CHIRP

MARITIME FEEDBACK

Issue No: 21 New Year 2009

EDITORIAL

CULTURE OF SAFETY

I was encouraged to receive the first report summarised in this MARITIME FEEDBACK. It describes a simple trip and fall on a fishing boat, the type of incident that occurs very frequently on vessels. Then why am I so encouraged?

First, we understand that the crew member has not suffered a permanent injury.

Secondly, there is wide recognition of the need to improve safety in the fishing industry. Reporting of hazardous incidents is an important part of this, so we are pleased to have received this one.

Thirdly, in submitting a report of this simple incident, the reporter has implicitly recognised that accidents are preventable rather than inevitable. This is fundamental to developing a culture of safety.

From reading reports to CHIRP it is apparent that the strength of the culture of safety varies considerably from organisation to organisation. At one end of the spectrum:

- There is little concern for safety
- Regulations are considered to be a nuisance
- Individuals do not feel able to raise safety issues

At the other end of the spectrum, safety is integral to everything done by everyone on the vessel or in the organisation.

In an organisation where there is a strong safety culture, the team members will not switch-off their safety consciousness when they leave their vessel or work-place. So here are some sample questions for self-reflection:

- Have I tested the smoke-alarms at home recently?
- Do I wear goggles when using an electric drill?
- Do I pay attention to the safety demonstrations when travelling by air?

And remember, it's not too late for a resolution:

Let 2009, be the year in which you report a hazardous incident to CHIRP!

Chris Rowsell

REPORTS RECEIVED

CHIRP receives reports on a range of hazardous incidents that have occurred within the commercial, fishing and leisure sectors of the maritime community. We cannot publish them all. In particular, we do not publish if it would prejudice the confidentiality of the reporter. However, here are a number of reports which will be of wider interest, together with the "lessons learned" as described by the reporter. The ***CHIRP*** comments have been reviewed by the ***CHIRP*** Maritime Advisory Board which has members from a wide range of maritime organisations, full details of the membership can be found on our website - www.chirp.co.uk.

A PAINFUL TRIP

Report Text: An experienced member of the crew of a fishing vessel in port was boarding his vessel. He was standing on the gunwale of the boat, and jumped down onto the deck rather than stepping down. As he did so he landed wrongly and twisted his knee.

Lessons Learned: Staff should not jump from the gunwale of the boat; they should step down.

(Editor's note: In all the reports, the "lessons learned" are those described by the reporter. ***CHIRP*** *may add to these in its comments.)*

CHIRP Comment: In this incident that occurred whilst boarding a vessel, the injury to the seafarer was fortunately not long-lasting. In another case that occurred in 2008, a seafarer lost a leg when he was trapped between the pontoon and the vessel he was boarding. So careful attention is needed to risks whilst boarding, and more generally to mitigating slip, trip and fall hazards. This wide subject was well summarised in May 2008 in the excellent "Alert" bulletin - the international maritime human element bulletin published by the Nautical Institute.

TUG, TOW & FISHING BOAT

Report Text: Whilst anchored and fishing some 3-4 miles south of the Nab tower off the Isle of Wight in clear and open water, with two friends, we observed a large commercial looking vessel making towards us at some distance. We became slightly anxious when this vessel, which could clearly see us, stood on course towards us. We could now see it was very large and getting nearer, about ½ mile. The vessel

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then sounded several blasts on its whistle and we were at a loss to know why when we were in un-restricted open water and could clearly be seen to be rod fishing.

We heard nothing on our VHF channel 16 and noticed the vessel was going to pass ahead of us. It was then we saw that this vessel was a large tug and was towing another vessel. As the tide was making towards us, the tug appeared to have altered course slightly and plus the tide movement was now towing the vessel ever closer to us. I then released the remainder of our anchor warp and called to one of my crew to stand by to cut our line. Before we had time to do this, the towed vessel passed some 20 to 30 metres ahead of our bows. In all my years of sailing and motoring it was the nearest thing to an accident that I have experienced.

Lessons Learned: If we had been radioed earlier that this vessel required a wide berth we could have taken appropriate action. But on a very clear day in open water when we could clearly be seen to be fishing, it was highly dangerous in our opinion for this vessel to almost run us down and only sound its whistle when close on us!

