

MARITIME FEEDBACK



Issue 63
June 2021

An independent and confidential reporting system for the maritime industry

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The CHIRP editorial

It took only Minutes...



Capt. Jeff Parfitt
Director (Maritime)

Our cover photograph is a dramatic shot of a motor yacht on fire, and although there were no serious injuries it was a traumatic experience for the two people on board at the time. The report of the incident marks an unusual departure for CHIRP Maritime, because it is based upon the accident investigation report rather than an account from an individual. The report contains many valuable safety lessons but, in addition, it stands as a model of how such incidents should be investigated. The crew are praised for their correct actions, while their mistakes are also pointed out so we can learn from them. The administration concerned should be applauded for bringing the safety lessons to the public as quickly as possible.

Serious incidents are almost always investigated by the administrations responsible for the vessel involved, or by the state where the incident took place, and it is a requirement



that the investigation reports are lodged with IMO so that lessons can be learned. Such reports are not intended to be used to punish the people involved, but merely as a means of learning safety lessons. The reports are often not made public until all court cases have been concluded so they cannot be used to incriminate the people involved, which is a sensible way of ensuring that witnesses can speak honestly and freely without facing punishment. By doing it this way, there is a much better chance that witnesses will tell the truth and help investigators work out exactly what happened.

The weakness of the system is that there is no requirement that the investigation reports should be made public

The weakness of the system is that there is no requirement that the investigation reports should be made public, and some administrations do not release them. In our opinion this is a mistake, and we urge all parties to publish all accident investigation reports so the safety lessons can be learned and there is a better chance

that similar accidents can be prevented in the future.

Elsewhere in this edition we have a worrying account of a vessel which tried to cover up the presence of Covid-19 on board, and a report about engine issues in bad weather which raises important questions about leadership, communication and company spare parts policies. We discuss the difficult topic of recreational vessels interacting with fishing gear, and consider an unmooring operation in deteriorating weather following a ship-to-ship transfer. This latter report contains valuable information about the elasticity of different types of mooring ropes.

We learn about a crew which tried to maintain a speed log at sea and ended up flooding a cofferdam, and our pilot's corner focuses on engine issues during arrival and departure manoeuvres. This is a varied and interesting edition, and we thank all our reporters for their efforts to enhance the safety of everyone at sea.

Until next time, take care and may all your voyages bring you safely home.

Failure to declare reportable cases on entering port

Outline: A conscious decision not to declare notifiable disease symptoms on board when entering port put the pilot, dockworkers, and the wider community at risk.

What the reporter told us

Following a full crew change in port, the vessel sailed that evening and went to anchor outside the port. Soon after joining, two of the crew exhibited COVID symptoms – one of them later learned he was a ‘close contact’ with a confirmed COVID sufferer – both seafarers were isolated on board.

Initially, the master kept the presence of symptomatic crew quiet, choosing not to inform the vessel’s management company, additionally the master falsified the seafarers’ temperature records by asking them to stand outside in the cold before recording their temperature. When the master was persuaded to inform the company (as per the COVID management plan), the company instructed the master not to disclose the issue – the vessel remained at anchor.

The symptomatic seafarers were employed through a manning agency which applied pressure to the management company to conduct COVID tests.’

Three days after COVID symptoms were first exhibited, the management company instructed the vessel to proceed into port. The two symptomatic seafarers would be replaced on board and then accommodated and tested ashore.

During the phone call with the company, the captain volunteered to lie to the harbour authorities about having COVID symptoms onboard – the harbour authorities ask all arriving and departing vessels “if they have any reportable symptoms onboard” – the company accepted the captain’s offer.

Subsequently, the vessel entered port without informing any authority of the reportable symptoms on board. The pilot who boarded the vessel was not informed of the symptomatic crew and neither was the taxi driver who drove the two seafarers to their accommodation ashore.

The day after the symptomatic seafarers were taken ashore, two replacement crew joined the vessel. Only one of them had been informed of the suspected coronavirus on board the vessel before they joined. The vessel departed the harbour after embarking the two crew replacements and taking on food stores. The vessel did not take a pilot for sailing.

