

MARITIME FEEDBACK



Issue 62
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An independent and confidential reporting system for the maritime industry

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The CHIRP editorial



If this happened to your ship, what would you do, who would you contact and who would you notify?

Is it Safe?



Capt. Jeff Parfitt
Director (Maritime)

Our cover photograph is a dramatic shot of damage to the stem and bulbous bow of an ocean-going ship. Our correspondent asked how the ship can determine whether it is safe to continue

the voyage, or whether the crew should attempt to make temporary repairs. Our reply was that in cases of this nature, the damage should be inspected by a classification society surveyor. Classification societies set the rules for safe ship construction and are the appropriate people to consult whenever there is structural

damage. Their surveyors can call upon a great deal of knowledge and experience and have tremendous resources to back them up if necessary. In this case, we also suggested the insurers should be informed. Mariners who find themselves in difficulty are never alone, there are many sources of advice and support available. There is no shame in admitting you are not sure how to handle an unusual situation, so do not be afraid to ask for help.

Elsewhere in this edition we have a wide range of interesting reports and, as always, we thank our reporters for taking the time to contact us.

First is an account of a crew member working from a stage where some aspects were positively dangerous. This is followed by a discussion about the benefits of simulator training, and the extent to which it should be utilised in lieu of sea time. We consider an interesting case involving Rule 10 of the collision regulations, and suggest our readers consider situations from the point of view of the other ships in the area. The report is a vivid reminder that perception can vary with height of eye.

In this edition, we have two reports which were forwarded by ISWAN, and they are a sobering reminder that not all ships are run as we would like them to be run. There are many

shoddy vessels and companies in our industry, but by shining a light on them we can help to ensure they do not prosper.

Next is another example of a ship which could not start its engine when departing from a port which is a timely reminder that technical staff must make themselves familiar with all aspects of the operation of the machinery on board. Modern engines are often programmed to behave in ways which are not obvious to the mariner, so please pay attention.

Pilot's Corner contains another depressing report about non-compliant pilot boarding arrangements, but also some heartening examples of ships being refused pilotage due to inadequate PBAs. Turning ships away from the pilot station is a powerful tool available to all ports, and our examples clearly show it to be an effective weapon in the fight to keep our pilots safe.

Finally we have two items of correspondence, including the welcome news that we have established a link to the Professional Yachting Association. We hope this will lead to more reports from the yachting fraternity, which is growing in importance as their numbers continue to increase.

There should be something for everyone in this edition, and we hope you will enjoy it. Until next time, stay safe.

Unsafe practice while working over side

Outline: A report which outlines another example of mariners putting themselves at risk by following unsafe practices.

What the reporter told us

A cruise ship was moored on the pier opposite my ship. I noticed a stage which was rigged on the port shoulder being relocated laterally whilst a crew member was standing on it. Although the person on the stage was wearing some PPE, (safety harness, safety shoes, gloves, and an inflatable lifejacket), I consider it quite an unsafe act. The crew member working on the stage should have vacated it to a safe position on deck before attempting to reposition the stage. (See photos below).



Figure 1 of 3 – Unsafe repositioning of a stage



Figure 2 of 3 – Unsafe repositioning of a stage



Figure 3 of 3 – Unsafe repositioning of a stage.

Further Dialogue

The photographs submitted had been taken through the cabin window of an adjacent vessel and were the only ones available hence the lack of clarity. At the time the stage was initially rigged, an officer had been in attendance apparently checking and briefing the crew members doing the job. The officer had been holding some paperwork which the reporter had assumed were the appropriate permits, checklists, and Job Safety Analysis. However, the reporter felt that there was a lack of supervision by the individual left in charge of the job after the officer had departed.

CHIRP comment

Although there are many assumptions being made, there is also a disconcerting sequence of photographs which illustrate poor safety awareness by the crew engaged in the task with an apparent lack of supervision, instruction, and training. Good practice would be to have a Jacob's ladder rigged for access to the stage from the deck above and a lifebuoy and line ready for immediate deployment close by. Furthermore, good practice would never allow a stage to be relocated laterally with a person remaining on the stage as this entails untying the gantline securing one end of the stage and supporting the weight by hand grip alone whilst the gantline is moved and resecured. Finally, there appears to be a tarpaulin rigged beneath the stage (to catch any drips?) which would imply an awareness of environmental protection, which makes the obvious lack of safety awareness even more baffling.