CHIRP Comment: **This very near miss could have resulted in a tragedy. The incident must have been caused extreme anxiety on both the fishing boat and the tug. But has the skipper properly identified the "lessons learned", as described above in their report?**

In encounters between small craft and larger vessels, we encourage the skipper of a small craft to envisage the situation as seen by the watch-keeper of the larger vessel, and vice versa.

Let's consider how the situation may have unfolded. The skipper of the small boat obviously knew he was at anchor and that he was rod-fishing. But would that have been obvious from the tug whilst still a few miles away when passing the Nab Tower? It would not be safe for the small vessel to assume that the other vessel could see his anchor rope or fishing lines.

(Rule 26 of the ColRegs requires that a vessel engaged in fishing, other than trawling, shall exhibit by day a shape consisting of two cones with their apexes together, or, if the vessel is less than 20 metres long, a basket.)

Whether or not the watch-keeper of the tug could see if the small craft was fishing, he may have been considering that his tug with tow was the stand-on vessel.

(Rule 18 requires that a power-driven vessel underway, or a vessel engaged in fishing when underway shall keep out of the way of a vessel restricted in her ability to manoeuvre.)

Although not stated in the report, we would expect that the tug was exhibiting a diamond shape.

(Rule 24 requires that a power driven vessel when towing, and when the length of tow exceeds 200 metres, shall exhibit a diamond shape where it can best be seen.)

Whilst the vessels were still two or three miles apart, it should have been apparent from the small craft that a close quarters situation was developing and, through binoculars, that the tug was towing another vessel.

(Rule 5 requires that every vessel shall at all times maintain a proper look-out so as to make a full appraisal of the situation and of the risk of collision. However, the ColRegs do not provide for the use of VHF as a substitute for keeping a look-out.)

When the vessels were within two miles of each other, it would have been prudent for the small craft to prepare to weigh anchor and to move out of the track of the tug.

Even assuming that the watch-keeper of the tug was considering that he was the stand-on vessel, he still had an obligation to take action to best avoid collision.

The watch-keeper would have been reluctant to slow down rapidly as the tow would catch up, so his available action would probably have been a large alteration of course, although care would have been needed not to catch the boat in the sweep of the tow-line. With hindsight, and bearing in mind how close the tow came to the small craft, such action should probably have been taken earlier.

(Rule 17 requires that when, from any cause, the vessel required to keep her course and speed finds herself so close that collision cannot be avoided by the action of the give-way vessel alone, she shall take such action as will best aid to avert collision.)

We surmise from the report that when the tug was approximately half a mile from the small craft, the watch-keeper on the tug was concerned at the imminent situation and sounded the whistle.

(Rule 34(d) requires that when either vessel fails to understand the intentions or actions of the other, or is in doubt whether sufficient action is being taken by the other to avoid collision, the vessel in doubt shall immediately indicate such doubt by giving at least five short and rapid blasts on the whistle.)

At this stage, the small craft should have taken urgent action to weigh anchor, or to let the line go (being careful not to foul the propeller), and to proceed as quickly as possible away from the danger.

We hope that the three fishermen had been wearing life-jackets throughout the trip as recommended by the RNLI, but, if not, they should certainly have been donned when the hazardous situation was arising.

If the circumstances had been slightly different and such that there was imminent danger threatening life or property and requiring immediate assistance, a Mayday message would have been warranted.

We sincerely thank the skipper of the boat for having submitted this report. It is far preferable that the lessons can be learned from a near-miss report rather than from an accident investigation.

GULF OF ADEN

Report Text: Upon taking the con it was noted that an echo was being received on the radar (approx 5nm

