

MARITIME FEEDBACK



Issue 61
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An independent and confidential reporting system for the maritime industry

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The CHIRP editorial

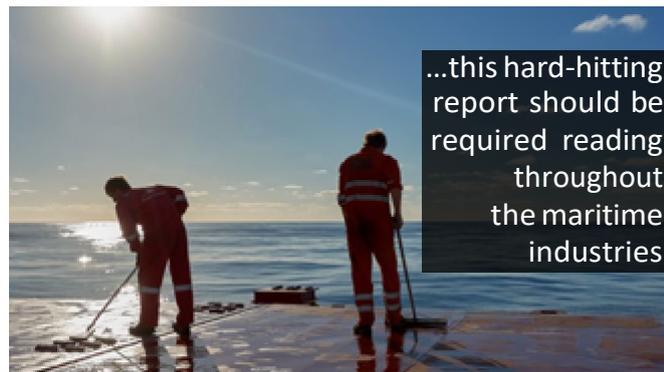
A Culture of Adjustment



Capt. Jeff Parfitt
Director (Maritime)

As we go to press, the World Maritime University has just published a major investigation entitled *A Culture of Adjustment: Evaluating the implementation of the current maritime regulatory framework on rest and work hours*. Written by seafarers, lawyers and social scientists, this hard-hitting report should be required reading throughout the maritime industries. The authors begin by asking whether the current regulations can effectively prevent fatigue, what are the barriers to effective implementation of the regulations on board ships, and whether there are effective levels of compliance? Sadly, their findings are obvious, and they show that malpractices are widespread, both the regulations and their policing are ineffective, and manning levels are generally inadequate. They call for an objective and research-based method for determining minimum manning levels in future.

Among their findings is that the ISM Code is not achieving some of its fundamental



objectives, and many crews are afraid to speak out because they fear losing their jobs. The report also points out that a two-watch system on board is incompatible with hours of rest requirements. It encourages seafarers to use existing reporting procedures to report violations and malpractices, and says that where there is fear of victimisation, “seafarers should report to any framework allowing sufficient confidentiality and protection such as CHIRP Maritime”. We are pleased that the report places such confidence in us, and we can assure all our readers that anything they submit to CHIRP will always be treated in the strictest confidence.

The report goes on to propose some potential

solutions to the problems, although it is unlikely that individual companies, flag states or administrations will take action to alleviate the situation since any increase in manning will place them at a disadvantage to their competitors. We believe it will require concerted international action before things improve. Let us hope this excellent study will get too much publicity for it to be swept under the carpet. The report is available to download using this link: https://commons.wmu.se/lib_reports/66/

Meanwhile, we have a varied and interesting selection of reports in this edition. We begin with another case where a watchkeeper was distracted at a critical moment, then consider

some mooring problems on a tanker which will strike a chord with many mariners. The leisure sector features strongly with a report about water ingress on a superyacht which could have been disastrous. This is followed with another example of people working overside and at height without resorting to PPE and a shocking tale about a runaway jet ski which could also have ended in disaster. We also learn about a tug where the brake on the towing winch was defective for a considerable period, and how a tanker almost had an accident due to incorrect valve alignment.

Our Pilots Corner contains reports about a broken pilot ladder, a ship where both pilot ladders were rejected, and yet another case where the design of ships makes it impossible for the pilot to board safely. Finally, we publish two items of correspondence related to earlier reports. One gives a clear explanation of adjusting a windlass brake properly, and the other highlights a potential problem with overweight rescue boats.

We hope you will find this edition both interesting and useful. Until next time, stay safe!

Distraction results in allision

Outline: Distractions can lead to serious, potentially fatal, consequences.

What the reporter told us

CHIRP received a report concerning the allision of a vessel with an offshore wind turbine tower. We attempted to clarify some points and gain more information, but the reporter declined to engage further. However, during our own investigation, the basic details of the allision were found in the public domain.

