

Editorial

In our last edition we announced the publication of Maritime FEEDBACK in Potunghua, this is now available to download from our website, and asked if anyone would like to sponsor a Tagalog version. There has been some interest in the idea, so we are hoping to secure sponsorship in the near future. Meantime, we would be delighted to receive your suggestions for other languages you would like to have available.

At CHIRP Maritime, we are always aware that we would not be able to function without our sponsors and our reporters, and once again our reporters have provided a wide variety of incidents for you to read and learn from.

There has been a lot of publicity about armed robbery from ships at anchor or waiting outside ports in the Far East, and we start with a classic example. Fortunately the crew were alert, and the incident was resolved effectively without loss or injury. We also feature cases about gangways, accommodation ladders and safe access, where

the responsible people were distracted at critical moments. This underlines the need for proper risk management and effective communication at all times.

Poor design of a newbuilding features again, as do some fishing boats which failed to treat the COLREGS with the respect they deserve.

We also include a number of short reports which were properly resolved on board, but we show how they might be analysed using the 'Deadly Dozen' for a deeper understanding of the underlying causes.

In the machinery spaces, incinerators feature prominently and we examine a case where a rating was expected to work alone at night in an Unmanned Machinery Space.

We also describe how we supported local fishermen who thought port safety was being compromised, and were prepared to stand up for what they believed.

There are lessons here for almost everyone, and we thank all the people who sent us their reports.

REPORTS ...

Attempted Armed Robbery

OUTLINE: A report where fishing vessels distract the crew at the stern of a vessel whilst others try to board from the bow.



Fisherman or pirate? One of the vessels involved in the incident

What the Reporter told us:

This incident occurred whilst the vessel was drifting outside port limits off a port in Vietnam. The crew noticed four fishing boats approaching the vessel, two from astern and two from the port bow. The vessels approaching from astern asked the duty crew if we have any scrap items on board.

The Officer of the Watch believed that the two fishing boats astern were a distraction and the fishing boats forward might be suspicious. The Bosun was requested to check the forward end of the vessel carefully. Five pirates armed with

knives boarded the vessel from the fishing boats on the bow, and tried to gain access to the forecabin by breaking the padlock. From a safe distance, the Bosun spotted the armed robbers and informed the bridge.

The Officer of the Watch activated the general alarm and informed the Master. Hearing the general alarm, the pirates fled, jumped overboard, boarded the fishing vessels and left the scene. The crew mustered in response to the general alarm and all personnel were accounted for. Investigation later revealed that nothing had been stolen.

Subsequently the Master informed the local VTS but received no response. In addition, the vessel informed IMB Kuala Lumpur, C.S.O, Alternative C.S.O, vessel's operator, charterers and local agents. The incident will be discussed at the next Company HSE Committee meeting.

CHIRP Comment

The Maritime Advisory Board commented that this report reinforces the need for ships' crews to ensure they have a security plan in place, and they each know their role as listed in the plan. The plan should not be generic but be tailored to suit the circumstances for the area of the world they are in. This could involve ISPS compliance, Best Management Practices, and intelligence-based reports of any security related activity that warrants defensive measures in a particular area. The incident as reported is similar to many attempted robberies in the Far East, but we have also seen similar reports coming from South America, the Caribbean, and East Africa.

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SUBMIT A REPORT –

CHIRP always protects the identity of our reporters. We are a confidential programme and, as such, we only keep reporters personal details for as long as we need to keep in contact with them.

ONLINE

Reports can be submitted online, through our secure encrypted online form.

<https://www.chirpmaritime.org/submit-a-report/>

BY EMAIL

Reports can be submitted online, through our secure encrypted online form.

reports@chirp.co.uk

A SAFE Means of Access

OUTLINE: CHIRP has received several reports related to means of access – wire failures, falling overboard and design issues are all discussed below.