Five days after the symptomatic seafarers were landed ashore (and 8 days after their symptoms first appeared), the two seafarers were finally tested by a private company. The test results were positive for coronavirus.

After departing the harbour no further symptoms presented on board.

Sometime later, the two previously symptomatic seafarers were re-tested – the results came back negative for coronavirus. The company offered them employment on another vessel, but they declined and their contracts were terminated. Their manning agency paid for alternative accommodation and flights back to their home country.

The reporter had contacted the DPA, but only after the two crew members were landed ashore, which the reporter recognised was too late. Earlier action might have led to a better outcome with proper procedures followed and safety precautions in place for the pilot and the taxi driver. However, the conversation between the master and the company had been with the company directors, by-passing the DPA. It is unclear if the DPA would have had any

influence given the direct relationship between the master and company directors.

Further dialogue

In response to questions the reporter noted the following: there are many human element failures within this report including the reporter’s own. Whatever the captain’s misguided reasoning for offering to lie to the authorities, the company should have declined and instructed him to make a full and honest declaration to the port authorities.

Finally, the reporter thought that there must be other vessels in similar situations waiting outside ports in various parts of the world.

CHIRP comment

The *CHIRP* Maritime Advisory Board (MAB) noted the following points.

- This report identifies an absolute violation of the WHO International Health Regulations (2005) concerning the requirements to report the presence or suspected presence on board of a notifiable disease. Beyond the regulations are questions of moral and ethical integrity.
- Long established by the WHO, IMO, and ILO is an obligation on the master of a ship to make an accurate declaration when entering port.
- Early in the coronavirus pandemic, a broad coalition within the maritime industry came together to produce a framework of protocols to facilitate safe crew changes and repatriation. On 5th May 2020, IMO issued a Circular Letter (No.4204-Add.14), informing maritime administrations, national authorities, and shipping companies of the Recommended framework of protocols for ensuring safe ship crew changes and travel during the coronavirus (COVID-19) pandemic. The protocols are detailed in MSC.1/Circ. 1636 02/12/2020.
- This report concerns a recent incident which was a wilful breach of the regulations and those established protocols, not just by the master but by the management company as well. Given the potential harm to those individuals involved in repatriating the two seafarers with symptomatic Covid-19 conditions, pilot, crew, agents and taxi driver, this case highlights the imperative to properly report any notifiable disease.
- COVID restrictions and quarantine have both direct and indirect consequences on seafarers and additionally on a ship’s ability to continue to work cargo. All such issues can be compounded by restrictive charters and inflexible charter parties.
- The reporter also highlighted that the master engaged directly with the company’s directors and by-passed the Designated Person Ashore (DPA) (The DPA is the authorised direct link between the ship and the highest level of management of the Company who is responsible for ensuring the safe operation of the ship.)
- While this is the first such report to be received by *CHIRP* Maritime it is unlikely to be an isolated case but rather the tip of an under-reported industry-wide problem, made possible by lack of enforcement.
- As far as *CHIRP* Maritime is aware, the company has not carried out an internal investigation so there are no lessons learned from this incident. However, *CHIRP* Maritime feels it is incumbent on all shipping companies and masters to understand the reporting requirements for reportable diseases and to make accurate declarations. Notwithstanding any charterer’s contractual agreements, the master must ensure

that the regulations are robustly adhered to and that reporting via the correct channels is followed.

- Clear guidance is available on how governments, national authorities, shipping companies and masters, should act – it just remains for everyone involved to follow the protocols to ensure that all seafarers and those involved with their repatriation are looked after safely.

Fire and sinking of a motor yacht

Outline: CHIRP Maritime received a newly-published flag state investigation report and safety bulletin regarding the above fire with an invitation to promulgate the contents to the wider maritime community.

What the reporter told us

The vessel concerned was a privately owned leisure vessel (although it had in the past been operated commercially for a short period). The vessel was conducting an international positioning voyage during the winter with only two crew aboard and was close to the coast at the time of the incident.

Shortly after weighing anchor, following an overnight stop, the vessel suffered a catastrophic engine room fire which spread rapidly throughout the vessel.

The two crew abandoned the vessel using a tender and liferaft combination and were unharmed.