on the port bow) yet no visual indication was present. This was surprising as the visibility was very good and noted to be more than 10nm. Being in the Gulf of Aden and transiting the newly appointed Maritime Security Patrol Area (MSPA) my pulse rose at the thought of a possible pirate attack. Yet as the range closed to approx 2.5nm a large shadow more consistent with a tanker or bulk carrier was visible. Checking with the AIS I was astonished to come to the conclusion that a Merchant vessel was underway and making way without any navigational lights displayed! After safely overtaking the blacked out vessel I decided to call up the vessel using VHF just to check that she was alright and had not fallen in to the wrong hands. After correctly identifying the vessel using all available means, I hailed her on VHF. The following is a transcript of the conversation: Own Vessel: "Good Morning Captain, are you aware that your vessel is not exhibiting any navigational lights? Is everything alright onboard?" Other Vessel: "Yes, we have turned our navigational lights off in order to hide from the pirates!" Own Vessel: "Captain, your vessel is now a serious navigational hazard, are you aware of your responsibilities under the Collision Regulations with regards to the displaying of navigational lights?" Other Vessel: "Yes of course, but we are trying to hide from the pirates!" Own Vessel: "Captain, that does not relieve you of your responsibility to display your navigational lights during the hours of darkness! Can you please turn your navigation lights on as I see you may have some head-on traffic approaching. You are substituting one danger for another!" Other Vessel: "No, I won't turn my lights on, I will call any approaching traffic on VHF. You are already clear now, continue on your passage, have a good watch, out". End of transmissions. Own vessel monitored the blacked out vessel as the expected end-on traffic approached and contrary to the Captain's claims of informing other vessels by VHF (hardly a substitute for navigation lights), this was not followed through which led to what can only be described as a barrage of VHF transmissions directed at the vessel to ascertain her condition.

Lessons Learned: An appropriate security strategy should have been implemented so as to transit this particularly risky area without contravening the ColRegs. A good Ship Security Plan would have been able to direct the Master on how to achieve this. Adopting a procedure which invalidates another is unsafe and pointless. Every attempt should be made to maintain integrity and not substitute one risk for another. Navigation lights should be displayed during hours of darkness from sunset to sunrise, during periods of reduced and/or restricted visibility and any other times deemed necessary. Not to do so is waiving the lives of your crew, ship and yourself away. Relying on VHF to prevent collision is not just foolish but shows an element of incompetence. However, failing to even make contact with other vessels to make them aware of your condition is just asking for a disaster.

CHIRP Comment: **Everyone involved in international shipping is concerned at the threat to vessels from armed assailants in the Gulf of Aden and other parts of the world. Whilst we hesitate to criticise from the safety of our office the actions of a master in a high risk area, we do not believe that sailing without navigation lights is appropriate, unless this were to be sanctioned by the authorities. If the Master determines it prudent to reduce the illumination from the vessel, this could be achieved by switching off deck lighting, but leaving the navigation lights on.**

In general, *CHIRP* often receives reports in which there has been protracted, and sometimes heated, VHF communication with a vessel that has contravened the ColRegs. In this case, the reporter refers to the "barrage of VHF communications" directed at the unlit ship from other vessels. We would make the point that such communications probably achieve nothing and may distract from watch-keeping duties. In areas such as the Gulf of Aden, the transmissions may attract the attention of the assailants who may well have VHF equipment.

AIS RECEIVER

Report Text: During a cruise to South Brittany it was noticed that AIS data was not being received from several ships sighted. A basic AIS receive-only set is fitted. The AIS antenna is a standard VHF antenna mounted on a short mast on the transom and 3 metres above sea level. All the vessels noted were 'within sight' between 6 and 0.5NM according to Radar, with the most distant having superstructure visible over the horizon and therefore its AIS antenna presumably in line-of-sight. Discussions with the manufacturer resulted in no explanation for this.

As an example, three large tankers either anchored or approaching the anchorage off the Loire did not show at all although several other vessels within a similar distance appeared on the screen. On another day during a Channel crossing, at least four ships of significant size and a tug towing a large barge failed to show although other vessels were received.

I feel it unlikely that all these vessels were failing in their duty to transmit AIS information and wonder whether low cost AIS receivers may be susceptible to installation problems where they work partially but do not receive all the transmission.

On return to port in the UK, the set was monitored whilst on my mooring and received transmissions from fourteen ships at anchor or in port. Five of the fourteen showed as 'steaming' although registering zero knots.

AIS receivers are a useful tool for slow sailing vessels crossing shipping lanes or other busy traffic areas where most of the shipping will be carrying AIS transceivers. Having speed and course data available makes the avoiding action or stand-on decision easier to make earlier.

Lessons Learned: Electronic aids to navigation are not totally reliable. Traditional methods must be kept up with and used in conjunction with modern technology!

CHIRP Comment: **We agree with the reporter that it is highly improbable that so many large vessels would have been failing to transmit AIS and therefore it appears that the problem lies in the AIS receiver and/or antenna on the yacht.**

AIS may provide additional information that enables the mariner to make a better interpretation of the traffic situation. However an AIS receiver should not be relied upon to detect other vessels in restricted visibility. There are two reasons for this:

First, not all vessels are required to transmit AIS. Fishing vessels and leisure craft are generally exempt, so an AIS receiver provides no warning of a potential collision with them.