Why do seafarers do something like this? Is it a genuine lack of knowledge and awareness of the potential dangers and consequences of their actions? If so, then it would appear our standards of training have fallen to an unacceptable level. Or is it a deliberate act of blasé bravado? Such acts are irresponsible and set a dangerous example for other ratings who learn and take their guidance from those around them. Whatever the reason, such actions are not acceptable - near misses such as these demonstrate the need to have better situational awareness, a greater understanding of personal safety, and to be able to speak up when asked to do something in an unsafe manner.

Colregs Rule 10 incident

Outline: A report highlighting a close quarters situation between a commercial fishing vessel and a container ship

What the reporter told us

A fishing vessel was engaged in fishing within the central separation zone of a major TSS following a basic loop pattern of courses, northwards on 330° then turning to port to follow the reciprocal heading (150°) to the south between the NE and SW traffic separation lanes at 3.3kts. A large container vessel was proceeding at 20kts in the SW lane, holding close to the southern edge of the lane.

On nearing the northern limit of the separation zone, the fishing vessel commenced her planned turn to port to reverse her course. At this time, the container vessel altered course to port leaving the SW lane and entering the separation zone. As the fishing vessel continued her turn to port passing through heading 170° the skipper found himself on the stbd bow of the container vessel and needed to make an emergency manoeuvre to stbd to avoid a close quarters situation or possible collision.

Further dialogue

CHIRP discussed the report with both the reporter (fishing vessel's fleet manager) and skipper to clarify some details and timing of the incident and garner any additional information. The fishing vessel was less than 12 months old and was fully equipped with a range of the latest navigation and fish finding equipment including ENC's. Furthermore, the skipper's emergency manoeuvre to starboard had taken the boat over a shallower patch which fouled the fishing gear, this was later cleared without damage or loss.

CHIRP also contacted the ISM managers for the container vessel, and details of the reported incident were passed to

the DPA. Subsequently, after contacting the captain of their vessel, the DPA reverted to *CHIRP* with a response including a series of screen shots from the bridge of the container ship and a commentary from the captain with regards to the incident. The screen shots show that the container vessel was south of the planned route and outside the charted safety corridor in a position close to the boundary between the SW lane and the central separation zone.



Figure 4 – Screen shot from the container vessel.

Both the reporter and the captain of the container ship quoted rule 10 of the Collision Regulations to support their position that the other party was at fault.

Rule 10 (e) (ii) allows vessels to engage in fishing within a separation zone.

and additionally

Rule 10 (b) (ii) states: a vessel using a traffic separation scheme shall: so far as practicable keep clear of a traffic separation line or separation zone.

However

Rule 10 (i) states: A vessel engaged in fishing shall not impede the passage of any vessel following a traffic lane.

CHIRP comment

There are some discrepancies between the two accounts of the same event, however it is not *CHIRP*'s function to carry out a forensic analysis of an incident but rather to highlight the situation that developed and to promote good practice in navigation and seamanship.

There are two sides to every story and those sides are normally dictated by the individual's perception of events. Different vessels have different handling characteristics, a 340m container vessel is much less manoeuvrable than a 34m fishing vessel and as such must plan and execute collision avoidance manoeuvres much earlier. For that reason it would be prudent not to follow a track unnecessarily close to a separation zone where fishing vessels may well be legitimately engaged in fishing and can change course erratically. However, vessels engaged in fishing and other small craft should bear in mind that the bridge team on large vessels are very uncomfortable with smaller vessels operating in close proximity to them, inside the reaction radius of the larger vessel, thereby taking any form of control away from the larger vessel. It will serve all seafarers well to consider any developing situation from

the other vessel's point of view, and to follow the normal precautions required by the ordinary practice of seamen.

The Collision Regulations have the answer to any situation from initial detection to finally passing clear, but there is always the matter of perception regarding the situation, which may vary with your height of eye.

Substitution of simulator time for sea time

Outline: We live in an ever-changing world but is all change appropriate?

What the reporter told us

It has recently come to my attention that it is the intention of a major flag state, with industry support, to reduce the sea time required by cadets in favour of simulator training. The proposal is to allow 5 days in a full mission bridge simulator to count as 15 days sea time, 10 to count as 30 and 20 to count as 60. It is my professional opinion that this will be of detriment to the industry. In a recent study of serving deck officers, 75%-80% reject this notion. I agree that more simulator training would be good for cadets in developing collision avoidance skills, but this should not be at the expense of time spent on board ship.

I believe that cadets will come out of their cadetships with certificates of competency (CoC's) of a lesser value because of this. The CoC is being seriously devalued and the flag is becoming a flag of convenience because of decisions that the flag state administrator is making regarding exemptions and dispensations such as this. Sea time during a cadetship is incredibly important as it allows cadets to get hands on whilst under the tuition of a professional and serving mariner, be that an officer or crew member. Life at sea cannot be replicated in a simulator. The whole of shipboard life including bridge watchkeeping, cargo work, dealing with crew and shore personnel is incredibly important in a cadet's development and these are skills that will be used throughout their careers.

Further Dialogue

CHIRP clarified the source for the figures quoted in the initial report with the reporter and was directed to a formal document in the public domain which does clearly state the figures quoted.

Correspondence was also held with one of the organisations that had been involved in the initial consultation surrounding this proposal. They informed *CHIRP* that while the figures quoted by the reporter were correct, the wording of the formal document had been poorly chosen and that the flag state had no intention of pursuing that level of substitution. The actual proposal discussed was for a maximum of 30 days remission of sea time for any cadet that completed a Bridge Watchkeeping Simulator Course consisting of 2 separate one-week modules with each stand-alone module attracting 15 days remission of sea time. The scheme would run for a 12-month trial period and was not compulsory. At the end of the trial period the scheme would be reviewed, and the results and other data assessed before a decision was taken regarding rolling out the scheme to all cadets training under the flag state.

CHIRP comment

After considerable discussion by our Maritime Advisory Board members, the following points were noted.

- There was unanimous support for more quality simulator time, at the appropriate stage of a cadet's training. Cadets enjoy the simulator experience and relate to the technology.
 - Full mission bridge simulators are very good regarding introduction of the Collision Regulations, ship handling, ECDIS and ENC's etc., but they do not simulate 'life' at sea. Simulator training sessions need to be more realistic, rather than "one on one" situations. Life at sea, both the good and bad aspects, needs to be experienced for cadets to develop a full appreciation of their future role and responsibilities as an officer.
 - Most week-long courses consist of 5 days actual instruction, it is difficult to see the rationale for 1 day simulator training equating to 3 days sea time.
 - Whilst accepting that standards of training on board ship do vary greatly, do not underestimate or undermine the hard work of the many officers and crew who give unstintingly of their time and knowledge to help train and mentor the next generation of seafarers.
 - Quality simulators are expensive and there are limited numbers available at present. For the proposed scheme to be effective there would need to be large investment, and if that sort of investment is going to be made then go further and incorporate integrated virtual reality.
 - The concept that the scheme is not compulsory is an issue. If the scheme is beneficial then it should be compulsory, so all cadets benefit from it. If only the trial is optional, then the results available at the end of the trial will not be representative, instead reflecting the effect on a small group of cadets who probably already work for companies whose training regimes are already more effective.
 - Finally, it was highlighted that this is currently a proposal and will be reviewed following the trial. Watch this space.
- made and the alarm was not re-activated.
 - A second remedial entry was made in the ship's logs showing that, on the day of the fire, 3 minutes after the initial alarm the crew muster was completed, and two persons were known to be missing. According to the reporter that was not the case – the muster was not completed properly, and initially only one person was unaccounted for. It was only when the terminal fire brigade recovered a body that was not the person thought to be missing that the crew realised a second person was unaccounted for.
 - After the fire, when giving a written statement, the reporter was pressured to change his statement (which he refused to do). At subsequent meetings on board the reporter was verbally abused and harassed about refusing to change the statement.
 - Although it was known that the source of the fire was electrical in nature, the vessel managers suggested and promulgated a cause of the fire, implying it was in some way the responsibility of the victims before the shore investigators had arrived on board the vessel to inspect the scene. The inspection by the shore authorities did not support the company's view and pointed to an alternative seat of the fire.
 - Two days after the fire and the day after the shore authorities attended the vessel the reporter was landed ashore for medical tests. On discharge from the medical facility the reporter was refused access to the ship, personal belongings were landed by the agent and subsequently the reporter was repatriated by the vessel managers.
 - The reporter has lost employment, credibility, and livelihood.

Accommodation fire – two fatalities

Outline: Even tragic accidents have learning potential providing the root causes are identified during the subsequent investigation.

CHIRP Maritime has a Memorandum of Understanding (MOU) with the International Seafarers Welfare Assistance Network (ISWAN) whereby CHIRP will refer any specific welfare reports to ISWAN, whilst ISWAN will refer any safety-specific reports to CHIRP. The following report was a referral by ISWAN.

What ISWAN told us

We were contacted by the reporter requesting assistance. Apparently, there was a fire on board his ship and two crew members died of smoke inhalation. The reporter had contacted the authorities on account of (alleged) errors in the account of the incident by the captain and the company. It was also stated that some of the records and logs of the incident had been falsified.

CHIRP contacted the reporter to clarify some details of his report and to learn anything further.

The reporter alleged that:

- A planned fire drill, the day before the fire broke out, did not take place but a remedial entry was made in the on-board logs stating that it was completed satisfactorily.
- On the day of the fire, the fire alarm was cancelled shortly after it was activated but no Tannoy announcement was

Further dialogue

CHIRP was able to confirm independently that the named vessel had been alongside a loading terminal on the date reported and had suffered an accommodation fire which had tragically resulted in the death of two crew members. Furthermore, the flag state administration were contacted and confirmed that "as for all reported 'very serious' casualties, a safety investigation into this occurrence is being undertaken, in accordance with the IMO Casualty Investigation Code", but due to the ongoing investigation no further comment was possible.

CHIRP comment

As stated earlier even tragic accidents serve a purpose so that lessons learned can be shared and thereby prevent similar tragedies happening, but only if a full and thorough investigation is carried out, the immediate and underlying causes are identified, and the subsequent report is published and placed in the public domain.

Mandatory drills are the minimum required but more frequent training can only lead to better and more proficient teams better able to deal with an actual emergency.

Muster lists and station bills are there for a reason and are based on a tried and tested formula adapted to meet the specific requirements of a vessel and the crew numbers available on board. Deviation from training can lead to poor choices being made and while musters may appear to be time consuming, a correct muster is essential.

Lessons cannot be learned, root causes of incidents cannot be found, and systems to prevent any reoccurrence cannot be put into place if records are falsified, and if there is such a poor safety culture running throughout the whole of a

company from top to bottom. The reporter is thanked for his courage in promulgating the various issues discussed above which are generic simply because the incident is under flag state investigation and thus *CHIRP* must not interfere in this process. However, from the information above it is clear there are many human element aspects to consider, Alerting, Communication, Pressure, Local Practices, Distractions, Complacency, and Teamwork are all factors to address.

CHIRP Maritime looks forward to the publication of the full and complete accident investigation report by the flag state.

Alleged MARPOL contravention and MLC non-compliance

Outline: A report concerning alleged blatant contraventions of both the MARPOL and MLC international conventions. Under the MOU that exists between *CHIRP* Maritime and ISWAN, the following was another safety related referral by ISWAN.

What ISWAN told us

We have been contacted by a seafarer having safety related issues on board. Oil from the vessel is being directly discharged into the sea without going through the ODME. The ODME equipment has not been working for over a year. The seafarer has raised this with the captain, but he threatened to fire the reporter.

Further details were included in the email sent by the reporter to ISWAN.

On board I am working with no MLC rules being complied with – this generally applies 24 hours a day. I complained to the master regarding this, and now he is going to terminate my contract for that reason.

In addition, a magic pipe is being used for sewage disposal. Not all crew have proper certificates (and some do not even have basic tanker course certificates).

Further dialogue

CHIRP Maritime contacted the reporter directly and over a series of e-mails more details emerged of the alleged contraventions and non-compliances.