What the Reporter told us (1):

A vessel was simultaneously engaged in a helicopter operation to disembark a pilot, and a launch service operation to disembark a cargo surveyor via the amidships accommodation ladder. While the boat approached the cargo surveyor, together with the pumpman who went down to assist, stood near the lower platform of the ladder. The vessel was underway at the time and the ladder faced aft. With the prevailing sea and swell, the launch was pitching heavily and decided to manoeuvre astern to approach the ladder. The launch struck the lower platform of the accommodation ladder heavily, breaking the ladder wire. The cargo surveyor and pumpman fell overboard, and were rescued from the water by the launch. They were extremely lucky to avoid any injury.

What went wrong?

- There was inadequate situational awareness – the vessel was doing two operations simultaneously. In the first operation, a pilot was being disembarked by helicopter and in the second a cargo surveyor was leaving from the accommodation ladder via a launch.
- The vessel had adjusted course to keep the wind on her bow as per the helicopter's requirement. As the helicopter had not arrived, it was decided to disembark the surveyor first by launch. However, with the prevailing course of the vessel the launch did not have a good lee from sea and swell, causing excessive pitching, and with her astern manoeuvre she had inadequate control.
- There was an inadequate on-site risk assessment and inadequate Personal Protective Equipment (PPE). Both men went down the ladder and stood near the lower platform instead of waiting at the top, despite the unsafe approach of the launch in the prevailing circumstances. A safety harness was not used before going over the side onto the accommodation ladder.
- The disembarkation procedure was inadequate. Only the accommodation ladder was used for disembarking the surveyor instead of using a combination, i.e. pilot ladder rigged together with the accommodation ladder. The use of just the accommodation ladder posed a hazard for the safe approach of the boat, while the vessel was underway at sea.

CHIRP Comment

Having discussed this report, the Maritime Advisory Board commented that, in addition to what went wrong above, when a ship is conducting simultaneous operations both should be subject to risk assessment. The results of each assessment should be compared, since the results of one may have an impact on the work of the other. In this case, the requirement for the vessel to steer in a certain direction for the helicopter, as per the ICS Guide to Helicopter/Ship Operations 4th Edition, meant that the lee

was inadequate to support a safe launch disembarkation. An intervention on safety grounds by any crew member might have prevented the incident, as would the rigging of a combination ladder.

CHIRP also notes that there is a need for personnel to have received basic training in the use and hazards of different types of ladder prior to being faced with such operations. In addition, whilst rigging a ladder should involve a safety harness, the use of a harness at the boarding platform is inappropriate and potentially dangerous. Wearing a lifejacket, however, is a **MUST!**

There are far too many cases where this type of incident, coupled with a lack of any flotation aid, has had a far more serious outcome. Whilst the [MAIB lifejacket review](#) recommends legislation that all fishermen must wear lifejackets, the safety lessons identified in the review can apply to the whole of the maritime sector.

What the Reporter told us (2)

Having completed mooring operations, and with the vessel safely berthed, the crew commenced to deploy the starboard accommodation ladder. The ladder was moved outboard via its winch from the stowed position. When the crew started lowering the ladder by winch, the wire rope parted at a distance of about 1.8 metres from the permanent connection of the ladder davit. As a result, the ladder dropped freely into the sea. It remained connected to the vessel by the two bolts/pins, with the lower platform in an almost vertical position. There was no personnel injury. The accommodation ladder was recovered and the wire end for ended. It was two and half years old. Replacement wires were ordered for both ladders on board.

CHIRP Comment

The Maritime Advisory Board noted that the regulations regarding the construction, maintenance, inspection and survey of accommodation ladders and gangways are governed by SOLAS II-1 Regulation 3.9. The associated guidelines for these requirements are detailed in [MSC.1 Circ1331](#).

Inspections should be recorded in the ship's Planned Maintenance System (PMS), with individual check lists for inspection of the wires and checking 'pinch points' where the wires turn around the sheaves in the stowed position. The PMS should include all maintenance as recommended by the manufacturer. It was also highlighted that in this case there was a danger that a shock load had been placed upon the bolts/pins in the platform due to the failure of the wire and that they should be thoroughly inspected prior to the ladder being brought back into service. In addition [West of England P&I Club – Gangways and Accommodation Ladders](#) give some useful advice.