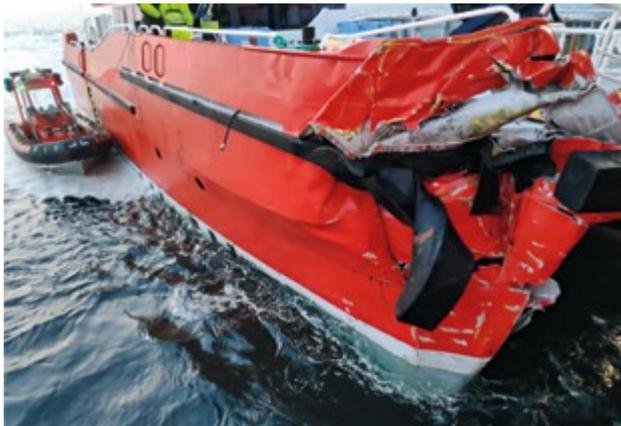


Figure 1 – The Consequence of distraction. (Photograph taken from the Flag State Administration Final Report – vessel name obscured)

The vessel involved was a service vessel engaged in transferring personnel between a shore base and wind turbines in offshore locations. The only other details initially available were that the hull had been breached at the bow and suffered water ingress, and that three persons on board sustained injury during the allision. The damaged vessel had then been escorted to port by an offshore lifeboat.

Further dialogue

CHIRP attempted to contact the DPA and managers of the vessel, but they did not respond. We later learned that, following an investigation, the flag state administration had published a report into the incident. CHIRP contacted the flag state administration who readily engaged and welcomed promulgation of the report to a wider maritime audience.

From the final report

The service vessel had finished the day's tasks and was released to return to port for the night; but whilst transiting through the wind farm at a speed of approximately 20 knots, it hit a tower. In the summary of findings, the final report notes "the primary reason why a proper lookout was not being kept was because the Master, who had the conduct of the vessel, was distracted from his primary role".

The report contains images taken from the wheelhouse CCTV that show the captain looking to his right and downwards prior to impact with the rapidly closing tower.

View the full report at <https://cdn.ports.je/web/2020-04-23-Njord-Forseti-Incident-report-FINAL.pdf>

CHIRP comment

Nobody sets out to have an accident, nobody plans to be distracted. On this occasion it happened to be the master who had control of the vessel and was distracted, but

anybody can become distracted and as a result could suffer the same consequence, or worse.

Distractions come in many different forms, from fleeting momentary ones to ongoing long-term distractions. This is particularly true if you consider the current COVID-19 pandemic where seafarers are being obliged to work much longer tours of duty than normal with possibly no prospect of relief on the horizon.

Modern, open bridges have many sources of potential distraction, including telephone calls both internal and external, numerous alarms – ECDIS, AIS, GMDSS, IAS (integrated alarm system), fire alarm control panel, ballast control system, CCTV systems and e-mail systems; so there can be little surprise that officers of the watch become distracted.

Some companies designate sea areas with high traffic density or numerous obstructions etc. to be Red Waters as opposed to areas of open sea with normal traffic density. The latter require normal levels of diligence whereas the former require heightened levels of attention and concentration. This may well require an additional person on the bridge as a dedicated lookout or even doubling-up of the watchkeepers. If that is not possible, one has to ask if there is a manning issue?

On virtually every vessel there are standing orders for both bridge and engine room personnel and those orders will usually include an instruction to call the Captain or C/E if required, and if in doubt to utilise an additional person. However, if the Captain or C/E have the watch, who do they call upon for back-up?

Mooring incident on an LPG tanker

Outline: This reporter sent details of an incident that occurred on his ship, a medium sized LPG tanker only 2 years old, which raises some questions about mooring arrangements.

What the reporter told us

The ship was moored alongside engaged in loading operations, with the deck watchman standing by the manifolds monitoring the ships position. The OOW was in the cargo control room. The watchman reported that the vessel had moved a few metres off the berth and at the same time the OOW noticed the wind had increased from 20 to 30kts. The OOW called the crew to stand by. The loading arms were not disconnected but all crew including the C/O were on deck and the master was on the bridge. The wind eased and the master ordered the crew to use the mooring ropes to bring the ship back alongside – which was done. No injuries were sustained, there was no damage to the vessel or terminal equipment and no pollution occurred.

An onboard investigation was carried out which noted the following:

- The berth in use was more exposed than others in the port.
- The vessel is fitted with soft line mooring ropes throughout whilst similar vessels are equipped with mooring wires.
- The vessel's length and fairlead positions are not ideally suited for the quayside bollards.
- The vessel is fitted with Panama fairleads throughout which are not best suited for soft lines.
- Mooring ropes on board are a mixture of split drum and loose ropes which turn up on the bitts.

