The CHIRP editorial

Distractions can be fatal

Recently, on our Facebook page, we published a summary of a report by the Marine Accident Investigation Branch concerning a Third Officer who was fatally injured on the ramp of a ro-ro ferry while he was using a mobile device. He was not aware of a trailer approaching from behind him, and lost his life as a result. The post about the incident generated far more interest and comment than normal, so the topic of using mobile telephones and other portable devices at sea is obviously one which strikes a chord with our readers. We would be very interested to receive reports on the use of mobile devices at sea, so please get in touch if you have witnessed accidents when people were using them, or if you have experienced a situation where a mobile device was instrumental in preventing an accident.

There are no international regulations about such devices although individual companies may have their own rules, but if lives are being put at risk then perhaps it is time to introduce legislation or prohibit the use of the devices in working areas. What do you think?

Meanwhile, we have an interesting and varied selection of reports for you in this edition. We consider a ship where the pilot had difficulty communicating with the people on board because they did not speak English, and we offer some good common-sense advice on echo sounder transducers. We also learn that incorrect settings in a ship’s ECDIS can affect a pilot’s portable piloting unit, and that wearing a face mask can have a serious effect on communications.

There is a report about very unsafe practices while working aloft, a claim that a pilot boat was speeding when passing other vessels, and more reports about engine failures when arriving or departing from a port. These are all topics which appear regularly, so please be on your guard and make sure they do not happen to you.

Our Pilots Corner features yet another report about non-compliant pilot boarding arrangements. This is both poignant and timely, because as we went to press we were saddened to learn of a second fatal accident involving a pilot boarding arrangement at the Sandy Hook boarding ground near New York on 5th August. Such tragedies can and should be avoided.

We conclude with some interesting recent correspondence from our readers about reports which have appeared in earlier editions of Maritime FEEDBACK. As always, we are grateful to all our contributors. Until next time, stay safe!
Communication and language barriers

Outline: Without effective communication safety is compromised.

What the reporter told us
I would like to report three issues I encountered on what should have been a routine pilotage operation, that effectively resulted in a complete lack of effective BRM and communication.

The initial area of concern was that communication with the bridge team was particularly difficult due to the almost complete lack of spoken English. We resorted to a well-known online translation app on a couple of occasions. The crew were willing enough but unable to communicate.

Secondly, the pilot card lacked some basic information. Neither the direction of rotation of the propeller, the astern power, nor the number of consecutive starts of the main engine were mentioned on the card. Given the language problems, I never received this information.

Finally, upon approaching the berth, the master was unable to start the bow thruster and despite repeated attempts, the bow thruster was unable to be used for the whole berthing operation. The master did not communicate this fact to me until pressed to do so. The translation app came to the rescue again, and it is believed that the problem lay with an auxiliary engine.

Two days previously the starboard windlass brake had failed to operate correctly when the vessel arrived at the inner anchorage.

CHIRP comment

SOLAS V - Regulation 14 states among other things that “English shall be used on the bridge as the working language for bridge-to-bridge and bridge-to-shore safety communications as well as for communications on board between the pilot and bridge watchkeeping personnel, unless those directly involved in the communication speak a common language other than English. The IMO Standard Marine Communications Phrases (SMCP) Resolution a.918(22), may be used in this respect”.

The use of an online translation app had two downsides (although it is completely understood why it was used). First, the pilot was potentially distracted from the job he was doing. Second, generic online translation apps, as good as they are, may not effectively be able to translate marine technical terms, particularly to and from languages that do not share a common alphabet.

In this case almost all the human element factors of the Deadly Dozen, as highlighted in Merchant Shipping Guidance Notice MGN 520 come into play, training, communications, local practices, and culture are particularly relevant. The vessel’s managers have a responsibility to ensure that crews employed on vessels engaged on international voyages have acceptable standards of English. Not only is it a safety-critical issue, but a SOLAS requirement. CHIRP did attempt to contact the vessel managers regarding this report, but they did not reply.

The issue concerning the non-availability of the bow thruster was never satisfactorily explained, it was possibly an issue with the auxiliary generator, in any event it was not properly declared to the pilot.

Pilot card information is a flag state and class requirement so to find it missing is a flag state non-compliance issue. The information might have been available on board, but without communications the pilot never knew.

All vessels should be aware that it is entirely within a pilot’s authority to turn the vessel around and take it out to anchor if safety-critical communications are not possible.

