go-around because of the height of the ship. It turned out that we did, in fact, cross directly over the ship on short final. If I had stayed on the ILS glideslope the clearance would have been very uncomfortable. Had this been IMC (instrument meteorological conditions) and with any deviation at all below the glideslope, there may have been inadequate clearance over the ship. Although I was able to fly a little high and conduct a stabilized approach in this instance, it seemed like a potentially hazardous situation that should be better coordinated in the future.

#### CHIRP comment:

There are several international airports around the world that are in close proximity to maritime traffic movements, including Singapore's Changi airport, Hong Kong's Chek Lap Kok airport and Gibraltar's North Front airport. At these locations there is organised co-ordination between the aircraft requirements and the vessel requirements, by having a restricted area or a vessel reporting scheme during approach to and passing of the end of the runways.

However, in this case, according to the air traffic control tower, the ships do not liaise with the tower and there does not appear to be any restricted area to limit the approach and passing of vessels in the vicinity of the end of the runway.



Figure 2 – Aerial view showing proximity of the runway and port entrance

Historically, small vessels and fishing craft were not going to be of concern to the pilot of a commercial aircraft making a landing approach. However, with the massive expansion in both the popularity of cruise holidays and the size of the cruise ships being used (modern cruise ships can have air drafts up to 72m), perhaps a review of the arrangements, at this and every other airport where potential for conflict between aircraft and large vessels exists, is overdue.

#### Final thought:

The original report was generated by a commercial aircraft pilot and was extensively promulgated but all the recipients listed appeared to be involved in aviation. As the other part of the potential conflict involved the maritime world, *CHIRP Maritime* decided to draw the report to the attention of the relevant port state control and maritime administrations.

## Parting wires

**Outline:** Three reports that all relate to wires parting in service.

#### What the reporter told us (1):

The vessel had berthed safely, and the deck crew was instructed to deploy the starboard accommodation ladder. When the crew started lowering the ladder, the wire rope parted about two metres from its inboard thimble eye, in way of the outrigger's outboard guide sheave. The gangway fell and hung vertically down the ship's side. Fortunately, no one was injured. The ladder was recovered and secured, and the portable wharf gangway was deployed and used at the port.

#### Further Dialogue (1):

The company operated a maintenance programme that called for wires to be end-for-ended after 30 months and renewed every 5 years. The parted wire had only been installed 29 months earlier. The maintenance programme also called for the accommodation ladder to be thoroughly inspected every six months, however no specific instructions or guidance were provided for determining the condition of the wire. On board records showed that the last inspection of the accommodation ladder took place 2 weeks prior to the wire failure, at which time no defects were reported, the wire had been

greased and all rollers and moving fittings were free to turn with no signs of defects. Subsequently the company amended their maintenance programme to include monthly inspections and maintenance requirements for the wires. Accommodation ladder wires constructed of galvanized wire rope must be renewed after 24 months.

#### What the reporter told us (2):

During mooring operations on arrival one of the ship's forward mooring wires parted at the eye whilst being heaved tight. The damaged wire was released from the shore bollard and replaced with a soft mooring line. The mooring operation was completed safely without further incident.

#### Further Dialogue (2):

According to the ship's records, the wire in question had been greased three days before arrival in port. A periodic inspection of the wire had been carried out less than 3 months before the failure, at which time the wire was assessed as acceptable. However, the records also showed that the wire had been in service for 5.7 years. No records of cutbacks, re-termination or periodic load tests were available. Spare mooring wires were available onboard.

#### What the reporter told us (3):

During routine discharge operations, 4 out of 6 strands of the inner breast mooring wire parted at a position 35-40 metres from the eye. The terminal was immediately informed, and permission was granted for the replacement of the damaged wire. The mooring wire was replaced and the discharge operation was completed without further incident.

#### Further Dialogue (3):

The wire in question had only been in service for 15 months. Records showed that an inspection one week before the vessel arrived in port had assessed the condition of the wire as 'very good'. The wire had been lubricated 3 weeks before arriving in port. Furthermore, vessel records also showed that the last brake holding capacity test for the mooring winch was performed less than three months before the failure. Spare wires were available on board. At the time of the failure, the breast lines were not equally tensioned, and the mooring brake of the parted wire had not slipped.

A company investigation concluded that the wire failed due to:

- Unequal tensions in the mooring lines and/or improper adjustment of the mooring brake and/or
- a hidden defect in the wire, although its general condition was very good

#### CHIRP comment:

Wire rope maintenance on board ships can be a major issue. Not all ships carry pressure lubricators for the wire ropes, while bigger ships mean bigger and heavier mooring wires being handled by smaller crews. Few ships have the capability to run a wire off the mooring winch drum for routine maintenance. Consequently, for many wires, surface dressing with a suitable wire rope lubricant (or simple grease) whilst still on the drum, is the best that can be hoped for.