The reporter also noted that similar incidents happened on two subsequent occasions on different voyages.



Figure 2 – Example of a typical modern mooring arrangement (Not the vessel in the report)

Further Dialogue

The excursion limit permitted by the loading arms was not known by the reporter and, while stopping the loading would have been a prudent precaution, it was not stopped on the orders of the captain.

The reporter had been sailing for 11 years on gas carriers and his present ship was the first one with all soft rope moorings, and whilst roller pedestals were fitted to improve the lead of some ropes; all the shipside fairleads were panama chocks.

The scope of the mooring ropes was nominally 60-65m for springs (split drum), 25m for breast lines (turned up) and 50-60m for head and stern lines (split drum).

The results of the shipboard investigation were sent to the company, but the reporter was not aware of any feedback.

CHIRP comment

A lot of modern ships are built with Panama fairleads (chocks) throughout, which are ideal if used in conjunction with mooring wires but are detrimental to soft mooring lines when compared to roller box fairleads. Equally, some modern ships are designed and built to moor using unrealistic mooring systems. Ports and terminals all over the world invariably demand additional mooring lines which challenge shipboard mooring arrangements - which maybe ill-designed and/or ill-equipped to comply with such demands.

This report highlights many human element issues and learning opportunities not least individual inexperience, vessel familiarisation and SMS procedures. In addition, Mooring Equipment Guidelines 4 published by OCIMF gives invaluable guidance for all types of mooring systems and usage.

Flooding of a superyacht

Outline: A report about flooding that could have had a tragic outcome.

What the reporter told us

A large yacht (100m+) weighed anchor and got under way with the intention of completing a 2-hour passage to another anchorage. The weather was good and the sea calm. Approximately 10 minutes after getting under way, an alarm for the elevator was received in the engine control room (ECR). The Chief Engineer dispatched the ETO to investigate. A minute later the ETO called the ECR

to report that a vast amount of water was coming down the stairwell and out of the elevator shaft doors. It was quickly ascertained that the port side, lower deck, shell door was not closed. The bridge was called and requested to stop the ship. The shell door was closed.

Water had flooded down two decks via the stairwell and the elevator shaft. On the bottom deck the water collected on the tank top and was contained between the closed watertight doors. The incident was responded to and dealt with quickly, but this could have ended very differently.

Cause: The vessel has several shell doors on the lower deck (at the waterline) and the main deck (normal freeboard deck). Some of these had been open at anchor and all should have been closed prior to departure. The bridge pre-departure checklist requires that all shell doors are checked as closed. The checklist was completed, but the task was not. The shell doors can be visibly sighted from the port and starboard bridge wings. They are also monitored by CCTV and by a mimic monitoring panel on the bridge that displays the status of the openings. None of these were checked by the bridge team prior to departure.

Conclusion: Various methods were available for checking the status of the shell doors however the bridge team appeared to be unfamiliar with them or complacent about their use. The SMS pre-departure checklist is a wipe-clean laminate with a series of boxes to be ticked, but it had not been signed as completed. The checklist was completed by 'box ticking' without verification that the tasks were actually done.

Further dialogue

CHIRP engaged with the reporter who confirmed that a new pre-departure checklist, which requires the ECR staff to check the hull doors are closed, had been drafted and submitted for approval before he left the vessel. He also asserted that in his 20-year sea going career he had never seen an incident like it. Apparently, most of the crew on board had never heard of the *Herald of Free Enterprise* disaster.

CHIRP comment

With the amount of money this vessel cost to build it is hard to understand why the mimic monitoring system which was installed on the bridge was not duplicated in the ECR. However, the consensus of our Maritime Advisory Board members was that individuals have to be responsible and accountable for their actions or lack of them. On this vessel the bridge officers had a clear duty to carry out the pre departure checks diligently; there was a checklist to follow, there were multiple methods to monitor and confirm that the shell doors were indeed closed and yet they failed to do so. Was the failure incompetence, a lack of safety culture, complacency or negligence? There was certainly a lack of oversight.

Superyacht – crew working outboard without PPE

Outline: The title says it all, but since CHIRP continues to receive a steady stream of reports on this subject, we feel justified to keep publishing them.