ECDIS / AIS position data affecting a portable pilot unit (PPU)

Outline: Defects, errors and anomalies with equipment do occur, but once they are identified they need to be addressed and resolved in a timely fashion.

What the reporter told us
The vessel’s ECDIS displayed an incorrect position - the vessel was displayed halfway over the wharf when alongside. In addition, the vessel’s AIS had significantly incorrect vessel dimensions programmed into it. The AIS is linked to and feeds the pilot’s portable piloting unit (PPU) through the ‘plug pilot’. Thus, errors were introduced into the PPU.

The last time the reporter piloted this vessel the same errors were noted, so the captain was requested to check and correct the errors. During this port call the master advised that they had tried to correct the errors but had no success. This is a significant concern and port state control have been requested to attend the vessel.

Further Correspondence

Three months ago on the vessel’s previous visit, the same errors had been observed, at which time the reporter had discussed the issue of antenna offset settings with the captain who had assured the reporter that the issues would be addressed. However, on this port call the master stated they had attempted to adjust this, but the settings kept reverting back to zero. This could mean that the ship had adjusted the GPS position offset, not the antenna offset, or they might have adjusted the antenna position offset but the internal battery could be dead, leading to a loss of the settings and the unit defaulting to zero offsets.

The AIS is another matter. Whilst it would also be affected by the incorrect antenna offset, the vessel’s dimensions were incorrectly programmed into the AIS unit. It was thought that this data was not programmable by the vessel but would require the attendance of a service technician. This requirement had been discussed with the captain on the previous visit, three months earlier.

This known issue has not been resolved to date.

Pilots use all navigational aids available, our own and the vessel’s, but having incorrect data coming through the electronic navigation aids is potentially a high safety risk.

A separate report about this event was sent to the port state authorities requesting them to attend to try to get corrective action taken.

CHIRP comment:

We did attempt to contact the DPA to bring this report to their attention but the ISM managers declined to engage with CHIRP. The MAB recommended contacting the vessel’s flag state regarding this report, which was duly done. The flag state positively engaged with CHIRP and details of the report were passed to the flag.
Issues like these are reportable to Port State Control and appropriate Vessel Traffic Service (VTS) stations so that vessels can be entered onto databases for monitoring, and ship inspections can be arranged.

This report does raise some general questions. CHIRP is aware that there are commercially available PPUs with independent AIS capability that can be carried on board by the pilot. These do away with the need for a data feed interface from ships’ systems.

AIS is covered by SOLAS and, whilst not a GMDSS requirement, it has become a de facto part of a vessel’s GMDSS equipment with the advent and acceptance of the AIS SART from 2010. On both counts the AIS equipment on board a vessel is required to be working and transmitting correct data. Indeed, the USCG highlighted the need for correct AIS data in a recent safety bulletin (04-20) relating to an incident where a causal factor in a number of fatalities was incorrect information entered into the vessels’ AIS. In this case, the fact that the vessel was sailing with a known defect for at least three months and had been advised to call a service team before they take responsibility as a watch officer.

CHIRP comment
The learning here is to ensure that bridge watch officers are familiar with all the bridge equipment fitted to their vessel. There are many different types of echo sounder; some have only a single transducer (normally forward) while others have two (commonly fore and aft) but normally and commonly are not good enough – bridge watchkeepers need to know exactly. Not all echo sounders equipped with two transducers readily indicate which transducer is in use. Equally the display may indicate the depth below the transducer or the total water depth depending on input settings and selection.

This report clearly demonstrates that assumptions can be dangerous and lead to an accident. The more familiar you are with equipment and the more you train with it, then the safer you and the ship will be.

It was also noted that whilst vessels may require a minimum aft draft to ensure propeller immersion the practice of good seamanship would suggest, where possible, to minimise sailing draft and trim in areas of shallow water. Additional ballast can always be added later once the vessel is clear of shoal waters.

COVID-19: Do you understand me?

What the reporter told us
As a pilot undertaking a routine pilotage in these extraordinary times, I wear a facemask which has resulted in an unusual side effect. On this occasion, it was noted that the master’s knowledge and understanding of the English language was excellent. However, his ability to understand me whilst my voice was somewhat stifled by the protective mask proved to be questionable. The master frequently said “yes” when it seemed to be inappropriate and I needed to confirm several important communications to be certain that I was getting a correct response.