The vessel subsequently sank in deep water whilst a firefighting vessel was attempting to extinguish the blaze.

The incident raised some interesting learning points both from things that went well and from those that did not, and these are reflected in the Safety Bulletin.



Figures 1 and 2

The full investigation report and safety bulletin can be read and downloaded at:

<https://cdn.ports.je/web/Just-Mine-Incident-report-Nov-20.pdf>; and <https://cdn.ports.je/web/SB02-of-2021-Lessons-from-a-fire-at-sea.pdf>;

CHIRP comment

The investigation report and the safety bulletin are too extensive to reproduce within the pages of Feedback, however CHIRP Maritime would recommend readers to follow the above hyperlinks and read these two documents which are both interesting and informative and contain learning opportunities for all seafarers.

For any readers without the facilities to access the two documents, the following extracts are taken from the Safety Bulletin.

Although anything mechanical can fail, the risks are reduced when equipment is maintained in accordance with the manufacturer's guidance.

Check (machinery spaces) frequently and act promptly if anything does not seem to be right.

Effective practice enables right actions to be taken, in the right sequence, at the right time. Although checklists may help, an emergency is not the time to be reading the instruction manuals.

The Golden Rule is 'Once a space containing a fire is sealed, do NOT reopen it except under the advice of, and preferably with the assistance of, trained firefighters. A significant period is required to allow cooling'.

'Mayday' or 'Pan'? If you need assistance, ask early; it is better to subsequently downgrade a 'distress' message to an 'urgency' message if the situation improves; than to be unable to send a distress message if it worsens.

Voice or DSC? Both, if possible. The DSC (Digital Selective Calling) function, which would automatically have included a GPS position in the distress message, was not used as it was not user-friendly, not routinely used aboard, and the crew were unfamiliar with its use. Familiarise yourself with your safety equipment. It is better to initiate a call using DSC and back it up with voice communication. Write down your position and update it frequently before making the call so it remains available if your electronics fail.

Hand-held VHF's should be distributed early in an emergency. VHF on channel 16 has the advantage in communicating with all stations in the area and can enable shore stations to obtain your position using DF (Direction Finding) equipment... /...A mobile telephone, preferably waterproofed, can on occasion provide useful backup to VHF, which should remain the primary means of communication.

Lifejackets are useless if not worn. They need to be distributed early in an emergency and must remain readily accessible. They should also be worn whenever there is a risk of falling overboard.

Summary: During this serious incident, the crew reacted quickly and despite the rapid spread of the fire and a couple of mistakes, took the necessary actions to attempt to save first the vessel and then themselves. It is always better to learn from the experiences of others, and it is hoped that all will benefit from the open nature of the crew sharing their experience.

The benefit of hindsight is that it gives the observer 20/20 vision, but what seems obvious to the writer and reader of this article may not have occurred to the two-man crew in the matter of minutes available to them from first detecting the fire to having to abandon the yacht.

The safety bulletin already highlights the "golden rule" about not opening a space containing a fire once it is sealed. Releasing a fire suppression medium like FM-200 into a compartment is the last throw of the dice that will either put out the fire or not - opening the space will only guarantee that it will not.

The fire was detected when the yacht had been under way for only 10 minutes after weighing anchor. That might suggest that there had been an issue in the engine room from the time the engines were started. It would be prudent to have the deckhand in the engine room for the start of the engines and to remain there until the engine systems have reached normal operating temperatures and pressures.

The investigation report lists the yacht's comprehensive features and equipment for fire protection and fire-fighting. However, an automatic fire/smoke detection system is not listed.

Finally, there is a requirement under IMO for all serious incidents and accidents on commercial ships to be investigated by the vessel's flag state. There is also a requirement for the findings of the investigation to be presented in a report to the IMO. However, there is no requirement for the findings to be published to the wider maritime community. The Jersey marine accident investigation department has done a very good job in publishing their report, but some flag states do not publish their reports. *CHIRP* Maritime asks the question, why are all accident investigation reports not put into the public domain and widely publicised to enable all seafarers to learn from the findings?

Engine issues in bad weather

Outline: This report was a referral from ISWAN (International Seafarers Welfare Assistance Network).