What the reporter told us

While conducting on board crew fire training it was noted that two crew of a yacht berthed nearby were working along the outboard (port) side of the yacht, high above

the waterline and without protective or appropriate safety equipment. Whilst one of the two crew members (aft in the picture) might possibly have had a harness attached to the rail above their heads, the other person (fwd. in the picture) certainly did not and was only holding on with his left hand. Neither appeared to be wearing life jackets.

There have been too many incidents within the superyacht industry, and it is almost the 'norm' on a vast number of yachts for crew to proceed aloft or outboard without wearing even the most basic of safety equipment. Indeed, within 2 minutes of spotting this incident another vessel berthed close by had someone walking over the top deck hard canopy around the mast without any harness or lifejacket. Unfortunately, despite deaths occurring, these incidents will continue to happen with no actions being taken by chief officers, captains, management or flag states. It appears all 'too difficult' to put on a safety harness and lifejacket, or for designers and builders to provide vessels with the appropriate means by which crew can attach themselves to specifically designed rails. Perhaps owners find them unattractive and aesthetically unappealing.

Further Correspondence

CHIRP engaged with the reporter and whilst there was no additional information about this specific incident a wide-ranging conversation took place regarding the difficulty of engaging with the yacht and superyacht sector. The reporter suggested that CHIRP contact the PYA (Professional Yachting Association) to establish an engagement. Sadly, although CHIRP did try, the PYA declined to engage.

CHIRP comment

Why do crew put themselves in harm's way like this? Why don't the captains and chief officers stop this type of behaviour? Why do the managers and owners allow this kind of behaviour on their yachts – surely there is a duty of care to look after the safety and wellbeing of their employees?



Figure 3 – Another example of poor safety culture in the superyacht sector.

My ship was proceeding at less than 2kts past a ferry pontoon when the pilot ordered 25% power from the tug secured aft to stop the vessel. The tug master called back to the pilot that his tug's forward winch brake was not holding, and we heard banging noises from the aft tug and could see the winch rendering the tow line. My ship was not slowing, and the pilot ordered the main engine to 'slow astern'. As the aft tug was still not towing, I ordered the telegraph to full astern and advised the pilot of my actions. He acknowledged, and my ship was stopped close to the berth before very cautiously going alongside. Once alongside the pilot spoke to the tug master who said his company knew about the issue and he was hoping the company would soon fix the problem.

For me there was no problem since my ship did not suffer any damage, but the next time I arrived at this port, some weeks later, we took the same tug on my ships bow. I asked the pilot if the tug's winch was repaired and we talked about the previous arrival. The pilot said he would be gentle with orders for the tug and not too much towing power would be used. I asked if it was possible not to use this tug and I would call the local agent to get another tug. The pilot said this was not possible as there were only two tugs on station. We berthed safely, and during our time alongside I spoke to the tug master and chief engineer. The tug captain apologised but also told me that the company were saying that the winch is fine and will be repaired at a later date. The tug captain said he had tightened the winch brake up to the limits and it now only slipped at about 50% power.

Further dialogue

CHIRP engaged with the reporter and also contacted the Harbour Master's office to corroborate the vessel name and port arrival dates, which were verified.

CHIRP wrote to the ISM managers for the tug; the fleet manager responded and was given the details of the report. Following their internal investigation CHIRP was advised that "The tug had conducted an intermediate dry-docking for 5 days and during this period planned maintenance had been undertaken, including overhaul of the winch and replacement of the brake bands".

CHIRP comment

With the pilot on board and tugs fast fore and aft what can go wrong? Be prepared for any eventuality and react positively to any unexpected event, but keep the pilot informed.

The pilots at this port were obviously aware of the situation regarding the tug's defective winch. Switching the tugs around so the suspect tug was at the passive end made sense. However, was this a formalised arrangement and had a risk assessment been carried out? The obvious solution was to take the tug out of service to rectify the issue with the winch brake, but it would appear there was a lack of redundancy. If a formal risk assessment had been carried out, CHIRP fails to see how the reduction in towing capability could have been mitigated. Was this a case of commercial considerations overriding safety and common sense?