The learning from this is to ensure that all communications are properly understood by using closed loop reporting, and by ensuring that any queries are made in an open manner as opposed to being leading or suggestive.

CHIRP comment
This is a simple report illustrating that a mask can stifle the full audible range of communication and can also obscure the more subtle aspects of communication such as body language and visual signs e.g. smiling or scowling. Whilst this report is specific to COVID-19, on a broader front it can be related to multinational ships where conversations and verbal communications are easier and more free flowing in a face-to-face situation, rather than remotely via telephone or radio. There may also be an element of lip reading between people, particularly in areas of high ambient noise and with older people in general.

The merits of wearing a mask or other face covering for personal protection or to prevent any potential spread of infection have been debated widely. Advice changes rapidly and varies in different parts of the world, but as a general principle masks are now highly recommended, and mariners should follow the latest WHO and national recommendations on the wearing of masks and face coverings.

Echo sounder display and under keel clearance
Outline: This report from a captain reinforces the need to be thoroughly familiar with the equipment on board your ship.

What the reporter told us
During the handover prior to taking command, I noted the echo sounder manufacturer and the type of installation. This ship had two transducers, one forward and one aft. There was a single display and forward or aft transducer could be selected. After the handover I carried out a familiarisation meeting with the bridge team to make my requirements and standing orders known, and to answer any questions that the team might have. During the meeting I offered the following question, “On departure of the ship from port with forward draft 5 metres and aft draft 8 metres, we have to drift awaiting orders. After a while, the officer of the watch checks the depth under the keel which reads 3 metres. Is it safe or not?” All the watch officers replied that it was safe, and none pointed out that it depends upon which transducer was in use.

Lessons learned
 Proper familiarisation should be conducted by all the bridge team before they take responsibility as a watch officer. All officers were instructed to check which transducer was in use and the opportunity was taken to reinforce the company’s requirement for under keel clearance. Additional information was inserted in the watch officer’s handover information template.

CHIRP comment
This report clearly demonstrates that assumptions can be dangerous and lead to an incident. The more familiar you are with equipment and the more you train with it, then the safer you and the ship will be. It was also noted that whilst vessels may require a minimum aft draft to ensure propeller immersion the practice of good seamanship would suggest, where possible, to minimise sailing draft and trim in areas of shallow water. Additional ballast can always be added later once the vessel is clear of shoal waters.
Working aloft

Outline: Nobody ever deliberately sets out to have an accident or to injure themselves, but some people appear to try very hard.

What the reporter told us

Whilst our vessel was alongside, I observed the following on an adjacent vessel. A crew member (or possibly a contractor) was standing on the outside of the back scratcher (ladder cage) of the mainmast ladder. He stretched from this position to change a lamp on the forward end of the mast. He descended the ladder and then returned, on both occasions climbing through the back scratcher. Upon inserting the lamp the light immediately illuminated, suggesting that the power was not switched off. On the first occasion, another crew member was standing at the starboard bridge wing door watching. He did nothing to stop the job and seemed to be taking an observing / standby role.

Further dialogue

After identifying the ISM managers, CHIRP emailed the DPA who engaged immediately, allowing CHIRP to pass over details of the report. The following day the DPA contacted CHIRP with the information that the photographs in the report did indeed show a member of the ship’s crew. The DPA said this was very disappointing as the actions shown were completely contrary to the vessel’s SMS. Furthermore, earlier in the month the DPA had sent out a fleet-wide safety bulletin emphasising the need to complete risk assessments and permits for all hazardous activities.
The pilot boat returned to our location and I asked for their company name and insurance details. I was given the name of their company and was informed that they had to maintain speed due to the strength of the wind – they were, however, apparently able to hold station 4 metres from us without any problem. After a brief exchange the pilot boat circled us a couple of times and then another crew member appeared in an aggressive manner and proceeded to inform us the incident was our fault for not fendering properly. When challenged about their speed he declined to comment and proceeded to insult us at which time our skipper lost his temper and swore at the crew member. I tried to calm the situation and then the pilot boat circled us again. A crew member appeared from the pilot vessel’s wheelhouse with outstretched arms shouting at us that we could do nothing to them at which point they left. Upon checking our AIS, they did not show up.