What the Reporter told us (3)

On a newly built vessel, mooring had been completed and the ship's gangway was being rigged to provide access to the shore. Whilst rigging, it was found that the ship's portable ladder, (bulwark ladder), did not fit properly on the ships side railings so it did not provide safe access to the vessel. Given the potential for personnel injury, it was obvious that the

portable ladder was incorrectly supplied by the shipyard.

The means of access to a ship should be safe, and may consist of an appropriate gangway or accommodation ladder with a properly secured safety net fitted. Particular attention to safe access should be given where there is a large height difference between the point of access to the ship and the jetty. When terminal access facilities are not available and a ship's gangway / ladder is used, there should be an adequate landing area on the berth so as to provide the gangway or accommodation ladder with a sufficient clear run of space to maintain safe and convenient access to the ship at all states of tide and changes in the ship's freeboard.

CHIRP Comment

This report reveals there are still newly built ships using poor design features that have not been challenged by ship owners and those approving plans e.g. Classification Societies. Who had oversight of equipment supply in the yard? Was it inspected and rigged before hand-over? Clearly not!

It is highlighted that the danger as reported is at the interface between the bulwark and the ladder, and that personnel must be able to safely transition between the two.

----- REPORT ENDS

Keeping an effective gangway watch – ISPS Code violation

OUTLINE: A report from a company where a ship's accommodation ladder submerged when left unattended. Officials trying to board were not impressed.

What the Reporter told us:

A vessel was starboard side alongside in port and had completed loading operations. The crew were busy preparing for a draft survey, cleaning hatch coamings and making other departure preparations. With no other available manpower, the duty AB on gangway watch left his station to attend to ship's moorings and did not heave the accommodation ladder prior to leaving the site. When the Draft Surveyor tried to board the vessel from the sea side accommodation ladder (port side), he found that it was immersed in the water.

Gangways and accommodation ladders are to be attended/monitored by a watchkeeper at all times. Should the watchkeeper need to attend another job, he should inform the officer of watch and be relieved appropriately. The accommodation ladder should not be left lowered close to the water when unattended. Additional crew should be called if required.

In this case, the AB should have heaved up the accommodation ladder well above water when leaving the site, since no one else was available to help.

CHIRP Comment

The Maritime Advisory Board commented that this was primarily a potential ISPS Code violation as opposed to a

safety issue. Apart from any possible mechanical failure, the ladder must have become immersed earlier during the loading and had not been effectively tended. At some point the ladder would have been in a position for anybody to board, without the knowledge of the crew. Many ports are extremely strict, and may issue fines for the poor control of ship's access. It is also highlighted that salt water immersion may result in accelerated corrosion of the equipment.

----- REPORT ENDS

More Issues Related to Pilot Boarding

OUTLINE: CHIRP continues to receive plenty of thought-provoking reports related to pilot boarding, and the following two reports are indicative of the problems being faced. In the first report, a new build vessel was not constructed in compliance with SOLAS, and in the second the pilot ladder was simply dangerous.

What the Reporter told us:

The attached picture is of a new build container ship 333m x 48m, constructed at a shipyard in the Far East. She arrived in Port "A" fully loaded, but when she sailed in light condition the pilot could not disembark because of the cut-away at the quarter. In light condition, the last meter of the ladder was not flush with the side of the hull and the pilot boat would have been forced to operate under the counter. The vessel was requested to ballast the ship down to enable the pilot to disembark safely.

For a new build vessel, this is obviously a design issue and CHIRP is requested to contact ship managers, the shipyard of build, and the vessel's Classification Society for comment.



The pilot door not lying within the parallel mid-body in light condition

What the Third Party told us (1)

CHIRP wrote to the DPA of the company in question, and also to the General Manager of the shipyard. Approaches to the local office of the vessel's Classification Society received no response, and the shipyard declined to reply. The Company, however, responded with a thorough appraisal as follows;

This is the first of a group of 5 new built vessels under our management. The fifth and final vessel will be delivered to us within the next few weeks. The current pilot boarding arrangement is definitely a design failure that was not

recognized before and during the building phase. We only became aware that at certain loading conditions the lower part of the pilot ladder would be left aft of the parallel body, imposing obvious hazards, after we took delivery of the vessel.

It goes without saying that, following a risk assessment and having also consulted the Classification Society and the designers, we took immediate measures to remedy this shortcoming. For the last vessel to be delivered, we altered the design and effected immediate structural modifications. For the four vessels already delivered to us and currently in service, we will alter the boarding arrangement to a combination ladder, using the accommodation ladder and a suitable pilot ladder, so that it will comply with SOLAS Regulation V/23 and IMO Resolution A.1045(27) requirements.

To resolve the issue we discussed possible alternatives with the shipbuilder and agreed to modify the vessels by adding a secondary means for pilot boarding. This involves installation of an additional pilot ladder to be used in conjunction with the existing accommodation ladder. The main features of the modification are;

- The secondary means of pilot transfer shall be used in case of draughts lighter than 11.609 metres. For drafts deeper than 11.609 metres, the existing primary pilot ladder with pilot door will be used, which is approved by the International Marine Pilots Association, (IMPA), and the Panama Canal Authorities;
- The additional pilot ladder will be fitted in way of Frame 81+600, by means of suitable eye plates (not a reel). This is within the parallel mid-body of the ship and within the midship half-length of the ship;
- The additional pilot ladder will be secured to the ship's hull by means of Class-approved securing fittings, (magnetic and detachable type), and all steps shall rest firmly against the ship's side;
- The additional pilot ladder shall be transported from its stowage position and shall be launched by means of suitable davits and messenger ropes; and
- The modification described above will be implemented on the last sister vessel before her departure from the building yard, while the previous sister vessels have already been, or will be, supplied with the required equipment and materials that will enable the crew onboard to carry out and complete the modification work.

Our next sister vessel to call at Port A, also on her maiden voyage, will be the xxx. Since this will be her first port, we have arranged for the vessel to arrive at the pilot embarkation point with a draft such that the existing pilot ladder will be safely resting against the side. At her next port, the pilot embarkation point will be changed. The vessel's Classification Society will be called in to verify, document and approve the new arrangement.

CHIRP Comment

The Maritime Advisory Board discussed the excellent response from the shipping company, commenting that they instructed the shipyard building their new ships to change the design and thereby remove the design fault once it was discovered.

A comment was made on the potential problems that can be caused by ballast water management and the ship's crew trying to minimise the changing of ballast at

sea, sailing with minimum ballast on a light draft and the possible impact on the positioning of the pilot access points.

It was also mentioned that this report highlights failings within the actual design and approval Quality Assurance process by the yard, Class and Flag State. In this respect, the International Marine Pilots Association, (IMPA), gives [Guidance For Naval Architects](#) which is a useful resource to help ensure that this type of incident does not occur.

What the reporter told us (2)

Upon boarding a vessel to pilot her to the berth, the following defects on the pilot ladder arrangement were noted;

- The man ropes had eye splices in the lower ends.
- The lower spreader of the pilot ladder was bowed.
- Several steps were loose.

It was additionally noted that the command of English on the bridge of this vessel was very poor, so effectively describing the problems that had been noted was extremely difficult.

CHIRP Comment

Having discussed this report the Maritime Advisory Board agreed that the description of the ladder made it extremely hazardous and that it did not comply with SOLAS V regulation 23, a section of which is shown below.

2. General

- 2.1 *All arrangements used for pilot transfer shall efficiently fulfil their purpose of enabling pilots to embark and disembark safely. The appliances shall be kept clean, properly maintained and stowed and shall be regularly inspected to ensure that they are safe to use. They shall be used solely for the embarkation and disembarkation of personnel.*
- 2.2 *The rigging of the pilot transfer arrangements and the embarkation of a pilot shall be supervised by a responsible officer having means of communication with the navigation bridge who shall also arrange for the escort of the pilot by a safe route to and from the navigation bridge. Personnel engaged in rigging and operating any mechanical equipment shall be instructed in the safe procedures to be adopted and the equipment shall be tested prior to use.*

In addition, the Board commented that from the description given, the man ropes would appear to have been rigged upside down. If so, this raises the question of who is checking the safe rigging of the pilot ladder before use? The regulations are clear, and any contravention simply endangers life.

It should be noted that all references in these two reports, [SOLAS V Regulation 23](#), [IMO Resolution A.1045\(27\)](#), [Guidance For Naval Architects](#), and [IMPA Boarding Arrangements](#) are available on the [CHIRP Maritime website](#) on the Publications page.

It is also appropriate to remind readers that such contraventions should be reported as soon as possible to Port State inspectors to enable appropriate action to be taken. The United Kingdom Marine Pilots Association, (UKMPA), have a facility on their web site to [report non-compliance](#). This may be adapted for use by anyone.

----- REPORT ENDS

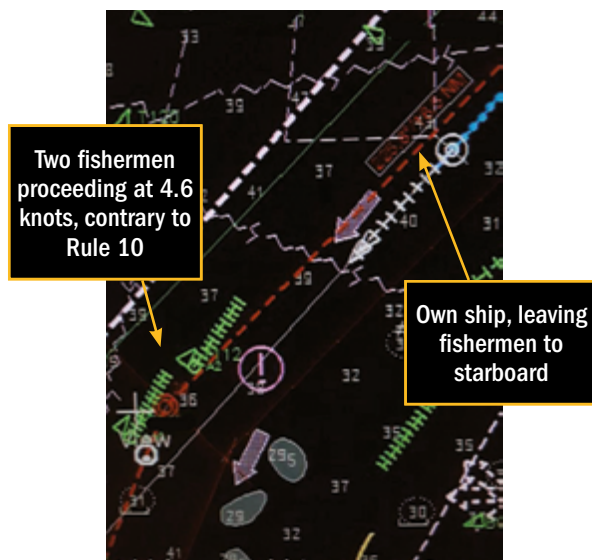
Fishing Vessels and Traffic Separation Schemes

OUTLINE: A report of fishing vessels contravening Rule 10 in the vicinity of the Foxtrot 3 buoy in the Dover Straits.

What the Reporter told us:

At least five fishing vessels were noted to be contravening Rule 10 in the English Channel. The vessels were in radar range of Dover Coast Guard/CROSS Gris Nez Traffic, but none of the fishing vessels were called by either station. I have observed this numerous times, and have seen many vessels get into difficult situations with fishing boats behaving in this way. At no point were any fishing vessels spoken to by either observing station during the course of my four hour watch.

The reporter additionally stated the belief that more awareness from Coast Stations and a stronger stance on COLREGS in places such as the English Channel is required, to ensure that there are no collisions caused by the behaviour of these fishing vessels.



ECDIS Display of fishermen contravening Rule 10 in the vicinity of F3 buoy.

Further dialogue with the reporter determined that tidal streams were against own ship for the transit and that the fishermen were showing a speed over the ground of 4.6 knots. CHIRP agreed to discuss the matter further with Dover Channel Navigation Information Service, and national fisheries organisations.

What the Third Party told us

Dover Coastguard responded as follows

“We at Dover Coastguard endeavour to ensure full compliance with the collision regulations by all vessels using the Traffic Separation Scheme, and a report and follow up action is always completed on any vessel found to be contravening the regulations, or going against recommended routing.

I will be looking back at the recordings for this incident to get a better understanding of it and any follow up action that came from it. If there is any requirement for awareness I will

ensure this is promulgated to our teams. However, it may be useful to mention that a vessel in this situation may report a breach of Collision Regulations to the Coastguard and can also do the same within French territorial waters to CROSS Gris Nez, this would then form a hazardous incident report which has a specific investigation procedure associated with it and can be useful to us to ensure effectiveness of the traffic lanes and maritime safety”.