One point that should be highlighted, – CHIRP occasionally reports on ship's captain's failing to make full disclosure during the Master / Pilot information exchange upon pilot boarding. But this is a two-way street and pilots are also obliged to notify the captain of all relevant facts that could affect a successful pilotage.

Finally, the tug management's engagement with CHIRP and their final update regarding the tug's winch is recognised and welcomed.

Defective winch brake on tug

Outline: A captain reports a disconcerting discovery while approaching the berth.

What the reporter told us

My vessel was arriving at a regularly visited port at which we take a pilot and two tugs for manoeuvring when berthing in a cargo basin with a narrow entrance channel.

Un-manned jet ski

Outline: A report highlighting a complete lack of respect for the water that could have turned into a tragedy.

What the reporter told us

At approximately 16:15 a friend and I were anchoring a RIB just off the beach. I was approached by a man in a wetsuit who asked for assistance as he had lost his jet ski. We then noticed an unmanned jet ski that was underway (approximately 3 knots) about 100m offshore. Using our RIB, we made our way out towards the unmanned jet ski. In the interim another jet ski intercepted the unmanned jet ski. We then noticed the rescue jet ski had recovered an unknown person from the water who looked tired and was not wearing a wetsuit or life preserver.

The owner of the jet ski shouted across and asked where the other jet ski occupant was. Realising the urgency of the situation I asked him to confirm if there was somebody still missing. On receiving confirmation, we set off to look for the missing person and very quickly located the second individual and recovered him. On being dragged aboard the RIB it was apparent that this individual was extremely tired, wearing no equipment and was intoxicated. He thanked us for "saving his life". We returned to the rescue craft and the owner of the unmanned jet ski informed us that it was his brother's friends who had been drinking all day and had taken the jet ski without permission. They had obviously not worn the kill cord and had fallen off the jet ski, which then continued unmanned.

Both recovered persons were transferred to the local beach lifeguard station by the rescue jet ski. Upon returning to my original location I noticed a lifeboat rescue craft whose crew confirmed they were looking for a jet ski and two persons in the water. I relayed the above information and advised that they liaise with the beach lifeguard station to confirm the casualties were safe and well.

Further dialogue

CHIRP engaged with the reporter who revealed he was an off-duty Coastguard SAR pilot, which explained his familiarity with lifeboat procedures. The reporter also stated, "It was an eye opener to be involved in some small part with an incident as I was, and to witness the issues and confusion that can quickly arise at sea level".

CHIRP comment

This report contains many learning points but at the top of the list is the fact that alcohol and the water do not mix. If that simple fact is not taken on board, then all the rest are a little bit blurred. Such as:

- Always wear the engine kill cord
- Always wear a PFD (buoyancy aid)
- Always wear suitable clothing – once outside the tropics, even in the summer, a lightweight wet suit is appropriate.

Jet skis are great fun and reasonably affordable to many people, and while most jet ski owners are responsible and conscientious, this particular mode of water sports has attracted a hooligan element. Those people who, through ignorance or temperament, do not care about the safety or enjoyment of other people using the water, and who think that the guidance, rules and regulations, which are there for the safety of everyone, do not apply to them, yet still seem to expect others to come to their aid when they get into trouble.

Many organisations are working very hard to educate and encourage jet ski and other water sport users to enjoy their sport responsibly and safely. Proactive videos have been produced and new signage developed to guide and educate. However, jet skis and other personal watercraft slip through gaps in the regulations, and these gaps need to be closed up so that deliberate and persistent exhibitions of hooligan-type behaviour can be prosecuted.

Incorrect valve alignment

Outline: A fresh pair of eyes identified an incident waiting to happen on a chemical / oil product tanker.

What the reporter told us

The vessel had orders for several loading ports, and in each port different parcels of cargo were to be loaded. The cargo loading plan was made out and sent to various parties for approval (including the office ashore) and agreed by everyone. The vessel's design gives two options to collect oil / cargo in the event of a spill on deck.

- In the port slop tank (aft)
- In bulk (1m³) spill drums (stb'd side midships)

Before arrival at the first loading port, spill collection was lined up to the port slop tank. In the first loading port the ship loaded a parcel of fish oil into a group of tanks, including the port slop tank.

On arrival at the second port, to load a parcel of ethanol, the spill collection arrangements were left lined-up to collect any cargo spillage into the port slop tank. A delayed crew change also took place at the second loading port.