Further dialogue
The reporter wrote to the managers of the pilot boat who requested that a report be submitted for evaluation. CHIRP also wrote to the managers. The operations manager promptly responded by telephone and advised CHIRP that the facts were still being gathered from the reporter, the launch crew and the local Vessel Traffic Service but initial indications showed discrepancies between the three accounts. Subsequently, the reporter failed to respond to CHIRP’s request for an update on two occasions but the operations manager for the launch responded by telephone and advised CHIRP that the incident was closed and whilst there were still discrepancies between the different accounts, the pilot boat operators had agreed to pay for the repairs to the motor cruisers as a show of good faith.

CHIRP comment
Situational awareness is essential. All seafarers, whether professional or recreational, need to be mindful of and considerate towards other boat users at all times. Whatever the situation there is no need for aggressive behaviour or abusive language, it is unnecessary and invariably counterproductive.

Inflatable lifejacket – service tag fitted incorrectly
Outline: The following report was received from a company DPA.

What the reporter told us
I want to share the following with you as I feel it would make a worthwhile safety flash to share across the industry. One of our vessels has reported that on two of its inflatable lifejackets, the servicing tags had been fitted in such a manner that they made it impossible to adjust the waist strap. Please see the attached photographs which illustrate the issue.

Further dialogue
CHIRP engaged with the reporter to confirm that the ‘next service’ tags in question had been fitted by a third-party service centre – they had been. After checking other vessels in the company, the reporter advised CHIRP that four other ships had equipment serviced by the same service provider. However, it appeared that this was an isolated incident which had not been replicated elsewhere. The DPA forwarded full details to the servicing company who gave assurances that it would not happen again.

CHIRP comment
Beyond this specific report there is a wider issue with regards to the integrity and quality of service provided by some third-party service centres around the world. Ships’ staff frequently assume that equipment sent ashore to a recognised third-party service centre is correctly serviced and returned in good, safe, operational condition. Complete with a new certificate, the equipment can be put into service around the vessel without further consideration.

However, CHIRP would suggest that upon return from third-party servicing, LSA and FFA equipment needs to be checked by ship’s staff and, if possible, tested before being put into service. CHIRP is aware of liferafts being returned with time-expired equipment and survival rations out of date – only discovered on a subsequent service in a different country. BA sets have been returned in an inoperative condition and fire extinguishers returned with either time-expired CO2 cartridges or unpressurised stored pressure units. It is possible that the renewed certificate is considered more important than a proficient health check on equipment.
More main engine problems whilst arriving and sailing

Outline: Although this topic was extensively covered in a recent issue of Maritime FEEDBACK, (MFB55), these two reports serve as a timely reminder to always be prepared for the unexpected.

What the reporter told us (1)
The vessel in question recently suffered a main engine problem shortly after departing her berth. It was found that the vessel could only proceed at a maximum of Slow Ahead, thus she proceeded to a local anchorage under pilotage to effect repairs. At the time of the pilot's disembarkation, the cause of the problem had not been identified.

What the reporter told us (2)
Approximately ten minutes after departing the berth and mid-stream on an outbound passage, the main engine developed a fuel leak which required the vessel to be stopped for approximately ten minutes. The channel does not have much room for manoeuvring, but we managed to hold station with the assistance of two tugs. With the fuel leak repaired the vessel got underway again, only to have to stop four minutes later due to a hydraulic pipe leak on the main engine. This time the delay was about thirty-five minutes. Nevertheless, the tugs again assisted us in holding station. Eventually the Chief Engineer cleared the vessel for transit, albeit at a maximum speed of half ahead. Upon clearing the channel buoys the vessel proceeded to anchor to effect full repairs.

A thorough inspection by a responsible engineer is essential for fault detection (image: Danny Cornelissen)

CHIRP comment
The testing of main engines and a thorough inspection of the machinery by a responsible engineer is essential. During such inspections existing leaks and faults will be detected, although in these two specific reports there is no guarantee that testing of the main engine prior to departure would have prevented the stoppages.

Good communication and integrity of communications between different departments will allow prudent decisions to be made.

Planning for “what if” scenarios such as having to stop mid-channel with no anchorages in the vicinity and submarine pipelines precluding anchoring, form part of passage planning and the practice of good seamanship. Consider when tugs should be standing by and when they can safely be released, bearing in mind the topography of the approaches, nature of the seabed and the prevailing weather conditions.