Secondly, as this report illustrates, not all AIS receivers can be relied upon to detect signals with a high degree of reliability.

As to the vessels whose AIS indicates that they are underway when they are clearly at anchor or in port, there does appear to be a significant incidence of failure to input the correct data. This does probably not in itself pose a major danger to navigation but may nevertheless be interpreted as a symptom of less than meticulous attention to bridge procedures.

TUG AND YACHT

Report Text: I was motor-sailing within the limits of a harbour. I saw a vessel on a steady bearing on my port bow exhibiting a green sidelight plus a single steaming light. I stood on. When it became clear that the other vessel - whose size, other than that she was not a large ship, was indeterminate - had no intention of giving way, I swung thirty or forty degrees to port so that we could pass, 'green to green'.

This policy successfully avoided a collision. The other vessel appeared to continue as though I did not exist, passing fairly close to me and generating such an extreme wash that the deck of my vessel was literally swamped.

Immediately after the incident I ascertained by AIS that the vessel concerned was the tug XXXX. Her owners should be made aware of her conduct. Had my vessel been an open boat, she would have been swamped and very probably sunk.

Lessons Learned: I did all that was required of me by the Colregs. The tug took absolutely no notice of me, despite proper lights being exhibited. She was not constrained by her draught and had plenty of room for a proper manoeuvre. I appreciate that there will be emergencies from time to time to which such craft are obliged to respond, but even if this had been the case, she was not released from her duties under the Colregs. I suggest that tugs proceeding in the harbour leave earlier and travel at a speed consistent with their waterline length.

CHIRP Comment: **We contacted the manager of the tug who discussed the incident with the Master of the tug. Whilst this has not thrown light on the underlying reasons for the close-quarters situation, it did reveal that the tug operators believed that their vessel did not produce a large wash. Whilst the hull form of this modern class of tug may conceivably produce less wash than that of other high powered vessels, the report indicates that it was still sufficient to cause considerable concern to the yachtsman, and, as he says, could have been a major risk to a less robust craft.**

We note that the yacht, which was motor-sailing, altered course to port to avoid a collision with the yacht. Let's look at Rule 17 in full:

ACTION BY STAND-ON Vessel

(a) (i) Where one of two vessels is to keep out of the way the other shall keep her course and speed.

(ii) The latter vessel may however take action to avoid collision by her manoeuvre alone, as soon as it becomes apparent to her that the vessel required to keep out of the way is not taking appropriate action in accordance with these Rules.

(b) When, from any cause, the vessel required to keep her course and speed finds herself so close that collision cannot be avoided by the action of the give-way vessel alone, she shall take such action as will best aid to avoid collision.

(c) A power-driven vessel which takes action in a crossing situation in accordance with subparagraph (a)(ii) of this Rule to avoid collision with another power-driven vessel shall, if the circumstances of the case admit, not alter course to port for a vessel on her own port side.

(d) This Rule does not relieve the give-way vessel of her obligation to keep out of the way.

The risk in altering course to port is that if the give-way vessel belatedly alters course to starboard, the two vessels will be turning towards each other. The normal recommendation for evasive action by the stand-on vessel would be to slow or stop and/or to make a large alteration to starboard, if necessary though 180 or 360°.

CLOSE ENCOUNTER IN FOG

Report Text: I am master of a trailing hopper Suction Dredger. On the morning of the incident I was dredging for sand in a dredging area in thick fog. At approximately 0800 the OOW reported a target on radar at a distance of 5 miles on a course of 030T making 9 knots. The CPA of the vessel was shown as 0.1 nm. At this time I was at the end of my southerly run and was in the process of turning to starboard for the run back to the north. My course on the run north was 340T and a speed over the ground of 1.2 knots. My track was approximately 358t owing to the ebb tide. Myself and the OOW continued monitoring the approaching target having identified the vessel as 'XXXX'. At a distance of 3 miles I attempted to contact the vessel to ask for a clearance of at least 0.5 nm and also to inform him of my operation. Despite

making several attempts on Channel 16 there was no response. At this point the CPA of XXXX was still 0.1 nm indicating he would pass under my stern. I was not comfortable with this distance so I decided to abort the dredging operation and lift the pipe clear of the seabed and increase speed with an alteration of course to port of approximately 20°. At the time I was six cables from a navigation buoy. XXXX passed between my vessel and the buoy at a distance of two cables from my vessel. I did attempt to contact him again after he had passed clear but again there was no response. Visibility throughout the incident was less than one cable.