After the crew change, during handover, the new Captain noted this arrangement and immediately had it changed to collect any cargo spillage into the spill drums.

Further dialogue

CHIRP engaged with the reporter and whilst there was no further information to add to the initial report, the reporter considered that the extended trips being worked by the crew (8-9 months) during the COVID-19 pandemic was a contributory factor in this human error.

CHIRP comment

This is a simple report about a human factors incident where a mistake was made. The question is why did those people make a mistake?

99% of the time, the people involved would not have made such a basic mistake, but on the rare occasion when a mistake is made (because mistakes do happen) the normal checks and balances that are incorporated into this routine operation would have identified and rectified it. However, on this occasion those checks and balances failed to identify the mistake and so the holes in the hypothetical swiss cheese aligned and waited for the final hole (a spillage of cargo) to line up, which would allow the near miss to by-pass the incident stage and turn into an accident.

Was fatigue and distraction caused, or exacerbated, by the extended tours of duty due to COVID-19? Potentially this was a contributory factor leading to this human error. Procedures, instructions and operational checklists with regards to using the slop tank to carry cargo should be reviewed, because this mistake slipped through the net too easily.

PILOTS CORNER

A lucky escape, consequences, and design issues

Three reports illustrating different aspects of an ongoing problem.

Outline (1): A report received detailing a lucky escape

What the reporter told us

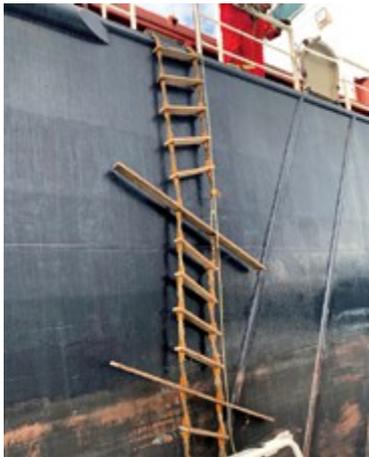


Figure 4 – Parted ladder

While boarding the vessel at the pilot exchange station, one of the side ropes snapped. No other pilot ladders were available.

Further dialogue:

Luckily, the pilot had only climbed two steps when the side rope parted, and he was able to jump back onto the pilot boat without sustaining any injury.

The vessel did not have a suitable replacement ladder.

After discussing the issue with the disembarking pilot, it was agreed that the vessel would proceed into the locks with the sea pilot onboard and the exchange pilot would join in the locks by gangway. It was also reported that the vessel had only recently been taken into the fleet by the vessel managers.

The local agent arranged for a new pilot ladder to be delivered to the vessel before sailing.

CHIRP contacted the DPA who advised the following:

The company already had maintenance routines dealing with pilot ladders, but immediately following this accident the procedures had been modified and increased to include monthly testing where the weight of several crew was added to the ladder in a safe way, while the ladder was suspended down the wheelhouse front.

A new pilot ladder was already on order for the vessel but unfortunately missed the ship by a couple of days when it sailed from its home port on the most recent voyage. The new ladder is waiting at the home port for the vessel to return.

In addition, the information about the incident was made available to all company vessels and crew. The company was not satisfied with using manila ropes in pilot ladders due to the quality of rope available and weaknesses being difficult to spot. They had started a replacement programme using better quality rope.

CHIRP comment

CHIRP asked about the alternative rope to be used in place of manila and requested details of the product and manufacturers but there was no further correspondence from the DPA.

The company's engagement with *CHIRP* was encouraging and their response was comprehensive but perhaps they need to look more closely at the procedure adopted when a

new vessel is taken into their fleet to ensure that the existing equipment on board is fit for purpose.

The reporter was indeed lucky, but so was the sea pilot who had boarded the ship earlier in the night using the same pilot ladder.

Outline (2): There are consequences for non-compliance

What the reporter told us

There were several ships in the anchorage awaiting berths. The first vessel to berth was instructed to prepare its engine and rig a pilot ladder. As the pilot boat approached it was clear that the pilot ladder steps were not level and for that reason it was rejected. Upon request, the vessel rigged an alternative ladder but when the pilot boat was alongside the whippings on each step were found to be very loose – it was possible to turn each step nearly vertical by hand. The pilot refused to board and pilotage was refused until a new pilot ladder was procured and delivered to the vessel at anchor. The next vessel in the anchorage was asked to prepare its engine etc. and the pilot boarded this vessel instead.