What the reporter told us

A seafarer asked us to report to you some issues related to their engine which he thinks compromises the vessel's navigation safety. According to him, they are unable to navigate at full speed because of the engine issues and the situation may be especially hazardous when there are large waves and strong winds.

The vessel involved was a ten-year-old 'Supramax' geared bulk carrier of 57,000DWT, several days into an ocean passage.

Further dialogue

The ship had sailed five days previously but on the day after sailing the engine problems started. Two days after sailing the ship was stopped for 10 hours to change an exhaust valve and piston. The parts fitted were not new but rather 'used but good'. After the engine maintenance, the vessel resumed passage but only an hour later had to reduce speed due to exhaust valve and temperature issues, the vessel then had a speed of 3-5 knots. The weather at the time was wind force 6-7 with a wave height of more than 4m.

The captain and chief engineer were of one nationality with all other ranks being of a different one.

The following day the reporter emailed *CHIRP* Maritime that the engine was better, and the plan was to increase speed after further checks on the fuel injectors.

Although *CHIRP* Maritime attempted to contact the reporter again, there was no further engagement, although we did follow the vessel's progress to its port of destination on a vessel tracking site.

CHIRP comment

The MAB members felt this report covered two separate issues – first leadership and transparency of communications, and second machinery maintenance and critical spares.

While there is a lack of technical information about the vessel's machinery, its fuel quality or what deviation from operational norms dictated repairs at sea, the following observations on good seamanship and engineering practice remain applicable. It was also brought to the MAB's attention that the very act of contacting ISWAN and *CHIRP* took courage on the part of the reporter and reflects the serious concerns there must have been on board the ship.

With regards to leadership and transparency of communications, in the current world of multinational crews, this aspect of the human element is more critical than ever.

While resting principally with captains and chief engineers, all senior personnel including bosuns have a responsibility to keep the crew informed.

CHIRP Maritime feels that it is incumbent in the training of all senior officers that they ensure effective communications are established concerning operational safety throughout the vessel. It is a well-established fact that good communication loops are instrumental in good safety performance.

Communication issues extend ashore to management offices, which also have a responsibility to keep the crew on board informed. When a ship goes to a high-risk piracy area, the management company should always inform the crew of any precautions taken or risk assessments undertaken. This report reflects badly on the vessel managers, since a good company system would have given assurances to the crew that internal issues and concerns onboard can be raised with the office.

Regarding maintenance issues and critical spares carried on board, the fact that major maintenance and repairs, undertaken at sea, utilised items that had been used before suggests that the vessel carried insufficient critical spares, which in turn brings into question the shore management's attitude towards vessel maintenance.

Ships should not stop mid-voyage due to engine issues. Routine and preventive maintenance should be scheduled and carried out between voyages.

CHIRP Maritime also feels that sufficient critical spares must be carried to mitigate the likely impact of unplanned maintenance as well as routine maintenance. Reliance on spares that have been used before is very unwise unless they have been sent ashore for reconditioning; they should not be part of the complement of critical spares. Company internal audits should seek to establish realistic inventory levels of critical spares.

Sailing boat propeller fouled

Outline: The following report reflects a perennial problem for coastal yachting

What the reporter told us

Whilst coastal sailing in wind force 4-5 at 6-7 knots an odd noise was heard, similar to a wave slapping the side of the boat. Nothing else unusual was apparent. Approximately two hours later, and after about an hour's motoring, I was berthing the boat. Upon selecting reverse, I found that there was a lot of vibration and little, if any, thrust.

After berthing safely, I looked underneath and saw something white was fouling the propeller. I then realised what the odd noise had been. It was not possible to clear the object until the boat was lifted out of the water.

The obstruction was caused by a short rope end with a loop that had caught on a propeller blade. The other end of the rope was attached to a small white fender's rope eye. The fender's other rope eye had been ripped off. The type of rope and the rope splice indicated that the fender had been used as a float to aid the picking up of a lobster pot. The fender's small size and profile meant it was inadequate as a visible marker to other craft and was certainly not visible in clear daylight and the prevailing sea conditions at the time of the incident.