CHIRP Comment: **We forwarded this report, without disclosing the identity of the dredger, to the manager of the coaster, who, in turn, followed it up with the master. Whilst the response did not reveal the underlying causes for this close encounter in thick fog, it hopefully served a purpose in letting this master know that his contraventions of the ColRegs had been noted.**

POSITIVE OUTCOME

Report Text: We were sailing in our yacht on a broad reach on a port tack. It was mid-afternoon. There were 4 adults and 2 children onboard, all wearing life jackets. We had two reefs in the main and about 50% of the genoa. A commercial vessel was approaching from abaft our port beam. We were converging and I assumed that she would give us a wide berth. However she continued on a collision course and made no attempt to stay clear of us. We stood on until she was about 100m away and was clearly going to run us down. To avoid collision, we crash gybed and the vessel passed down our port side. A member of the crew was seen to run across to the starboard side of the bridge. Without our quick action we would have been run down. Members of my crew were visibly shaken. I tried calling her on channel 16 but received no reply. I reported the incident to the coastguard.

CHIRP Comment: **We sent a copy of this report to the manager of the vessel who followed it up with the Master. The response was very open, with full acknowledgment that the ferry should have kept clear of the yacht. The Master himself and the company have reviewed their bridge procedures to apply the lessons learned. The company is implementing a programme of bridge team management courses. Both have apologised to the yachtsman for the anxiety caused. This has been accepted by the yachtsman.**

This is a good example of the value of near-miss reporting. The yachtsman was very helpful in submitting a report, the company acted responsibly in following it up, and the Master of the ferry and his company have taken appropriate remedial action. We thank them all for this.

ACTION ON FISHING POT HAZARDS

Report Text: While on passage from Yarmouth (IOW) to Southampton, my sailing boat became caught by a fishing pot line.

In an area known to contain 'pot floats' the Mate and I were keeping a good lookout for pot markers. One marked by a 'flagless pole' had been noted but generally the area seemed to be free of floats. We were proceeding at about 5.6 knots under power and autopilot when I saw a small white fender in the water just dead ahead. (I first saw it through the pulpit, so it must have been about 3 to 4 metres ahead of our bow). I immediately selected neutral to stop the prop, but there was no time to change heading. I allowed the boat to stop and it became apparent that we had fouled the line. At this point I dropped anchor, switched on the anchor light, stopped the engine and then checked that I could rotate the prop shaft by hand, indicating that the rope was not around the propeller. I informed Southampton VTS of our position, which was now just inside the Thorn Channel, and told them that I would keep them informed. I could see the line out on the port quarter, so used my dinghy grapnel anchor to haul the line to the surface, by which time I had been joined by several yachts with whom we had been travelling in company. Having hauled in sufficient line to provide slack, I attached the end nearest the boat to my aft pulpit and cut the seaward end of the 20mm line free using a diver's knife kept in the cockpit. A friend launched his dinghy and pulled the fender clear of my rudder and we were now free. Having checked the steering for full and free movement and the engine in ahead and astern, we weighed anchor, extinguished our anchor light, informed VTS and continued to Southampton.

CHIRP Comment: **Whilst this report initially appears similar to many we receive, there is an interesting development. We have learned that the Harbour Authority has authorised its craft to remove fishing gear that has been improperly marked or laid. Other Authorities may wish to consider similar action.**

TOO FAST, TOO CLOSE

Report Text: My yacht was anchored in about 4 metres off an island off the West coast of Scotland. A French yacht was anchored about 100 metres. south of us. As we prepared to weigh anchor I spotted a motor boat coming towards us from the north, obviously at speed. We weighed anchor and, as my crew stowed it, I motored at about 2 knots heading approximately North. The motor boat still appeared to be coming straight at us: longer inspection made me believe that she was going to just clear us to starboard, but much too close for comfort.

The boat subsequently cleared us by about 30 metres, and the French boat by less, with no noticeable reduction in the speed, which I would put,

at a very rough guess, as about 20 knots. Immediately she passed I turned into the wash and my crew later reported that the resulting pitch put our bow roller well under water. The French yacht was left rolling like a metronome. We hadn't spotted the motor boat's name, but the company's name was painted prominently on her side.