The introduction of new low sulphur fuels has been much heralded in the maritime press and technical publications. CHIRP would be interested to receive reports dealing with any proven or suspected issues resulting from the use of these new fuels.

PILOTS CORNER
This month’s pilots corner feature is based on two reports received.

Non-compliant trap door pilot boarding arrangements

Outline: Non-compliant by design, known about by port state authorities, owners, and flag state administrations – yet still these vessels are allowed to sail the world endangering pilots.

What the reporter told us (1)
A vessel was identified by the port authority as having a non-compliant pilot ladder arrangement on 17.03.2020. The vessel has a trap-door platform, but the pilot ladder does not extend 1.5 m above the platform. A report was submitted to the national regulator who visited the vessel and confirmed that the arrangement is non-compliant. Pilots are told not to use non-compliant arrangements and can be penalised should they do so or report such ladders and then use them despite the known defects. However, this ship, and others are still making calls to the port. If inspected, non-compliant ships are simply issued with a letter from the regulator, but this does not stop them sailing and pilots are put in an impossible position because management and port authorities tacitly condone these arrangements and simply tell pilots not to board if it is unsafe.

Further dialogue
There was a lot of dialogue arising from this report and the salient details are as follows.

CHIRP contacted the DPA of the company in question, the harbour master of the port, and the port authority. The DPA confirmed that the issue was known to them and that the vessel’s flag state, and classification society had already been contacted. The view of the harbour master was that the issue was a Port State Control issue whilst adding that liaison with the port authority on all marine safety issues would continue and is paramount.

The port authority was very helpful and highlighted their support for pilots who refused to board vessels which
they believed to be dangerous. They requested that pilots inform them of any deficiencies in order to enable effective follow-up. A comprehensive system for investigating incidents and reports is maintained, including dynamic risk assessment. It was also highlighted that there is close liaison with the national regulator.

There was a lot more correspondence about procedural issues in order to overcome the problems raised, but in summary there is no easy solution for a problem that has been 20 years in the making! CHIRP can however proactively engage with all parties and apply appropriate pressure to highlight any potential issues and the need for resolution.

Arrangement at the New York, Sandy Hook boarding ground of a second fatal accident involving a pilot boarding prior to publishing this edition of FEEDBACK we learned pilot boarding arrangements in general. Tragically just focus on the safety of these trap door arrangements and pilot in New York earlier this year. This has led to a renewed more needs to be done. Members of the MAB noted that quite a lot of improvement on trap door pilot boarding arrangements has been seen in Europe. Some companies have carried out improvement on trap door pilot boarding arrangements.

The response from all parties was refreshing, nevertheless the vessel remains non-compliant. Potentially the letter from the regulator did its job, since the company, flag, and class are all aware of the issue. However, since the vessel was built to pre-2012 regulations, there is "wriggle room" in the wording of the regulations and the argument of must and should comes into play. So, the vessel continues trading and remains non-compliant. The port authority knows of other vessels on a fairly regular trade which also fall into this category. All are well run and have reputable managers – they were just built with non-compliant pilot boarding arrangements.

Members of the MAB noted that quite a lot of improvement on trap door pilot boarding arrangements has been seen in Europe. Some companies have carried out modifications with class approval. CHIRP is also aware of at least one flag state administration that is in consultation with class to resolve the issue. This is encouraging, although more needs to be done.

Tragically it was one of these non-compliant trap door pilot boarding arrangements that resulted in the death of a pilot in New York earlier this year. This has led to a renewed focus on the safety of these trap door arrangements and pilot boarding arrangements in general. Tragically just prior to publishing this edition of FEEDBACK we learned of a second fatal accident involving a pilot boarding arrangement at the New York, Sandy Hook boarding ground on 5th August.

The whole point of compliance is that it makes the equipment safe to use. Non-compliance means that it is not safe to use. While a port state regulator does not have the power to tell the ship what to do, the pilot does have the power not to move the ship.

A pilot about to sail a ship can insist on sighting a compliant pilot boarding arrangement before letting go any lines. Upon arrival at a pilot boarding station, if a non-compliant arrangement is presented the pilot should refuse to board the ship.

It is time to say Enough is Enough.