Lessons learned (reporter's words)

As always, keep a sharp lookout. However, in the prevailing conditions, it is unlikely that such a small object could have

been seen in good time to take evasive action. I am in the process of fitting a rope cutter which may have mitigated the propeller fouling when the engine was started.

Further dialogue

During correspondence, the reporter mentioned a similar incident that occurred last year which required the reporter's boat to be recovered and towed in by a shore-based rescue boat. The reporter also raised the issue of non-buoyant cordage being used to mark pots etc. in preference to buoyant cordage.

CHIRP comment

The MAB, which includes members from both the yachting community and the fishing community, engaged in a healthy discussion about the issues raised by this report. Among the many points noted were the following:

- The problem of poorly marked fishing gear has been around for many years. Now, in the UK, there is a working group chaired by the MCA (Maritime Coastguard Agency) under UKSON (UK Safety of Navigation) that is looking at how to address this problem.
- Many entanglement incidents involve inappropriate gear laid out by non-professional (recreational) fishing boats.
- Whilst this is a very emotive topic, a good start would be to ensure that lobster pots and other fishing apparatus are properly secured with floatation devices that are fit for the intended purpose rather than using plastic litter (plastic milk bottles and the like) – which should be banned on environmental grounds.
- A guide to setting fishing gear already exists and can be found via the following link-<https://www.gov.uk/government/publications/marking-of-fishing-gear-2008-advice-to-fishermen-and-yachtsmen>
- While it is accepted that most sailing and other recreational boating takes place during daylight hours, risks are increased when sailing during darkness. Wherever you are in the world, unlit marks will rarely be seen during the hours of darkness.
- Sailing boats and other recreational craft which sail in areas where there is a high degree of fishing activity should consider fitting rope cutters. Additionally, and in accordance with good seamanship, the sailing plan should be made to either give popular fishing areas a wide passing distance or at least to ensure they are navigated during daylight where buoys can be more readily seen. A good lookout is always required when sailing in these high-risk areas.
- CHIRP Maritime recognises that there is no definitive answer to this problem and both the fishing industry, and the sailing community should try to reach a practical solution. A handbook which highlights the risks and consequences of being fouled by inappropriate fishing gear should be considered with input from both the fishing industry and the PYA.

Ship to Ship mooring incident

Outline: Specialist operations require extra diligence.

What the reporter told us

A ship to ship transfer was taking place between a 106,000DWT tanker (discharging) and a 40,000DWT tanker (loading), the transfer was completed at 10:36 and cargo hose disconnection was completed at 10:42.

Shortly afterwards, at 11:00, the person in overall advisory control (POAC) informed both vessels to prepare to commence the unmooring operation due to rapidly deteriorating weather conditions. The departure checklist was completed at 11:12, by which time the actual weather conditions were wind NE 25kts, gusting 30kts, with a NE swell of 3m (both elements exceeded the agreed weather criteria for the STS operation).

The agreed unmooring plan called for the larger vessel's fore and aft wires to be cast-off first. This was to be followed by the simultaneous release of all the smaller tanker's head and stern lines.

At 11:25 the smaller tanker's two (2) aft spring lines parted. At this time, the larger ship requested the smaller tanker to run off its three (3) headlines and two (2) forward back springs as his crew (large tanker) were unable to release them.

At 11:30 the unmooring operation was completed.

Subsequently, the mooring ropes released into the water were returned to the smaller tanker by a service vessel.

Additional Information: The deterioration in the weather had been forecast but not until later in the day. There were no tugs available at the site of the STS transfer.

CHIRP comment

Ship to Ship (STS) transfers are specialist operations fraught with potential hazards with parting mooring lines being high on the list of possible dangers.

- Two dissimilar vessels will each have their respective pitch, roll, heave, surge, yaw, and sway movement periods, potentially in opposition to each other at any given moment. This can put tremendous snatch loading on the mooring lines.