Lessons Learned:

1. Although visibility was good, before weighing anchor I should probably have made a VHF call to advise the motor boat that she was currently heading towards two anchored yachts and an inflatable dinghy.
2. It might have been better to remain at anchor until the motor boat had passed since (a) this would have clarified the need for her to take avoiding action, and (b) this would have eliminated the risk that a delayed anchor recovery, e.g. a need to clear weed, could, in the worst scenario, have seen us breaking free just as the motor boat arrived.

CHIRP Comment: **We contacted the company that owned the motor boat. They advised that they had reinforced their guidance to their skippers to avoid such close quarters situations at speed and apologised for the anxiety caused. As in a previous report in this newsletter, we compliment the yachtsman for having reported the incident and the company for having followed it up responsibly.**

REPORTS FROM SHIP MANAGERS

CHIRP Narrative: **Ship managers with well established safety management systems typically have their own in-house near miss reporting schemes. Often such reports would be of interest to the wider maritime community. *CHIRP* is pleased to receive and publish these. We respect the confidentiality of the reporters and do not disclose identities of ships.**

INJURED IN BAD WEATHER

Report Summary: A vessel had arrived off port in the morning and anchored. The next morning, the weather had worsened, with wind force 8, and the anchor was dragging. The Chief Officer went forward to weigh anchor. However, the locking pin for the anchor cable stopper bar was found to be stuck and, as a result, the anchor cable could not be heaved up.

The Chief Engineer went to the forecastle. While he was there, a sudden wave hit the area. He held onto a lashing wire but the force of the wave was so strong that his lower part was lifted by the water and hit against the anchor roller foundation. He suffered multiple fractures of the hip region.

Root Causes: There was no indication of any previous problem with the locking pin. Apparently the pin bent as a result of the severe jerks and load that came on the anchor cable stopper during the bad weather. An earlier response to the worsening weather would have avoided this and the need for people to go forward in such conditions.

Preventive action:

- **Maintain windlass and machinery in efficient condition so that people are not exposed unnecessarily, particularly in unfavourable weather conditions.**
- **Weather forecasts to be closely monitored.**
- **Vessel to be moved to safe position before weather worsens.**
- **If it is necessary for people to go forward, the vessel should be turned insofar as possible to provide some shelter for them. Proper personal protective equipment, including harnesses, should be worn.**
- **Carry out a risk assessment before working on deck in bad weather.**

CHIRP Comment: **We thank the company for sharing this report. The risk to people working on deck in bad weather has been highlighted by a number of fatal accidents investigated by the MAIB. We reinforce the company's observation that early action is needed prior to the onset of heavy weather so that, if possible, personnel do not need to go on deck in adverse conditions. If, however, that does become necessary, it is essential to review the specific hazards to personnel and what preventive action will be carried out to mitigate the risks. Assessing the risks, both formally and dynamically is a fundamental tool of safety management.**

CORRESPONDENCE

CHIRP **welcomes correspondence about the reports we publish. We reserve the right to summarise letters received. We apply the same rules as for reports, i.e. although you must provide your name, we do not disclose it.**

BATTERIES (1)

Correspondence: A colleague here has brought the report concerning a battery explosion to my attention.(MARITIME FEEDBACK No 20). My company is a specialist battery supplier and has supplied the marine industry for many years. For marine applications we recommend the use of AGM batteries - absorbed glass mat or re-combination - as these will gas significantly less when charging compared to the "wet" batteries used by that unfortunate mariner. The charging process will cause hydrogen and oxygen to vaporise out of the sulphuric acid electrolyte. The AGM batteries are sealed, with a valve to release gases under more extreme conditions, whilst wet batteries require the loosening of the cell caps. Both hydrogen and oxygen are highly explosive, odourless and invisible and therefore most dangerous if not adequately vented. Unfortunately the AGM batteries are relatively expensive when compared with standard "wet" batteries but do have a good working life, and

are maintenance-free, and therefore the actual cost of ownership over time is more favourably comparable. Used correctly, they can also be mounted on a side or end to fit tight compartments.