From the very first time the mooring wire dips into the water, insidious saltwater corrosion begins to weaken the wire from the heart out. CHIRP would suggest that no mooring wire should be considered fit for purpose and 'acceptable' beyond 5 years.

The smaller wires used on an accommodation ladder may never go into the water, but their location at the ship's side is very exposed and renders the wire liable to constant attack from saltwater spray. The wires are also exposed to sunlight and, potentially, tropical heat and dust, which is not ideal.

The first report is a perfect example of why combination pilot boarding arrangements, where the pilot ladder is secured directly to the accommodation ladder platform, are just inherently unsafe and wrong and should never be allowed.

In the first report, CHIRP commends the company who moved away from a 30-month end-for-ending and 5-year renewal policy to a straightforward 2-year renewal policy. One also has to question the wisdom of SOLAS permitting lifeboat fall wires to remain in place for up to 5 years. A simple 2-year renewal policy would have been so much easier and safer – surely?

## A very near miss

**Outline: A moment's thoughtlessness could have had fatal consequences.**

#### What the reporter told us:

A bulk carrier had arrived at a major iron ore terminal and commenced loading without delay the previous evening. At approximately 06:27, loading of No2 hold was completed and the shoreside loader was relocated to the next hold. Moving the loader to No6 hold was completed at 06:36 and the operator confirmed readiness with the chief officer to continue loading.

A few seconds before resumption of loading, the operator observed a crew member in the bottom of No6 hold. The circuit was suspended immediately, and the crew member was ordered to exit the hold by the deck officer on watch. Loading was resumed and completed uneventfully. The captain reported the Near Miss incident to the authorities, as required, and informed the company.

#### Further Dialogue:

The subsequent investigation noted the following:

From the ship/shore safety checklist review, it was noted that the main communication method between both parties was via handheld radios provided by the terminal on a given channel. It was also agreed that "the ship loader will be informed before access is made to any cargo compartment and that the covers of that compartment will be kept partially closed during the period of such access".

The chief officer had issued his standing orders for the cargo operation providing, amongst other things, specific precautions to be observed by the crew.

No 6 hold was in ballast condition on arrival, and it was planned to be de-ballasted and then mopped prior to being loaded. Once the de-ballasting was completed, an entry permit was issued at 05:00hrs for two AB's to enter and carry out the hold wiping.

A Risk Assessment for this operation had been carried out and communicated to the involved personnel. The entry into the hold was being supervised by the bosun. The deck officer on watch was attending to the cargo operations whilst maintaining contact with the chief officer and the terminal.

The work activities of the crewmembers in the cargo hold were completed at 06:30 hrs and both AB's were ordered to exit. Whilst exiting the space, one AB noticed

that his cabin keys had been dropped in the hold and returned immediately to pick them up. Fortunately, the loader operator noticed the AB in the hold and the loading was suspended.

The officer on watch had not given any specific notice to the loader operator to commence or withhold loading operations to No 6 hold whilst he was expecting both AB's to exit the cargo hold.

From the review of the work/rest hours there was no indication that the involved crewmembers had inadequate rest periods prior to the incident.

Investigation conclusions:

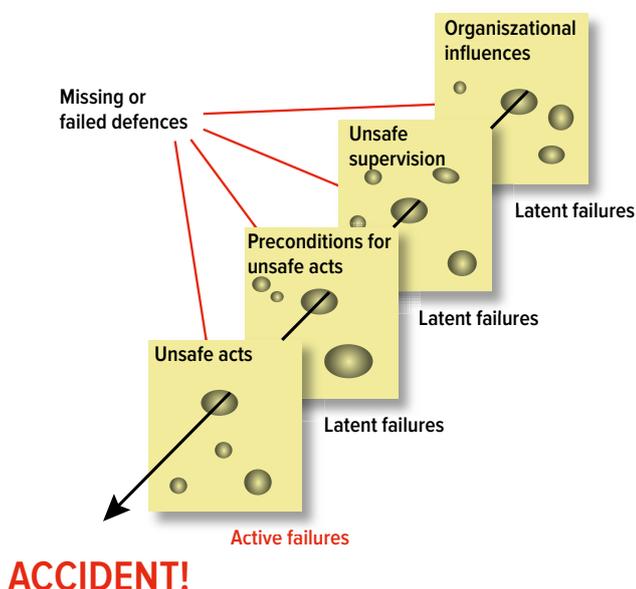
There was no proper notification given by the responsible ship's personnel to the ship loader in order to delay the shift to the next hold as required by the ship/shore safety checklist (inadequate communication/non-compliance with established safety reporting procedure).

The supervision/control of the enclosed space exit was not adequate since the supervisor failed to see that one of the crew had returned to the hold without obtaining permission. In addition, the AB who returned to the hold to pick up his keys failed to report this to the responsible watch personnel (inadequate implementation of cargo hold entry procedures).