▲ Figure 6 – Second ladder rejected due to very loose whippings

◀ Figure 5 – First ladder rejected due to uneven steps

Further dialogue

CHIRP contacted the reporter to enquire about the outcome of this report and learned that the ship's agent was able to source a new pilot ladder and deliver it on board the next day. Unfortunately, as the port only had a single suitable berth on which the vessel could load its cargo, the ship lost 3 days waiting for the alternate vessel to complete loading and vacate the berth.

CHIRP comment

We do not know what charter rate the vessel was on but are quite certain that three days of lost hire is greater than the cost of a new pilot ladder.

Outline (3): Non-compliant by design. The following report was received from the area manager of a national pilotage authority.

What the reporter told us

I have read your publication on pilot ladder failings and am seeking your advice. We have several vessels in our area that are constructed in a way unsuitable for boarding by pilot ladder. Most of them have a railing (rubbing strake) without a gap to allow safe access for the pilot boat. The rubbing strake will also press down and damage the pilot boat in the case of rough seas. In some cases, the railing (rubbing strake) is so wide that the pilot ladder swings freely underneath it when rigged above the railing.

SOLAS stipulates that the pilot ladder must lay against the ships side, but we have had a hard time finding rules for railings (rubbing strakes) without gaps. Do you have any useful information on this matter?



Figure 7 – Examples of ship side features that render the vessels non-compliant by design

Further dialogue

CHIRP highlighted the relevant sections of both SOLAS Chapter V Regulation 23 (section 3) and IMO Res 1045(27) to the reporter. Unfortunately, as with so many SOLAS and IMO regulations both include the ubiquitous get-out clause to the effect that the rule does not apply if it is deemed to be impractical by the ‘administration’ or providing an alternative arrangement is deemed acceptable to the ‘administration’.

CHIRP comment

To repeat a previous mantra “if a pilot boarding arrangement is not compliant it is not safe” and anything that is not safe is dangerous, pilots have the right to refuse to use a dangerous PBA. The inevitable delays and costs incurred as a result of such refusals would very quickly focus the attention of the operators and owners of these vessels to solve the problem.

The SOLAS and IMO rules and regulations are about safety. The safety of ships and the safety of the seafarers who use, live and work on them. Naval architects and flag administrations should address and resolve these identified problems at the design and building stage of a vessel and not abuse clauses in the regulation that are intended for exceptional circumstances.

The pictures above both show what appear to be ferries with relatively low pilot access doors. It may be possible to modify a pilot boat with one or two raised platforms that would present the pilot at the level of the access door or certainly above the obstructing rubbing strake. The advantage of this would be that the pilot authority would be taking control of the issue rather than trying to influence multiple vessel operators to modify their ships. At the end of the day it is the safety of the pilots that is the main concern.

CORRESPONDENCE RECEIVED

Regarding – Incorrect windlass brake band adjustment

On many vessels I have sailed on we have the same situation – the bosun tightens the bolts and chief officers and masters do not pay any attention to this problem. But the consequences of this wrong adjustment are slow speed of winch, damage to the brake liner, slackening of ropes and

anchor and possibly injured crew members, hydraulic oil spills and damage to the vessel. The following investigation report was made by a previous company I worked for:

Following the windlass brake failure and subsequent loss of the starboard anchor and all 12 shackles of chain aboard one of the company’s vessels, the opportunity was taken to thoroughly investigate the possible cause of failure by inspecting the starboard windlass and braking mechanism aboard the sister vessel.

With the starboard anchor and chain tightly secured using the guillotine bar and a wire rope stopper, the weight was removed from the windlass brake. The brake band adjusting bottle screw and fixing plates were removed to the engine room workshop where the threads were thoroughly cleaned and lubricated.

On refitting the fixing plates and bottle screw the adjustment of same was kept to a minimum with only approximately 5 threads entered at both ends of the screw. The brake was then fully applied using the strength of two able seamen. With the drive clutch engaged, the hydraulic motor turned the windlass gypsy wheel with ease and there was absolutely no braking effect.