(2)

Report Text: MARITIME FEEDBACK No 20 includes details of an explosion on a yacht due to battery gas exploding and causing extensive damage. Similar explosions have started fires which have burnt boats to the waterline. Lead-acid batteries can give off a highly explosive hydrogen-oxygen mixture if they are over-charged, eg due to a regulator failing (that's happened to me).

It should be more widely known that a standard gas detector will detect hydrogen well before the danger level is reached. If you are fitting a gas detector, consider fitting a dual head, with one head sited at the top of the compartment as hydrogen rises). Also consider fitting forced ventilation: a 12v computer fan, switched on when the batteries are charging (from the alternator or shore power) as it is easy to install and may save your life and your boat.

BOOM PREVENTER

Report Text: Comment to your report in MARITIME FEEDBACK No 20 entitled "Human Boom Preventer".

The major problem with just supplying a length of rope as a boom preventer is its awkwardness to fit, especially in the heat of a race. These preventers are rarely if ever pre-rigged, indeed it is awkward to do so!

This inconvenience is the major reason why the preventers are never used. A more convenient system is to have the preventer in two parts.

One part is a rope secured permanently to the outboard end of the boom, with the other end of the rope clipped temporarily at the inboard end, e.g. to the kicker fitting. The other part of the preventer is a rope led forward to a block on the gunwale, then back to the cockpit.

To rig it is then easy to unclip the first part from the boom and re-clip to the gunwale-rigged line and tighten as required.

CHIRP Comment: **We thank all of the correspondents for their suggestions.**

CULTURES OF SAFETY

Report Text: I am writing in response to the report in MARITIME FEEDBACK Issue No 19, entitled 'Medical Indisposition'.

I have been a Chief Engineer at sea for many years. In all these years I have sailed under many superintendents of different nationalities. In my experience most of the superintendents remember the ISM Code only when convenient to them or when some discrepancy is pointed out to them by auditors. There are very few superintendents who are willing to stand up to the commercial pressures and side with the Captain and say "I fully support you in your decision to delay the ship's sailing because you have to take rest to comply with the ISM Code" And if the concerned superintendent is not one of those few enlightened persons; then it is a most sure way of getting relieved at the earliest, even with tight availability of officers.

I can give many examples from my personal experience. But will mention only two of them. In one instance we had a main engine breakdown at anchorage and were working round the clock so as not to miss the berthing schedule. After 20 hours of continuous working, the superintendent said to me "Chief, stop the work and everybody get some sleep for six hours and continue work after that. Don't worry about missing the berthing schedule. I will take care of it." No doubt that boosted the morale of the staff and after the short break, guys were back on the job with a lot of enthusiasm.

Another incident: Again at anchor and we had a breakdown with the windlass. It was only one day's sailing to the next port and four days to the berth as per schedule. We worked around the clock for 36 hours, with a small break of three hours. When the problem was fixed, the superintendent said, "Heave up the anchor and proceed to the next port immediately. "I suggested that since guys were tired and since there was more than two days to the berth at the next port, with one days sailing, we should take a break of six hours before starting the engine for sailing. The reply was a terse, "Heave up the anchor now and proceed to sea. If you want to take rest you can stop and drift when the ship is at sea."

These are two extreme examples, in the same company, but different superintendents.

CHIRP Comment: **The response of a ship manager to a fatigue issue provides a good test of the culture of safety in a company. A good response from a superintendent to a Captain in situations such as those described in this letter would be: "I fully support the delay to the ship. We certainly don't want to be carrying out safety-critical operations if the key people are fatigued."**

If you are a senior manager, are you confident that all your superintendents will consistently give priority to safety over commercial considerations? Do you have safety management procedures that reinforce this?

If you are a seafarer and are under pressure to do something that may compromise safety, then ideally you should feel able to discuss this with a senior officer or with the company's Designated Person. If not, please do contact *CHIRP*. We will follow it up in such a way that the confidentiality of the report is maintained and your identity is not disclosed.

MAIB 24 hr Telephone No:
02380 232527

CHIRP

MARITIME REPORT FORM

CHIRP is totally independent of the MCA and any organisation in the maritime sector

Name:

Address:

Post Code: Tel:

e-mail:

▙ Indicates Mandatory Fields

1. Your personal details are required only to enable us to contact you for further details about any part of your report. Please do not submit anonymous reports.
2. On closing, this Report Form will be returned to you.
   NO RECORD OF YOUR NAME AND ADDRESS WILL BE KEPT
3. **CHIRP** is a reporting programme for safety-related issues. We regret we are unable to accept reports that relate to industrial relations issues.