CORRESPONDENCE RECEIVED

Regarding – Discrepancies in the pilot ladder poster

CHIRP’s attention has been drawn to a number of discrepancies between the regulations concerning pilot ladders and pilot boarding arrangements as stated in SOLAS (Chapter V Regulation 23) and IMO Res A.1045 (27) and the depiction of the arrangements on the IMO accredited IMPA poster “Required Boarding Arrangements for Pilot”. All seafarers are advised that while the poster is a good starting point it remains only an illustration to draw attention to the contents of the written regulations which should always be referred to as the definitive requirement for pilot ladders and pilot boarding arrangements.

Regarding – Minimum speed for going astern

With respect to your article in MFB56 regarding the master pilot exchange, it mentions that the main engine failed to start astern because the vessel was travelling at 3.5 knots. When the vessel reduced to 3 knots then there was no problem in getting the engine to go astern.

Is the 3 knots figure an owners, IMO, or similar requirement? I have never experienced any problem going astern at whatever speed the ship or engine has been running and would be grateful if you could advise where this came from and reasons for this arrangement.

Following discussion, the Maritime Advisory Board responded as follows

Assuming the vessel does not have a controllable pitch propeller, then in many cases, with way on the ship, the engine will not be able to go astern until a minimum speed is reached – in this case 3 knots or less.

It is normal in a critical, emergency situation for the master to instruct the engine room to perform a crash astern manoeuvre. This procedure should always be posted in the wheelhouse and all the bridge officers must be familiar with it.

A fully loaded motor ship of about 14,000 tonnes displacement manoeuvring from “sea speed” to standstill from a speed of about 14 knots, will still be moving ahead at approximately 2 to 3 knots around fifteen minutes after the ‘Stop’ order was given. The engine rpm will fall from 110 to 40 in about 7 to 8 minutes and gradually come to rest after about 12 minutes.

If a crash stop is demanded, the engine can usually be reversed after about 3 minutes, while still running ahead at about 30 rpm and can be running at 60% power astern in about 5 minutes. A slower vessel, or one in ballast, would take less time to accomplish this. It should be noted that
a crash astern manoeuvre causes very high stress levels within the engine and may cause damage. A master, and indeed a pilot, needs to know the maximum ahead speed through the water at which he can obtain an astern movement. It varies from ship to ship. Some modern vessels with “optimised” designs of engine are not able to apply braking air for a substantial period – on one class it was a full 17 minutes at loaded draught – from slow ahead. This was discovered after delivery from the yard and had been designed-in, presumably for fuel efficiency and environmental factors rather than concentrating upon vessel manoeuvrability. The company in question ensured that this “quirk” was made a prominent opening part of every Master / Pilot information exchange - standard practice became that a braking tug with a large bollard pull was attached as soon as possible.

**Regarding – Drug abuse follow up**

Further to your article, “Drug abuse on fishing vessels” in MFB58 I was interested in the comment “However, CHIRP is not aware of any similar type of simple device on board vessels for detecting the presence of drugs. Such a procedure usually requires third party involvement, similar to the monitoring of sports personnel”. It is possible to test for 13 separate recreational drugs by using the saliva, urine or hair follicle testing method depending on what is required. Each one has a different ‘Detection Timeline’ with saliva detecting 2 to 3 days back, urine up to 30 days and hair follicle dependent on the length of the hair. Many flag states have adopted a zero-tolerance drug policy, but they have no method of enforcing this and pass on the directive to management companies to enforce. ‘Captain-managed’ superyachts frequently carry out their own testing.

One of the directives from the STCW 2010 Manila amendments states; “In order to identify drug and alcohol abuse, screening programmes should be implemented for all whose duties involve designated safety, prevention of pollution and security duties to prevent alcohol and drugs from impairing the ability of crew”. It would seem that many companies are not aware of or are ignoring this regulation. CHIRP looked into the matter further and learned that simple urine sample, multi-drug detection kits are available. A basic (13 drug spectrum) urine test kit costs around £12 / 15 USD and its primary function is to indicate if a seafarer is “drugs free”. If this initial (13 drug spectrum) test does not come back as ‘clear’, the same urine sample can be used for a more detailed testing, but for that a separate kit is required for each of the 13 drugs you are testing for. These more specific single drug test kits cost approximately £48 / 60 USD per drug being tested for.

CHIRP notes that the reporters’ comments apply to all mariners and not just the fishing sector. It is also worthy of note that, for drug and alcohol testing, there are several companies which offer services to conduct initial and follow up D&A testing. The services are not cheap, which simply reinforces the adage “What price HSSE?”

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