The National Federation of Fishermen’s Organisations advised that the lack of enforcement in the TSS on the French side and even for foreign fishing vessels in the UK side is well known. It is typical for Dover to contact vessels to give them a warning and the UK fishing vessels tend to react immediately but vessels of other nationalities tend to disregard the warnings. This is an observation rather than a criticism, but without an even-handed approach towards all vessels it is only encouraging the good vessels to do bad. It is also highlighted that sometimes tidal streams can affect the speed or drift of fishing vessels and they may not realise they are already within the TSS. They should monitor their position regularly.

CHIRP Comment

Having discussed the report, the Maritime Advisory Board commented that there is obviously an issue to be resolved, and took the unusual step of agreeing that the location of the report be identified in order for the safety lessons to be promulgated accurately.

Another factor for readers to be aware of is the widespread use of rotating amber lights by fishermen in addition to the lights required by COLREGS. This is often confusing and leads to vessels giving way when they may not be required to do so - hence their popularity with fishing vessels.

Should you find yourself in a position where fishermen are contravening Rule 10 in the Dover Straits, then **CHIRP** advice is to report this to Dover Coast Guard / CROSS Gris Nez as appropriate in order for them to create a hazardous incident report and launch an investigation.

----- *REPORT ENDS*

Loss of night watchmen in a harbour

OUTLINE: A report of a Port Authority’s commercial decision which failed to address safety concerns.

What the Reporter told us:

I am contacting you over our Port Authority’s decision to stop the night watchman service for our port. The Authority decided it needed to save money in the harbour budget so it decided to discontinue the harbour night watchmen service, thus leaving the commercial harbour with no VHF coverage from the hours of 1700 hours to 0800 hours the following morning. This is a very important service, as it is a difficult harbour to enter with a long narrow channel then a ninety degree turn to port to gain entry - only one boat can enter the harbour at a time. One of the roles of the watchman is

to catch a rope at the end of the harbour channel and place it upon a bollard to enable a vessel to effectively manoeuvre around the ninety-degree bend in the channel and into the harbour. Without this service, we fishermen feel it is too dangerous to jump from a moving boat onto a pier to put a rope onto a bollard. It is felt that jumping from a moving boat onto a pier risks serious injury or death if the person misjudges the jump or falls into the water.

I have met with the Authority and challenged this decision, but they feel jumping from a moving boat onto a pier does not involve a high risk.

Although they have signed up to the government’s Code for Port Management, they have not done any risk assessments relating to removing the harbour night watchmen. They have not revised their practices in respect of what I and many feel is a “change in harbour operations”.

I have asked the Authority why they have not revised their own port safety management code and their reply was they feel that not having night watchmen to operate the VHF and take our ropes does not constitute a change in harbour operations. The Authority does not have any mariners in the management team, yet they are risking mariners lives.

This is an accident waiting to happen, and it is sheer cost cutting which will put harbour users lives at risk. The Authority will be meeting on the 1st June 2017 to give their final decision.

Further dialogue:

The following is a précis of many exchanges between the Reporter, **CHIRP**, and other parties;

- It was agreed that **CHIRP** contact the Port Authority with advice relating to the dangers of a leap ashore, proper risk assessment, and responsibilities for incidents.
- The reporter had written to local government officials who had responded by supporting him. A petition had attracted over 1000 signatures. These points would be addressed by **CHIRP** when writing to the Authority
- Local and national fishery organisations were also involved with letters to the Authority.
- **CHIRP** wrote to the Authority who responded just prior to the meeting and stated that cover would be maintained with watchmen available around the clock. The reporter was advised of this and informed **CHIRP** that the cover would actually be one watchman for three ports - a fact that had not been properly addressed in the risk assessment.
- The reporter managed to speak at the Authority meeting, and the first decision taken was to dismiss the risk assessment (which was correct – it was poor as there were no proper mitigation measures put in place).

On the 08th June 2017, the Authority issued a press release stating that the decision to axe night watchmen had been cancelled. In addition, they undertook to look at port health and safety in conjunction with local users in future.

CHIRP Comment

The Maritime Advisory Board commented that the report is a fine example of **CHIRP** working with other bodies to raise awareness of the inappropriate use of risk assessments and the need for maritime professional input.