It is CHIRP policy to acknowledge a report on receipt and then to provide a comprehensive closing response, if required. If you do not require a closing response please tick the box:

No. I do not require a response from CHIRP ☐

If your report relates to non-compliance by another vessel with regulations, for example the International Regulations for Preventing Collisions at Sea, CHIRP generally endeavours, when appropriate, to follow this up with the owner or manager of that vessel, unless you advise otherwise. The identity of the reporter is never disclosed.

No. You do not have my permission to contact a third party ☐

If your report relates to safety issues that may apply generally to seafarers, it may be considered for publication in MARITIME FEEDBACK unless you advise otherwise. Reports may be summarised. The name of the reporter, the names of vessels and/or other identifying information are not disclosed.

No. Please do not publish in MARITIME FEEDBACK. ☐

PLEASE COMPLETE RELEVANT INFORMATION ABOUT THE EVENT/SITUATION

YOURSELF - CREW POSITION

MASTER	☐	NAVIGATING OFFICER	☐
CHIEF ENGINEER	☐	ENGINEER OFFICER	☐
DECK RATING	☐	ENGINE RATING	☐
CATERING	☐	OTHER (HOTEL, ETC)	

THE VESSEL:

TYPE (TANKER, BULK CARRIER, PASSENGER, ETC)		
YEAR OF BUILD / GT		
FLAG / CLASS		
NAME OF VESSEL:		

EXPERIENCE / QUALIFICATION

TOTAL YEARS	YRS
YEARS ON TYPE	YRS
CERTIFICATE GRADE	

PEC ☐ YES ☐ NO ☐ NA

OTHER QUALIFICATIONS:

THE INCIDENT

DATE OF INCIDENT		AT SEA ☐	IN PORT ☐
TIME	LOCAL/GMT	DAY ☐	NIGHT ☐
VESSEL LOCATION		HOURS ON DUTY BEFORE INCIDENT (IN PREVIOUS 24 HRS):	

TYPE OF VOYAGE

OCEAN PASSAGE	☐	COASTAL	☐
INLAND WATERWAY	☐	OTHER	☐

TYPE OF OPERATION

COMMERCIAL TRANSPORT	☐	OFFSHORE	☐
FISHING	☐	LEISURE	☐

WEATHER

WIND FORCE		DIRECTION	
SEA HEIGHT		DIRECTION	
SWELL HEIGHT		DIRECTION	
VISIBILITY		RAIN	☐
FOG	☐	SNOW	☐

VOYAGE PHASE

PRE-DEPARTURE	☐	ARRIVAL / PILOTAGE	☐
UNMOORING	☐	MOORING	☐
DEPARTURE / PILOTAGE	☐	LOADING	☐
TRANSIT	☐	DISCHARGING	☐
PRE-ARRIVAL	☐	OTHER (SPECIFY IN TEXT)	☐

THE COMPANY

NAME OF COMPANY:	TEL:
DESIGNATED PERSON ASHORE (OR CONTACT PERSON):	FAX:

DESCRIPTION OF EVENT - PHOTOGRAPHS, DIAGRAMS AND/OR ELECTRONIC PLOTS ON A CD ARE WELCOME:

Your narrative will be reviewed by a member of the **CHIRP** staff who will remove all information such as dates/locations/names that might identify you. Bear in mind the following topics when preparing your narrative:

Chain of events • Communication • Decision Making • Equipment • Situational Awareness • Weather • Task Allocation • Teamwork • Training • Sleep Patterns

continue on a separate sheet of paper, if necessary

PLEASE PLACE THE COMPLETED REPORT FORM, WITH ADDITIONAL PAGES IF REQUIRED, IN A SEALED ENVELOPE (no stamp required) AND SEND TO:

CHIRP • FREEPOST (GI3439) • Building Y20E • Room G15 • Cody Technology Park • Ively Road • Farnborough • GU14 0BR • UK

Confidential Tel (24 hrs): +44 (0) 1252 393348 or **Free***fone* (UK only) 0808 100 3237 and Confidential Fax: +44 (0) 1252 394290

Report forms are also available on the **CHIRP** website: **www.chirp.co.uk**

For market research purposes, where did you obtain this report form?: