

## Editorial

Welcome to the 50th edition of Maritime FEEDBACK which is being prepared at Lunar New Year – so *Kung Hei Fat Choi* to all our readers, reporters and sponsors, and we wish you a safe and happy Year of the Dog.

Appropriately, perhaps, Chinese astrologers tell us that success in this Earth Dog year depends upon the quality of the communication between people. Whether you believe them or not, there is no doubt that good communication and teamwork are a recipe for success in any year. It is a recurring theme in our **CHIRP** reports, and something we should all work toward.

In this edition we discover what can happen if lifting strops are wrongly connected – a simple mistake which could have had very serious consequences, but could have been prevented with better communication between the crew members who were responsible for unrigging the strops and those who put them back again.

Communication is also a factor in our reports about a bow thruster which was not available, and a helmsman who lost concentration. Then in some of our reports about pilot boarding arrangements, there are obvious communication problems.

We consider a classic COLREGS dilemma in this issue – the scenario which sometimes arises when it may not be clear whether vessels are in a crossing or overtaking situation. In this case, in either situation, the reporter's vessel was the stand-on vessel, but took action when it

became obvious that the give-way vessel was not going to give way. All bridge watchkeepers should consider this report, and bear in mind that you can never assume the other vessel will obey COLREGS.

There are a number of reports about pilot boarding, and it is disappointing to see how often pilot ladders are improperly rigged. Doing it properly is not difficult, and there are numerous sources which explain how it should be done, so why do some ships still fail to comply? It might be a good idea to check your own vessel to ensure your pilot ladder does not look like some of the ones we have illustrated!

Fortunately, we conclude this edition with some examples of good communication. A report about a main engine which failed to start was addressed by the company swiftly and professionally, and serves as an excellent example of how best practice can be adopted both in responding to an incident and ensuring it will not happen again.

We also include two pieces of correspondence which we received as a result of reports in earlier editions of Maritime FEEDBACK. One reader sent us a photograph of some very unsafe practices, and we invite you to see how many you can identify. Finally, we have a message which refers to our earlier efforts to keep a night watchman in a port, describing how the watchman averted a potential tragedy. This is an excellent example of how your reports can make a positive contribution to safety, so please keep them coming!

## REPORTS ...

### Rescue boat lifting strops

**OUTLINE:** Rescue boat lifting strops were renewed but when refitted, were secured to the incorrect strongpoints, resulting in the potential for a serious incident to occur.

#### What the reporter told us:

The lifting strops for the vessel's two inflatable rescue boats, (IRB's), had recently been renewed. At the time of the incident the vessel was alongside, and the opportunity was taken for some familiarisation training. This included swinging out the port rescue boat. Unfortunately, the deck crew who had fitted the new strops attached the aft strops to strongpoints on the hull, and not to the correct lifting points on the transom. This resulted in an unstable lift as the weight of the outboard motor caused the boat to rotate about the aft strops and assume a vertical position, bow up, as shown in the photograph.



Rescue boat – hanging vertically because strops have not been fitted correctly

Company procedures require all boat launches which are carried out for training purposes, to be undertaken with fall preventer devices (FPD's) in place. In addition, launching is to be preceded by swinging out, lowering, and recovering the boat empty. It was during this process that

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the problem was discovered when the boat assumed a vertical (bow up) position.

Once the port boat had been swung out over the ship's side it was lowered a few metres, at which point the boat tilted to a vertical (bow up) position. The boat was subsequently recovered by attaching a heaving line to the bow which in turn was secured to the mooring deck, thus bringing the boat to the horizontal position for stowage.

With the boat fully secured, the lifting strops were measured against those in the starboard boat and found to be identical. A similar test was then carried out on the starboard rescue boat. As this boat was lifted from its cradle the forward lifting strops became slack, indicating an identical problem. The boat was re-stowed.

Investigation revealed that the aft strops on both boats had been attached to the wrong strongpoints on the hull and not to those on the transom. Having positively confirmed that this was the root cause, the strops were repositioned to the correct strongpoints, and both boats were successfully test launched.

The investigation determined that the crew members concerned were unsure of which strongpoints to use when refitting the strops and, unfortunately, chose not to seek clarification. In order to prevent a recurrence of this incident, the correct strongpoints were then permanently marked.

This incident is being reported because of the potential for serious injury (or worse). Had circumstances prevented testing of the boats after the replacement of the lifting strops, it is entirely possible that manned boats may have been deployed in an emergency situation (which overrides the use of FPD's).

Whilst the changing of one piece of equipment with an identical certificated replacement may appear to be straightforward (and in this case, was not difficult), it is important that there is appropriate supervision and that such items are then cross-checked / tested before use.

When equipment is removed or replaced full notes/ photographs should be taken and kept on board to ensure replacements are fitted correctly. On this occasion, it seems that further clarification was not sought when questions were raised amongst the crew who were refitting the strops.

**CHIRP Comment**

Having discussed the report, the **CHIRP** Maritime Advisory Board agreed that this incident had the potential to cause an extremely serious accident. They highlighted the following;

- It is good practice for vessel operating procedures to include photographs and accompanying notes in a clear logical order – these should be unambiguous. In this case, the procedures would include both the launching and recovery procedures, and the procedure for changing out the lifting strops. A picture is worth a thousand words and can be extremely helpful.
- The above, coupled with a briefing and risk assessment prior to undertaking the task, would negate the Human Element comments in the report related to appropriate supervision and crew not clarifying the location of the strongpoints when refitting the strops.

- In addition to any company or vessel procedures, it is vital that LSA / SOLAS training manuals should be fully up-to-date and that there should be a process for regular review. As a general comment to readers, **CHIRP** asks when YOU last took the opportunity to have a look at the manuals? Are they fit for purpose and up to date?
- Whilst the colour coding of the strops was certainly an effective preventative measure, once again **CHIRP** highlights a design issue. The boats should have been designed so as to avoid this fundamental error. Naval architects and designers please take note.

**Useful references:**

- Avoid Lifeboat Accidents – BIMCO - September 2017
- Launching and Recovery of Boats from Ships – The Nautical Institute – January 2018
- 2017-12 Lifeboat Falls Paper. Lifeboat Incidents – A review of Issues – **CHIRP**

----- *REPORT ENDS*

**Bow thruster availability**

**OUTLINE: A misunderstanding when changing over the control position for a bow thruster.**

**What the Reporter told us:**

I was recently piloting a vessel and experienced an issue whilst changing over the bow thruster control from the central station to the starboard bridge wing. The Master and Chief Officer (of different nationalities) had some misunderstanding as to the correct procedure to transfer control. This resulted in the Master becoming flustered, and running from the bridge wing to the wheelhouse whilst the vessel was approaching the berth.

I had to intervene and ask the Master to stay at the bridge wing control for engine movements. Two tugs were made fast, so the bow thruster was not crucial for the manoeuvre. Eventually the problem was resolved and thruster control was made available should it have been required.

**CHIRP Comment**

The Maritime Advisory Board commented as follows;

- he report demonstrates a lack of understanding of the bridge equipment and changeover procedures. It is essential that changeover procedures are clearly understood and implemented. Testing of the changeover procedure should form a part of the pre-arrival checks. In addition, the design of the changeover of controls should provide for a simple, unambiguous process, with appropriate operational instructions.
- Human element issues can be noted in the lack of situational awareness and communication between the bridge team members.
- Since two tugs were made fast, the bow thruster might not have been needed. Nevertheless, as a generic learning bow thrusters should be tested prior to arrival so that they are available in case of any emergency.

----- *REPORT ENDS*

## Helmsman error

**OUTLINE:** A report outlining a loss of concentration by the helmsman whilst under pilotage.

### What the Reporter told us:

On the northern bend in a port approach channel, the helmsman put the wheel to port instead of to starboard. The Pilot and Master immediately picked up on the error and rapidly corrected the helmsman.

A few minutes later the Pilot ordered starboard five degrees helm, but the helmsman seemed to be disorientated and left the wheel amidships. The request was reinforced by showing a hand direction to starboard prior to the helmsman refocusing his attention. Initially the helmsman seemed to be very alert, but his performance deteriorated quite suddenly during the pilotage.

This occurrence was near midnight and reinforces the fact that crew fatigue can creep in at any moment, especially around the hours between midnight and 0300 hours when the body clock is most susceptible.

### CHIRP Comment

**CHIRP** contacted the DPA and were disappointed that there was no response. The Maritime Advisory Board commented that this is an example of effective bridge team supervision, and noted that best practice is to reinforce a helm order with a hand movement indicating direction to ensure that the request is understood.

It was noted that fatigue is a possibility but there are other potential factors which affect the ability to concentrate, e.g. bad news from home. The Board mentioned that the helmsman is an extremely important member of the bridge team and suggested the following best practice:

- Know your personnel – the helmsmen should be encouraged to alert any bridge team member if there are any distracting issues, or if feeling fatigued.
- The helmsmen should be relieved on a regular basis.
- Always have someone to check the rudder angle indicator for correct response to helm orders.
- Good company procedures will take the above factors into account.

It was finally noted that fatigue is an ongoing topic at the IMO, and the Human Element, Training and Watchkeeping (HTW) sub-committee is currently revising fatigue guidelines.

----- REPORT ENDS

## Unexpected swell – lucky escape

**OUTLINE:** A Pilot experiences a lucky escape whilst boarding a vessel.

### What the Reporter told us:

Whilst boarding a vessel from the pilot launch, an unanticipated swell picked up the ladder which I had just stepped onto. This resulted in me dropping to a position that

had me sitting on the rungs of the ladder on the deck of the pilot boat whilst still holding on to the ladder. I continued to hold on, and as the boat dropped away, I quickly resumed climbing the ladder. Fortunately, the event did not result in an injury, and I safely boarded the vessel. At the time, the weather was a southerly wind of 10-18 knots with a low swell. Vessel steering 075°T at 10 knots to create a lee.

I feel that this was a case of being caught by an unexpected sudden change to the boat's motion, which even caught the boat skipper by surprise. It would suggest a policy of not rushing to transfer to the ladder before getting a good feel for the relative movement of the two vessels. Following the incident, I discussed the incident with my manager to investigate whether we could have done things differently, but nothing stood out to me or my boat crew, other than to take time to assess every task well, before transferring.

### Further dialogue:

**CHIRP** requested confirmation that the lee was requested, that the pilot ladder was correctly rigged and that an officer was in attendance. Positive confirmation was received to all of these points. We also asked if there was any knowledge of historically unusual swells, which might prompt a review of the requested lee or gain additional information as to the timing of the swells. The reporter replied that it is in an area where heavy swells are often a way of life. They have a good wave-rider device that gives them information to plan for the transfer well before leaving the harbour.

### CHIRP Comment

The **CHIRP** Maritime Advisory Board commented that this was indeed a lucky escape. Different circumstances could have led to a very serious accident. The report highlights the inherent dangers that a pilot experiences when boarding or disembarking a vessel. In addition to the reporter's comment relating to assessing every task, it is essential that the vessel's personnel both on the bridge and at the pilot ladder, along with the crew member of the pilot launch assisting the pilot, and the launch skipper are all fully alert to dangers such as those described in the report. One error of judgement can have serious consequences.

----- REPORT ENDS

## Fishing vessels and pilot ladders

**OUTLINE:** A report outlining the need for fishing vessels to rig pilot ladders safely

### What the Reporter told us (1):

Whilst preparing to disembark a fishing vessel after an outbound pilotage, the following was noted at the pilot ladder: shackles were used to connect side ropes together as a loop around the ship's side rail, no bulwark ladder was provided and there were no stanchions in place. There were also no fittings for them on the deck. No lifebuoy with light was provided at the disembarkation position, and there was no deck officer at the ladder.

Following a VHF conversation and agreement with the launch master to ensure a safe disembarkation, the transfer was completed inside the harbour in sheltered waters. A Port State Control inspection upon the vessel's next arrival was recommended.

I have piloted this vessel in and out a number of times in the three and a half years that I have been here, but on previous occasions the pilot ladder was rigged abaft the bridge with arrangements that met the IMO regulations. On this occasion it was rigged forward of the bridge and close to the flare of the bow, which was contrary to requirements. The vessel had been laid up for some time and reflagged. The crew were unfamiliar with the bridge equipment and what a Pilot Card was, so this was probably their first departure. The ship was heading outbound to fishing grounds and was not expected to return to port in the near future.

At 47m LOA and 897 GRT, she was not a 'small fishing vessel' and would expect to take a pilot in most ports. I could have ignored the deficiency and moved on, but in order to ensure the safety of pilots boarding the vessel in the future, it needed to be reported! I get so annoyed when so-called 'professional seafarers', ignore regulations put in place for my safety!

**What the Reporter told us (2):**

This 105m fishing vessel is engaged in fishing offshore around our country and regularly calls at our port. Following an outbound pilotage, when disembarking, it was noted that the man ropes for the pilot ladder were synthetic, and that they were less than 28mm in diameter. As conditions were calm with little movement between the fishing vessel and the pilot launch, I had the option of holding the pilot ladder rather than manropes. I disembarked safely but stress that the man ropes were unsafe.

**CHIRP Comment**

The Maritime Advisory Board commented that irrespective of the type of vessel, a pilot ladder should always be rigged correctly in accordance with SOLAS Chapter V Regulation 23, and IMO Assembly Resolution A.1045(27), as amended by A.1108(29). In addition, reference is made to the IMPA Pilot Boarding Arrangements poster. All of the foregoing may be found on the publications page of [chirpmaritime.org](http://chirpmaritime.org).

For clarity, the application of SOLAS V regulation 1 states *inter alia* that;

*The Administration shall determine to what extent the provisions of regulations 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27 and 28 do not apply to the following categories of ships:*

- 4.1 ships below 150 gross tonnage engaged on any voyage;
- 4.2 ships below 500 gross tonnage not engaged on international voyages; and
- 4.3 fishing vessels

Rule 23 however, states that *Ships engaged on voyages in the course of which pilots may be employed shall be provided with pilot transfer arrangements*

With respect to manropes, SOLAS V Regulation 23 – 7.1.1 states that *“Two man-ropes of not less than 28 mm*

*and not more than 32 mm in diameter properly secured to the ship if required by the pilot; man-ropes shall be fixed at the rope end to the ring plate fixed on deck and shall be ready for use when the pilot disembarks, (or upon request from a pilot approaching to board), the manropes shall reach the height of the stanchions or bulwarks at the point of access to the deck before terminating at the ring plate on deck”.*

CHIRP would comment that whilst synthetic ropes are not explicitly forbidden, best practice and a pilot's preference is for natural fibre such as manila rope, as this gives a much better grip

Finally, CHIRP would mention to all readers there is absolutely no obligation for a pilot to use a non-compliant ladder arrangement.

----- REPORT ENDS

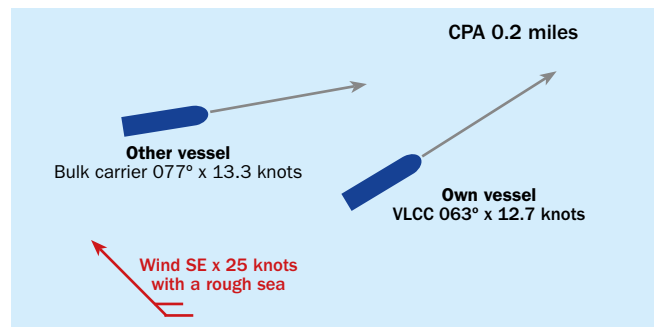
**Overtaking or crossing?**

**OUTLINE: A report detailing blatant non-compliance with collision regulations.**

**What the Reporter told us:**

At the time of the incident, (1700 hours local time in daylight), we were in the middle of the ocean with no risks to open navigation, and with plenty of water under the keel. The weather was a south-easterly wind of 25 knots with rough seas. The Second Officer was on watch and the Master was on the bridge during the entire event.

Vessel “xxx”, (a bulk carrier), was on our port quarter with a heading 077° and a speed of 13.3 knots. Own vessel, (laden VLCC), was proceeding on heading 063° and a speed of 12.7kts. See diagram below.



Schematic diagram showing relative positions of the two vessels

It was a slightly doubtful as to whether this was a Rule 13 situation in which “xxx” was overtaking us, or a crossing situation as per Rules 15 and 16 in which she was the give-way vessel and we were the ‘stand-on’ vessel as per Rule 17. Given the relative aspects of the vessel, we perceived it as an overtaking situation and in line with Rule 13(c), good seamanship would dictate that it was an overtaking situation. Either way, we were the stand-on vessel and “xxx” was supposed to take avoiding action.

No avoiding action was observed from “xxx” and with a CPA of 0.2 miles and TCPA of 30 minutes, we decided to contact her on VHF to ask for her intentions. She replied that she intended to maintain course and speed.

We therefore decided to take our own actions and altered course 30° to starboard in order to maintain a safe distance of at least 1.5 miles. By altering to starboard, we let her overtake us at a safe distance. Due to the relatively small difference in speed between the two vessels, we were ‘pushed’ off our intended track by about 3 nautical miles. As we were in the open ocean, we considered this the safest action given the complete ignorance of the other vessel in judging the situation.

**Lessons Learned**

- Never trust the give-way vessel (even in the open ocean). Remain vigilant and whenever it becomes clear that no actions are being taken on the other vessel, challenge her and carefully consider your own options.
- 0.2 miles passing distance in an open ocean situation cannot be considered as a safe distance for a fully laden VLCC. The inclement weather conditions were an additional factor.
- When ample sea room is available, stay well clear of other vessels. If it becomes clear that another vessel is not complying with COLREGS, consider your own options to avoid danger (always in accordance with COLREGS).
- Remember that Rules 13c and 14c explicitly state that when you are in doubt, you have to consider the position as an overtaking (or end-on) situation and act accordingly.

**CHIRP Comment**

The Maritime Advisory Board commented that this was a good example of positive action by the stand-on vessel in a straightforward case of COLREGS violation. Regular readers of Maritime Feedback will be aware that **CHIRP** discourages the use of VHF for collision avoidance. In this case, however, the request was not likely to create a VHF assisted collision, but was simply intended to request the other vessel’s intentions, following which the Master of own vessel correctly decided to take early and ample action to avoid collision. **CHIRP** would additionally comment that in open waters there is absolutely no need for vessels to be in close proximity to one another.

----- *REPORT ENDS*

**Pilot ladders – don’t do this!**

**CHIRP** has received several reports including pictures showing bad practice related to pilot ladders. Some of these are highlighted:

- Incorrect pilot ladder rigging (see picture 1).
- Pilot ladder bottom rubber steps – chock missing. Steps at uneven gaps and angled. The manropes have been fitted with monkey’s fists at the ends, and the side-ropes are not continuous as the regulations require - they do not pass under the steps but terminate lashed together (see picture 2).
- Rope ladder secured to ship’s side by only one magnet which was loose and located more than 2 metres from the bottom of the gangway platform.
- Whilst disembarking a vessel using a port side ladder, the

- Pilot noticed a nylon chock loose and hanging out, approx. 3.5 metres from the bottom of the ladder on the aft side.
- A tripping line was fitted below the bottom spreader, and the ladder steps were not horizontal (see picture 3)
  - A heavy metal socket was fitted at the end of a heaving line. The line was lowered during a transfer on the outward pilotage.
  - Rung bent on rubber ladder steps. Tripping line fitted below spreader. Side ropes not continuous as also mentioned in the comment for picture two (see picture 4).



1 – Dangerous loop at bottom of ladder



2 – Uneven ladder step



3 – Tripping line below spreader



4 – Bent step and tripping line below spreader

**CHIRP Comment**

The **CHIRP** Maritime Advisory Board commented that the SOLAS requirement for a tripping line states: “When a retrieval line is considered necessary to ensure the safe rigging of a pilot ladder, the line should be fastened at or above the last spreader step and should lead forward. The retrieval line should not hinder the pilot nor obstruct the safe approach of the pilot boat.

As the pictures show, there is a long way to go to improve ladder safety. Pilots, and indeed vessel personnel, are risking their lives with these arrangements. All ladders should be carefully inspected prior to use and should be maintained properly in order to ensure that they remain fit for purpose.

----- *REPORT ENDS*

## Main engine – failure to start

**OUTLINE:** An outline of a main engine failure when departing the berth.

### What the Reporter told us:

During an unberthing/departure operation at a container terminal, the main engine failed to start. Control was transferred from bridge control to manual local control in the engine room, and after approximately 10 minutes the main engine was able to be started and run ahead. The aft tug remained attached for the passage out of the harbour until clear of the channel. The vessel was deep draft and was restricted to the centre of the channel which at the time was experiencing a strong flood tide. The Master was advised that the problem was a stuck fuel valve on one of the main engine units. The vessel subsequently went to anchor and carried out repairs to rectify the problem. Once completed, the vessel continued on its voyage to the next port.

Further dialogue with the reporter confirmed that it was not normal practice to have an outward-bound escorting tug. With respect to any speed issues caused by the stuck valve, it was confirmed that speed was kept to a minimum to accommodate the escorting tug and to reduce squat in the narrow channel. There was thus no attempt to increase outbound speed.

**CHIRP** wrote to the company and received the following response;

The main engine failed to start due to non-operational spill valves in the fuel pumps for six units. As a precautionary measure, the vessel tried to start the engine from the local stand in the ER. At this point, failure of the push rods was noted. All were loosened, and from there the vessel immediately resumed normal operations. We suspect the fuel oil quality to be the possible cause as the fuel pumps were recently overhauled by the manufacturer. The fuel oil specification was checked and found to be within ISO specifications. The vessel eventually eased up the push rods and the engine resumed normal operation. We are currently in discussion with the manufacturers as to what exactly triggered this malfunction.

**CHIRP Comment**

The **CHIRP** Maritime Advisory Board commented that the response in this case has been positive from the company and is evidence of a good report and the adoption of best practice. In this case not only has the problem been rectified, but moves are underway to ensure that there is no repeat.

**CHIRP** is aware of other cases where an engine has either failed to start, or that the response has been “sluggish”. Any further reports detailing these issues will be welcomed.

Finally, although not mentioned in the report itself, **CHIRP** would comment that it is best practice to test a main engine prior to departure by turning it over on both air and fuel. This will necessitate suitable precautions – such as raising the gangway and having personnel standing by moorings.

----- *REPORT ENDS*

## Get me to and from the bridge on time

**OUTLINE:** Two short reports from Pilots outlining difficulties in making a timely entrance to the wheelhouse, and in disembarking following a pilotage.

### What the Reporter told us (1):

When boarding the vessel there was no “responsible officer” at the ladder – a cadet with a radio was in attendance along with crew members. As I was boarding in heavy swells, (3-6 metres), I had to call up to the cadet and ask him to pass a course alteration to the bridge. Due to his apparent inexperience, he didn’t immediately grasp what was required.

Once on board, there was a significant delay getting access to the elevator as it appeared to be held up on another deck. This added a few minutes delay in getting to the bridge. I suggested using the stairs, but the cadet appeared reluctant to do this. Due to the long time it took to get to the bridge on this large car carrier, I advised the Master that either the elevator should be held for the pilot, or the stairs used.

Finally, when entering the accommodation, I slipped on a towel that had been laid on the deck at the entry door. Fortunately, I caught myself before falling completely. If people are required to wipe their feet, an appropriate mat should be fitted

**CHIRP Comment**

The **CHIRP** Maritime Advisory Board noted that there were a number of significant issues in this report, indicating causal factors that are relevant to the Human Element “Deadly Dozen” as follows:

- A lack of radio contact between pilot and bridge. (**Communication**)
- A cadet rather than an officer at the pilot boarding station. (**Capability, Teamwork**)

- The delay with the lift and the slippery towel. (**Local practices, Situational awareness, Complacency**)  
 With respect to the radio contact between the pilot and the bridge, **CHIRP** reinforces the fact that a cadet is not an appropriate person for supervising pilot transfer operations and that the regulations are quite specific as to the supervisory requirements. In addition, the Board commented that a request to alter course made from the pilot boat directly to the bridge may have been the better option.



**CHIRP Comment**

The **CHIRP** Maritime Advisory Board commented that vessels should be well aware of the transfer arrangement requirements through SOLAS V 23, and the Pilot Boarding IMPA placard. Additionally, they should be well aware of their freeboard, and thus know exactly what to rig unless specifically requested otherwise. Nevertheless, the reporter highlights the necessity of clear instructions from the port. **CHIRP** would suggest that "SOLAS compliant" is perhaps not specific enough, and that a written or verbal phrase such as "Pilot ladder on the xx side of the vessel 2.5m above the water - please do not rig a combination ladder unless your freeboard is greater than nine metres" would be a clear request. This may well be of assistance where personnel receiving the request do not have English as their native language.

--- REPORT ENDS

**Correspondence Received**

**Painting over the side – Who needs safety culture?**

**What the Reporter told us (2):**

A Pilot boarded for an outbound passage from the offshore side of the vessel, through a combination ladder arrangement with the lower platform about 2.5 meters above the water. The vessel's responsible officer was advised that the arrangement was far from compliant with SOLAS Chapter V Rule 23. Once on board, the Pilot requested that the combination arrangement be removed, and to rig the pilot ladder directly as the freeboard was less than nine metres.

By the time the pilot boat arrived alongside for pilot disembarkation, the crew were trying to rig the ladder properly, but for some reason they were unable to do so. This was possibly due to the crew having been involved in unmooring operations, or a lack of education and training regarding pilot transfer, since they seemed to be unaware as to what the Pilot and pilot boat crew were requesting. Finally, because the ship was already leaving the pilot disembarking area and there was other traffic waiting for pilotage, the Pilot decided to disembark through the combination ladder arrangement. The weather conditions were good. The officer on deck was advised that the vessel should revise its procedures.

It is a mistake to expect that just asking to rectify a non-compliant arrangement will result in it being available on time. We should revise our communication procedures prior to pilot boarding, informing vessels clearly that boarding arrangements should meet SOLAS regulations, otherwise this could cause a delay until proper arrangements are provided.

Both the reporter and **CHIRP** wrote to the vessel's management, but no response was received.

The following is a brief description of a scene that I witnessed whilst alongside in a small Mediterranean port. There was a small coastal ferry moored directly astern of us which is used to connect the port with a nearby island. On her starboard (outboard) side, I could clearly see a crew member working over the side in an unsafe manner. He was dangerously leaning over a metal embarkation ladder and was not wearing any kind of personal protective equipment apart from safety shoes. This picture was taken at the time. There was also what looked like an officer supervising the job from the deck... demonstrating a complete lack of safety culture!



Painting over the side – lack of safety precautions

**CHIRP Comment**

**CHIRP** sees many things wrong in the picture. As a “smoke oh” exercise, or perhaps at a Safety Committee Meeting, or even just for fun, why not examine the picture to see how many hazards you can spot. You may well be inclined to check that all of your own onboard procedures are robust in terms of planning, risk assessment, toolbox talks and execution of the job itself.

**CHIRP** would welcome any pictures that may be suitable for a “Spot the Hazards” and/or learning exercise for use in future editions of Maritime Feedback.

his vessel, and so he proceeded to walk toward the vessel to make sure that the crew member boarded safely. The watchman was about thirty feet from the vessel when he heard a splash – the crew member had fallen into the harbour. The night watchman acted as he had been trained by raising the alarm, then he proceeded to help the crew member as best as he could.

The night watchman successfully managed to get the crew member out of the water and safely onto the pier. The crew member sustained minor cuts and bruising to his arm. Had the night watchman not been there, then the situation could have been far different. The Harbour Board requested that I thank **CHIRP** for their help in the matter of persuading the local authorities to overturn their decision to remove the night watchman.

## Manoverboard

Further to the article that **CHIRP** published in Maritime FEEDBACK 48 – “Loss of night watchmen in a harbour”, we have received the following message relating to the same port.

Recently a night watchman saw a crew member attempting to board his boat which was moored in the harbour late at night. The watchman noted the apparent difficulty which the crew member was having trying to board

**CHIRP Comment**

**CHIRP** is very relieved that the crew member came to no harm and, further to the article in Maritime FEEDBACK 48, this report shows the true value of having the night watchman in place. Safety should always be given the highest priority and override cost savings. In this case, a life has potentially been saved.



**CHIRP** Maritime is reaching out to seafarers of every calling. But we also want to hear from those who interface in port operations which have impact on vessel operations. So, don't hold back – your contribution is valued, and YOU can make a difference.

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