The reason for the freedom of movement was that the crosshead, located between the brake application shaft and the brake tensioning plates, was in contact with the windlass foundation, as shown in the photograph below:



Figure 8 – Incorrect Brake Adjustment

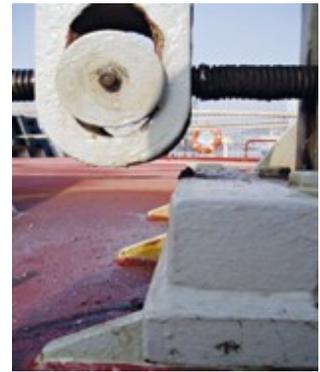


Figure 9 – Correct Brake Adjustment

The bottle screw was then tightened to the correct setting, i.e. allowing the gypsy to rotate freely in the brake ‘off’ position, but in the brake ‘fully on’ position the hydraulic motor could not rotate the gypsy. The clearance between the crosshead plates and the foundation with the brake fully applied was in the region of some 30 – 35mm.

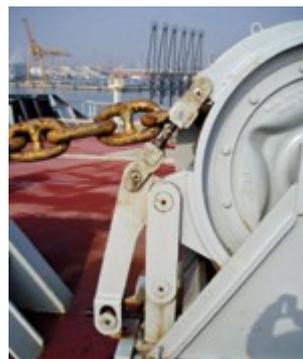


Figure 10 – Brake ‘Fully On’



Figure 11 – Bottle Screw Adjustment

Both port and starboard foundations were showing signs of contact with the crosshead plates, therefore it would seem that it is not uncommon, on this type of windlass, to have the brake tensions incorrectly set.

Conclusion: The loss of the starboard anchor on board the sister ship was probably due to incorrect brake adjustment.

Corrective Action: With immediate effect, all in the same class are to strip down and clean the internal and external threads of the bottle screw arrangements, insuring that before removal the anchors are fully secured using the lashing wire and compression bar. With the bottle screws refitted the brakes are to be adjusted to give 30 – 35 mm clearance between the foundation and the crosshead plates when the brake is 'Fully On'. To test the holding ability of the brakes, engage the drive shaft clutch, with the brake 'Fully On' and try and rotate the drum in a chain lowering direction using the hydraulic motor, there should be no motion of the gypsy wheel relative to the brake.

Prior to every anchoring operation it is the responsibility of the deck officer in charge on the forecastle deck to apply the brake fully and report to the master that there is a suitable 30 – 35 mm gap as previously described. (The engine department is to manufacture a two ended feeler gauge, one end with a 35mm thickness the other a 30mm thickness, this gauge is to be kept by the bosun who will measure the gap in the presence of the aforementioned deck officer).

Training: All personnel involved in the anchoring operation and the maintenance of the anchoring equipment are to be trained by the Chief Engineer and Chief Officer in the correct procedures prior to being permitted to operate or carry out any work on the equipment. The senior personnel are to include this message in their handover notes and give instruction to their relievers.

Regarding – Overweight rescue boats

Several years ago, I was reading an article about a rescue boat that parted the fall wire and fell into the dock during a practice drill because it was overweight due to water entering the buoyancy spaces – one person was killed and two others badly injured.

The next day I checked our own rescue boat, and it was a surprise when we found that the covers of some openings were broken, and we found water inside.

- we stopped all drills with the rescue boat, awaiting instruction from the office.
- we were not able to check the weight of the rescue boat on board because we had no appropriate load cell. It should be included on the dry dock job list.
- on board newly delivered vessels, these openings should be filled up with silicon and then closed with a plastic plug.

We tried to mop out the water for two days, but it kept coming back, so the company instructed us to turn the boat upside down for a week to allow any water in the foam inside the compartments to drain out, which was successful. We then turned the boat up the right way and used silicone to seal the openings before fitting new plastic caps.

CHIRP comment

The article mentioned in this correspondence referred to the MAIB report into the fatal accident on board the car carrier *Tombarra* in 2011. <https://assets.publishing.service.gov.uk/media/547c71c1ed915d4c0d000149/SB1-11.pdf>

While acknowledging that this report is historic, the topic is still relevant today and while it was widely promulgated by certain flag states at the time, there are many vessels around the world and a whole generation of seafarers who may not be aware of the incident, the report or the remaining dangers.

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