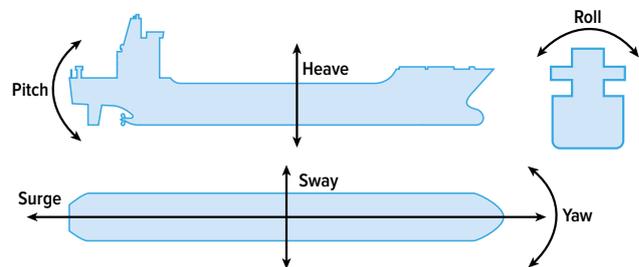


Figure 3 (image courtesy of Witherbys Publishing)

- This differing movement makes balancing the load on the mooring lines more difficult than conventional mooring operations.
- For this reason, ship to ship transfers should be carried out only under favourable weather conditions with constant monitoring required to ensure that the agreed weather parameters are not exceeded - especially the sea and swell conditions.
- Weather forecasts are more important to a vessel engaged in an STS operation than they are at sea, due to the proximity of obstructions and hazards.
- The authority to cease STS operations rests with both ships involved, either one can stop the operation on the grounds of safety.
- STS operations will normally have their own mooring requirements but if not, or if there is any dispute, then the OCIMF Mooring Guide (MEG4) should be considered the definitive mooring guide.
- All crew members of vessels involved in STS operations should be fully conversant with all aspects of the agreed standard operating procedures including any special arrangements for quick release of mooring lines if this

becomes necessary. Regular emergency preparedness exercises for unmooring should be practised.

- It is important that all mooring lines in each of the three (3) groups, breast lines, spring lines, and head / stern lines are of the same size, construction, breaking strength and length to ensure equal tension on all lines. Dissimilar characteristics within a group can lead to rapid parting of mooring lines.

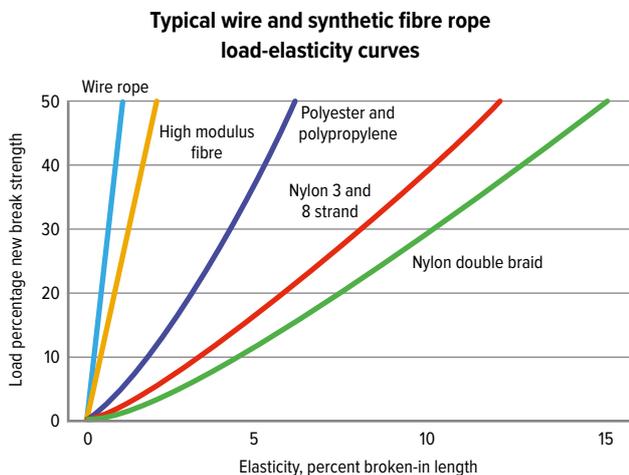


Figure 4 (image courtesy of Witherbys Publishing)

Flooding cofferdam during speed log maintenance

Outline: The crew attempted to carry out repairs to the speed log unit, which was in the forward cofferdam, while the vessel was underway.

What the reporter told us

The repair team consisted of the chief engineer who was to supervise the job, the 3rd engineer, and the electrician, none of whom had carried out this type of repair before. The repair team planned to follow the manufacturer's troubleshooting instructions.

Upon request, the manufacturers of the speed log had sent instructions to the company's electrical department, who forwarded them to the ship. Neither the company's technical department nor the HSQE-marine departments had been notified of this planned non-routine repair job.

The master reported that the job had been discussed at the morning work planning meeting although no specific risk assessment was carried out for this work.

Enclosed space entry procedures were followed, and the necessary entry permits issued. Furthermore, a team was standing by outside the cofferdam to assist the team in carrying out the work.

In addition to the risks associated with entry into a confined space, the additional risks associated with this specific task are flooding, operational delays, and personal injury.

Additional information

The repair team attempted to inspect the sensor and repair the malfunctioning speed log following the manufacturer's troubleshooting instructions.

The work involved removing and inspecting the sensor of the speed log which was in the forward cofferdam. No details are available concerning the size of the cofferdam.

As per the maker's manual, a series of steps were required to be followed to carry out this job safely and effectively.