REPORT ENDS

The Human Element – still a long way to go!

CHIRP has received many reports which may be categorised individually as minor near misses. Whilst the reporting of these shows that a behavioural-based safety programme is in place, it also shows that the Deadly Dozen has yet to be embraced.



The Deadly Dozen – see MGN520

Several of these near miss “one liners” are detailed below. They all had remedial action applied, in the form of direct intervention.

- A first trip deck hand’s first mooring experience had him actively tending moorings. **CAPABILITY**. (The inexperienced deck hand should have been mentored until he was deemed experienced enough to actively engage in mooring operations).
- A bunker tank nearly overflowed when the engineer overseeing the operation left to answer an engine room alarm. **DISTRACTIONS**. (A dangerous oversight – proper planning would have freed up personnel in order to prevent this near miss).
- A lower forepeak space required cleaning – during the planning the supervisor asked for everything to be made ready in half an hour and he would return at that point. When he returned personnel were already at work inside the compartment even though they had not received an Entry Permit. **COMMUNICATIONS**. (The supervisor had in fact tested the compartment and had gone off to write up the permit – the crew however misunderstood the correct procedure).
- An oiler taking daily tank soundings walked under a crane that was in use for storing operations. **SITUATIONAL AWARENESS** and **ALERTING**. The oiler could not have been aware of his surroundings or else he would not have stepped under a crane with a load. But who had the forethought to stop him?
- Sunglasses were used instead of safety goggles during deck scaling maintenance **CULTURE, COMPLACENCY** and **LOCAL PRACTICES**. If “That’s the way we’ve always done it around here”, is the philosophy then the culture both on board and ashore needs to be modified to change how people think.

- A supervisor became involved in a mooring operation. The ship had undertaken several port calls in the previous few days, with associated cargo and administrative operations. Amongst other factors, **FATIGUE** could have been an issue. Tired people make mistakes and the supervisor should have restricted himself to supervision and NOT become involved in the actual work.

The above reports are encouraging and indicate that people are thinking about safety, but it is worth remembering that the Human Element can involve multiple factors. Take the first example of our deck hand getting involved with mooring - this points to a poor on-board safety culture, a lack of standard operational procedures, and a poor company culture within the Safety Management System. A proper risk assessment and toolbox talk would have prevented the deck hand from getting involved.

Some of the examples may sound very familiar from your own ship – if so, what are you doing to prevent it from happening in the first place? All of the above examples could have been prevented if the people on board, backed up by shore management, had a healthy **TEAMWORK** ethic which encourages people to challenge unsafe procedures where appropriate, and which involves proper planning and co-ordination of onboard activities. Good planning also reduces the danger of people being placed under too much **PRESSURE** since tasks are more evenly distributed.

For any “near misses” that you become aware of, try to decide which of the twelve aspects of the Deadly Dozen are most appropriate. There may be more than one, in fact there are often several categories. From a personal perspective, thinking about your surroundings or the tasks that you have been allocated helps you become more self-aware and able to see the dangers before they cause an accident. Why not discuss the near misses that you experience at your Safety Committee meetings and bring in the aspects of the Human Element? You might be surprised at the results.

----- *REPORT ENDS*

MLC Issues – UMS Operations and abuse of authority

OUTLINE: A report alleging that single persons were working in the engine room at night when in UMS mode. Also, personnel issues said to include abuse of authority.

What the Reporter told us:

I have a concern related to the Unmanned Machinery Spaces (UMS) operations on board our vessel. When we are sailing, our duty rotation on watch is four hours on and four hours off for three Motormen. When the vessel goes UMS, the 2nd Engineer gives us job orders but we are alone in the engine room at night, and this is unsafe for us. The problem is what if something unexpected happens to us? Furthermore, the 2nd Engineer is not good in the way he approaches his men - he gets angry if his job order is questioned, and he pushes us to make overtime after our watch and remain for another

two hours duty. This is abuse of his authority and it has been going on since I joined the vessel in October.