The risk assessment carried out prior to the operation had not adequately identified the hazards related to the entry of personnel in the hold during cargo operations (inadequate risk assessment).

#### CHIRP comment:

A classic 'swiss cheese' incident. There were various checks and precautions either in place or available which should have made this potential accident impossible. One by one they failed because assumptions were made, or possible checks were not followed through and the final hole to line up was a momentary lapse in concentration by an AB who turned back into the hold to recover his dropped cabin key without thinking of the potential consequences. Luckily, the operator of the shore loader noticed the crew member before starting to load the hold. If the ship had kept the No 6 hatch covers partially closed, as required by the ship / shore safety check list during the mopping, it would have been obvious to all parties that the hold was not ready to load.



## Unsafe crew practices

**Outline: A report highlighting dangerously unsafe practices by members of a ships' crew.**

#### What the reporter told us:

Disregarding recommendations for ladders to be stowed away from contamination and protected from UV damage, the pilot ladder had obviously been left on deck throughout the port stay and discharge of palm kernel expeller (PKE), as it was covered in drifts of cargo residue. Prior to rigging for disembarkation, I requested that the dry PKE was brushed off the ladder as it becomes slippery when wet. An AB was issued with a hand brush, but instead of cleaning the ladder while it was on deck, it was put over the side. Even though the vessel was underway the AB climbed down the ladder to the bottom rung with no lifeline, lifejacket or hard hat. He held on with his left hand whilst brushing the steps with his right hand.

#### CHIRP comment:

The worrying thing about this report is that it was not an individual moment of madness. The crewman in question was issued with a hand brush by his supervisor and the ladder was not deployed by a single man, but rather by a two or three man team who watched without comment as the dangerous and reckless action took place.

Where was the safety culture? Where was the individual responsibility for personal safety? Where was the collective responsibility to look out for the safety of a fellow crew member?

#### Final thought:

Do similar examples of the breakdown of the safety management system or safety culture occur onboard your vessel?

## Pilot's corner

This month's article has been written by a senior member of the New Zealand Maritime Pilots Association (NZMPA). Whilst some parts are specific to New Zealand the vast majority of the issues and points raised are applicable on a global basis. Equally, a large portion of the initiatives introduced by the NZMPA for implementation within their sphere of influence have been introduced by other maritime pilot associations around the world.

In recent years, the NZMPA has undertaken to implement a number of steps and initiatives in relation to pilot boarding safety. In following this process, we have identified two areas of concern - these being non-compliance by design (cases such as trapdoor arrangements or other shipboard design deficiencies not necessarily related to the crew), and non-compliance by ignorance (cases where the crew show a complete disregard to pilot safety, regulations and the condition of their boarding arrangements).

The initiatives developed are designed to cope with both areas of concern, and in NZ we are now starting to see positive results. In addition to regular engagement with members and industry stakeholders we are doing the following:

- Pro-active engagement with our regulator. Here we are engaging in high level discussions around policy, regulation and education.
- A successfully implemented online event reporting

system. To date, pilot ladder related issues are the most common report type, with container vessels being the most common vessel type reported.

- A published NZMPA Safe Pilot Transfer Good Practice Guide
- Design and publication of the 2020 Pilot Pete's Pilot Ladder Tips calendar
- Development of descriptive guidance notes designed to educate and clarify rule requirements and be an aid to masters & pilots in demonstrating compliance vs non-compliance. A trapdoor PBA advisory notice is about to be published here.

To give weight to our campaign, in November last year Maritime New Zealand presented the results of a pilot ladder focus campaign. What was discovered raised concern and highlighted the extent of the issue, with:

- 8% of all pilot boarding arrangements not properly inspected by crew
- 9% were of non-compliant construction
- 30% without mandatory records, and
- 40% of all pilot boarding arrangements improperly rigged or unsafe for use.

The next step for NZMPA is to issue a set of regulator-endorsed guidance notes. The first version will focus on accommodation ladders used in conjunction with pilot ladders.

The intention of the guidance notes are to be a useful tool for ship owners, operators, agents, ship masters, ports and pilots to determine compliance vs non-compliance within the framework of NZ pilot ladder regulations (Maritime Rule Part 53).

As the first set of notes focuses on accommodation ladders used in conjunction with pilot ladders, they relate primarily to combination and trapdoor arrangements. As an association we have been formally challenging trapdoor arrangements since early 2018 based on our local regulatory framework, which states ladders must be secured directly to the ship's structure and not to the accommodation ladder.

We are now seeing positive changes in NZ where previously non-compliant ships are now presenting modified boarding arrangements to ensure compliance within the NZ rule framework. This drive ultimately culminated, last December, in the first ship being refused pilotage services by NZ ports for repeatedly presenting a non-compliant and unsafe boarding arrangement.



Figure 3 – Example of a compliant combination PBA with trap door.



Figure 4 – Compliant combination PBA with trap door – pilot ladder and man ropes extend up to and are made fast on vessel's deck

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