- A chain stopper was required to be fitted to both the sea valve and the sensor. This was necessary to hold the sensor in the sea valve until the valve was confirmed to be fully closed. Only after the sea valve was fully closed should the chain stopper be removed.
- The required chain stopper was installed by the crew before the commencement of the job as per the maker's instructions.
- However, when performing the last step, the crew could not close the handle of the sea valve fully. The crew assumed that the sensor was obstructing the valve and they decided to remove the chain stopper and pulled the sensor out from the sea valve with the valve still not fully closed.
- As a result, seawater entered the cofferdam from the sea valve when the sensor was removed.
- The crew attempted to insert the sensor back into the housing, but this was not possible due to the ingress of seawater.
- With the sensor removed, the sea valve was then closed completely, and the work postponed. The cofferdam was sealed, and control measures established to monitor the condition of the compartment for any further flooding.
- Eight days later when the vessel was at anchor, divers attended the vessel and sealed the sea chest. At this time, the job was carried out, with the assistance of a service engineer from the manufacturers, by the responsible crew who located the sensor back into position to restore the speed log's function.

An in-house investigation was carried out which concluded that the incident had occurred due to failure to comply with and implement the company's basic safety procedures and failure to follow the equipment manufacturer's instructions.

Direct Causes

- Improper implementation of the company's instructions and procedures.
- Failure to follow the maker's safety instructions for the specific job.

Basic Causes

- Failure of basic communication within the company offices
- Inadequate instructions from the company and improper planning of the job. Neither the HSQE-marine nor the technical department's responsible person were informed about this non-routine and high-risk job.
- A proper risk assessment was not conducted for the non-routine job.

Lessons Learned (Reporter's conclusions)

No instructions should be given to vessels in the fleet for non-routine works unless they have been agreed by the technical and HSQE-marine department personnel and a risk assessment has been carried out in cooperation with the vessel.

Every work activity needs adequate & proper planning, detailed hazard identification and a comprehensive risk assessment to determine the necessary control measures to mitigate the likelihood and consequence of an undesired event taking place.

CHIRP comment

It was the unanimous opinion of the MAB that opening a hull penetration below the waterline while underway and mid-ocean is not a good policy. The following points were also noted.

- The team on board were too close and engrossed in the small details to step back and see the dangers of the bigger picture.
- Some on board risk assessments for non-routine or exceptional tasks are too focused on ticking the boxes and completing the form rather than taking the time to identify and make in-depth assessments of individual potential hazards.
- The technical and HSQE – marine departments had not been informed by the electrical department, who were aware of this non-routine job because they had forwarded the instructions received from the speed log manufacturers to the ship. All technical and HSQE-marine departments in the office must communicate with each other to understand the risks.
- While there were failures on board the ship, there were also failures of management with the shore technical and HSQE-marine teams being unaware of the planned operation. The office should ask itself what went wrong at their end and promulgate their findings to the fleet.

PILOTS CORNER – MORE ENGINE ISSUES

In this edition of Feedback, we have gathered a further selection of reports dealing with different aspects of engine issues encountered by the pilots who reported them.

Was it an engine issue or a communication issue?

What the reporter told us (1)

On departure from the berth, the container ship exhibited main engine problems. Engine revolutions were restricted to 37rpm (between Dead Slow and Slow Ahead). As a precaution, the tug was kept in attendance until the vessel had cleared the channel and the engine issues were allegedly rectified. No explanation was given by the captain.

Further dialogue

The reporter clarified the following points.

- The Master/Pilot exchange reported no defects or deficiencies.
- The engine tests prior to departure were carried out satisfactorily.
- The first engine movement, once the vessel had been swung off the berth, was when the engine failed to respond as the reporter expected.
- The engine eventually gave 46rpm (roughly Half Ahead)
- The reporter was given no indication that the engine issue had been resolved by the time he disembarked or any explanation why the engine failed to respond as expected.
- After disembarking the pilot, the vessel proceeded to its next port. The pilot station at the next port was notified of the issue.

CHIRP contacted the DPA who readily engaged, which allowed details of the report to be passed on. After

checking with the vessel, the DPA responded. “We have verified with the vessel and the master confirms that there was absolutely no issue with the main engine on departure from the port in question. It is possible that the RPM came up gradually due to less underwater clearance in the channel which the pilot misunderstood as a restriction on the main engine.”

Not being familiar with the vessel's sailing draft or the available depth of water CHIRP felt unable to comment further, but the DPA's response was forwarded to the reporter to close the loop on the communication. The reporter's final response was to note... “At no time was I informed of any restriction on the main engine due to lack of under keel clearance. The pilot card made no mention of this and the master failed to pass this on”.