What the Third Party told us

The reporter requested details of the local ITF office, which were given. CHIRP was also aware of the involvement of the International Seafarers Welfare and Assistance Network through their SeafarerHelp.org helpline.

CHIRP contacted the DPA of the company in question and got a response stating that this would be investigated. However, subsequent attempts to engage with the DPA over several months did not get any response. The advice from the Maritime Advisory Board was to inform the vessel’s Flag State of the matter. **CHIRP** wrote to the Flag State giving the report as detailed above. The Flag State have responded to **CHIRP** stating that the Administration takes any violations of MLC 2006 very seriously, and that the report will be investigated with the ISM Managers of the vessel.

CHIRP Comment

If anyone is working alone in the engine room the UMS Patrolman alarm should be in use, and/or the bridge should be contacted at regular intervals. MAIB report 17-2016 relating to an engine room fire on board Arco Avon highlights the dangers. Four on, four off, does not comply with the Hours of Rest Regulations, and is an MLC 2006 violation.

----- *REPORT ENDS*

Incinerating outside of the incinerator!

OUTLINE: A report where misplaced oily rags almost caught fire with a potential for a far more serious incident.

What the Reporter told us:

While incinerating oily rags, a bucket full of oily rags was left near the incinerator door by an engine room rating. The heat coming from the incinerator door initially heated up the oily rags in the bucket and it started to smoke. The bucket was immediately doused with water and a fire was prevented.

Proper procedures should be fully observed whilst the incinerator is in operation, and it should not be left unattended while in use.

CHIRP Comment

The Maritime Advisory Board mentioned that poor housekeeping may have been a causal factor and that placing the items in a more sensible location would not have allowed this incident to occur. A toolbox talk is recommended, as this would have raised awareness of the dangers involved. (See **CHIRP** report “Incinerators – Too hot to handle?” (Maritime FEEDBACK 39 or search ‘Incinerators’ on our web site).

----- *REPORT ENDS*

Correspondence Received

Vacuum packed

Whilst commissioning an incinerator, six people were trapped inside the incinerator room due to the strong vacuum (negative pressure) in the room.

The incident happened when the air supply damper was closed and the incinerator combustion air fan drew exhaust from the room, creating a vacuum inside. Smoke filled the room due to a burner seal failure. The door to the room was held shut due to differential pressure, trapping the personnel inside. This near miss could have resulted in a fatality.

Differential pressures can occur as a result of improper operation of machinery room dampers, mechanical ventilation, or an AC unit. If these ventilation systems and dampers are not operated correctly it could result in unsafe conditions like those described above. Other near misses reported include three medical related finger injuries due to differential pressures. Not understanding the dangers of differential pressures can also cause machinery and equipment damage, serious injury and fatality.

It is important to remember that good seamanship means to always:

- Ensure that ventilation & dampers are controlled as intended for normal operation and maintained properly;
- Ensure vents/dampers are open before starting mechanical ventilation;
- Look for signs of excessive differential pressure and investigate the reason; and
- Maintain a slight positive pressure inside the accommodation, especially during cargo handling.

Do not:

- Close vent flaps / dampers against forced ventilation except in emergency;
- Deviate from normal ventilation practice without carefully assessing the risks.

Battery Fire

In the early hours of the morning during a period of adverse weather the fire alarm in the vessel's battery locker was activated. The crew mustered and a fire team assembled. Upon investigation it was discovered that there was a small flame and sparks being emitted from a spare battery that was stored in the battery locker on the top shelf.

The battery had been delivered during a previous port call and stored within the battery locker. Unfortunately, it had been placed on a storage shelf with no attempt to secure it in place.

During a period of heavy weather, the battery tipped onto its side and slid against the steel lining of the bulkhead. As the battery terminals were not covered, this caused the battery to short and led to it overheating.

Once the battery had reached ignition temperature the casing melted, setting off the fire alarm.

Corrective Action

- All batteries, including spares, must be secured in place to prevent movement
- All spare batteries should have the terminals covered with insulating material to prevent accidental shorting



Damaged battery after the fire.

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