CHIRP comment (1)

After discussion, the MAB noted the following.

- Modern slow speed marine engines and power management systems do not respond in the same way that older medium speed engines did in the past.
- Ship handling with restricted under keel clearance can be a significant issue when handling large vessels.
- The manoeuvring characteristics of a ship included in a vessel's pilot card are normally ascertained during the builder's trial, which is most often carried out in open water.
- If the reduced revolutions were a normal function of the limited under keel clearance due to increased load on the engine, the captain may not have perceived them as a problem and therefore did not think he needed this limitation to be highlighted or explained to the pilot.
- Pilots are very well trained nowadays and are trained to anticipate increased engine load due to limited under keel clearance.

Better to keep going than stop

What the reporter told us (2)

After clearing the inner harbour without incident and proceeding outwards at slow ahead, the engine was put to half ahead but the main engine alarm sounded about one minute later. The engine room advised it was the main engine main bearing alarm and requested to stop the engine at the earliest opportunity to investigate. The master was advised the engine was OK to proceed at Slow Ahead until there was an opportunity to stop.

Tugs were attending the imminent departure of another ship, one of which accompanied our vessel outwards as a precaution.

Regular requests were made to the engine room to advise on the condition of alarms and the main engine. Assurances were given that temperatures were not increasing. The pilot encouraged the master to keep the engine going, considering it was prudent for the vessel to proceed if possible, to safer water outside rather than investigate within the harbour. The vessel proceeded to the heads without incident with a tug escort and once clear of port limits proceeded to deep water to investigate.

Further dialogue

The bridge team and engine room team were multinational with English as the common language; however communication was not easy. The regular requests to the engine room for status updates were initiated by the pilot.

The water depth was very limited within the harbour to anchor and investigate.

After disembarking, the pilot and port heard nothing further from the ship.

Once restarted, do not slow down

What the reporter told us (3)

The vessel was LOA 261.84m, beam 32.00m with a conventional propeller and rudder with a single bow thruster.

After letting go and clearing the berth, the vessel built up speed to 12 knots for outbound transit. Just before turning to port to negotiate the main bend in the channel, the vessel lost power to the main engine.

The momentum of the vessel assisted in making the turn safely before the ebb tide started to take effect. The bow thruster was used to keep the vessel in the middle of the channel, but a breeze and ebbing tide started to set the vessel to starboard towards the channel limit. Although the vessel still had headway, it was dropping rapidly into the breeze.

The master was frantically trying to get the engineers to restart the engine, first from bridge control, then engine room control and finally from the emergency local platform. Just before the vessel lost sufficient headway to let go anchors, the main engine was restarted from the emergency local controls.

The main engine was unresponsive for 14 minutes in a very critical part of the pilotage.

Harbour Control was kept informed once the situation was assessed. Both harbour tugs were manned up and ready to head out and assist (ETA would have been close to

30mins at least), the Harbour Master was kept informed of the events by Harbour Control.

With the main engine being operated from emergency local control, it seemed like the engineers were giving revs for Full Away as the vessel rapidly picked up speed and passed the breakwater at close to 17 or 18 knots.

The Master tried to have the engineers reduce the revolutions, but I requested them to be retained to clear the harbour without any further incident now that the vessel had emergency propulsion.

When queried, the master mentioned it was a 'faulty fuel rack' that was the cause of the main engine shut down.

Additional information

The buoyed channel is the only deep water between the heads and the berth for the vessel to remain afloat. The channel is about 300m wide and is narrower in some parts making it very limited for anchoring a 262-meter-long vessel.

CHIRP comment (2 + 3)

After discussing these two reports the MAB noted the following.

- While the bridge team needs to know what is happening, answering telephones can be a distraction from the task at hand.
- Once the question, "how long will it take?" has been asked with a request for regular updates and notification of any change in status, let the engineers get on with their job.
- Confidence and trust between departments are crucial but it takes time to establish, while language and cultural differences can make that establishment harder.
- Companies make conscious decisions to engage multi-national crews and must accept that their decision can have consequences in terms of efficiency.

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