- STCW and MLC regulations regarding hours of rest are not being complied with and records are being falsified.
 - On three consecutive days the reporter was required to work throughout without rest breaks and on the fourth day he was again called by the master for duties outside the scheduled shift pattern.
 - At the end of the month the master presented the reporter with a completed hours of rest form that did not reflect a true record. When the reporter refused to sign the document, the master signed in his stead and filed the document.
- MARPOL contraventions.
 - Waste oil is illegally disposed of by filling empty drums and dumping same into the sea and falsifying vessels positions in the Oil Record Book.
 - There is a 'magic pipe' within the engine room allowing discharge of sewage without passing through the waste treatment plant. The vessel is allegedly discharging sewage within port limits and inside special areas contrary to Annex 4 of MARPOL.
- SOLAS contraventions.
 - The port lifeboat engine has an issue with starting

and has been like this for more than a year (according to notes on board).

- The GMDSS HF/MF transceiver is not working properly.
- The ECDIS, ENC's and paper charts on board are not being corrected up to date because there is no internet at sea to allow the corrections to be downloaded.
- Crew Certification.
 - Not all crew have the basic tanker safety course certificate as required.
 - A crew member joined without a yellow fever vaccination certificate and one was falsified onboard to avoid problems and prevent an inspection.

According to the reporter there are also issues regarding withheld wages and a payment of \$4000 to an agent to secure placement on board the ship. The reporter accepted that this was illegal but where he lives it is the only way to gain employment.

CHIRP Maritime contacted the flag state administration for the vessel who responded and requested details of the report, which were duly forwarded. In a subsequent email the flag state acknowledged receipt and expressed appreciation for *CHIRP*'s direct communication and advised that they had also been made aware of the complaint raised by the crew member through other channels.

CHIRP comment

The prompt and positive engagement by the flag state is acknowledged and commended by *CHIRP* and is one of the few positive highlights in this report.

The question is, how has this situation been allowed to arise? Audits, inspections, and vetting programmes should prevent this type of situation from existing but there are too many ships and too few inspectors. Surveyors and inspectors tend to be concentrated in major shipping hubs for obvious reasons but there are many smaller and more remote ports and terminals around the world where there is less likelihood of an inspection taking place. Is it any wonder that these are the very ports and terminals that the older vessels tend to operate in?

As new shipping tonnage is built by the leading companies in each branch of shipping, the older ships that are being replaced are often not scrapped for recycling but sold on to other companies for a further working life. So, the process continues with many ships being sold numerous times during their working life. Each time they are sold the ships are older and require more maintenance to keep them operational and in a safe condition. The irony is that companies that buy ships that are 20 or 25 years old tend not to have the money or the inclination to spend it on the ship and crew so the gradual decline with age becomes a race to the bottom of the barrel, to make as much money as possible from their asset before the ship fails surveys and is sold to the breakers or slips beneath the waves.

As reported to *CHIRP*, this case is a damning indictment of the shipping industry in the 21st century. Companies, and their employees have both a legal and moral duty to not just comply with the various legislation but to adopt a safety culture whereby incidents of this nature cannot happen. Whilst many companies do indeed have an effective safety culture in place, it is clear that many others do not. This report highlights the fact that *CHIRP* will follow up reports of this nature with flag states and that the flag states will take up the concerns. Any further reports of this nature would be welcomed.

Engine failed to start on sailing

Outline: A report highlighting a main engine failure and demonstrating the reason that pre-departure checks are carried out.

What the reporter told us

The main engine failed to start on departure from the berth. The ship's electrician had somehow disabled the main engine after repairing the bow thruster which had failed on arrival.

Further dialogue

The vessel involved was a large (294m LOA) container vessel which was moored in a restricted basin. There was another vessel moored 26m ahead, the end of the basin was 50m astern, and another vessel was secured on the opposite side of the basin 100m away. According to the captain and the bridge logbook entry, the main engine had been tested 30 minutes before the pilot came on board. Based on that information the pilot proceeded to utilise two harbour tugs to pull the vessel off the berth and into the middle of the basin before calling for the first engine movement – whereupon the engine failed to start.

Deciding it was too dangerous to attempt to put the ship back alongside with tugs alone, the decision was made to tow the ship out to a safe anchorage. Five minutes into this operation the main engine became operational. The ship proceeded outwards under her own power with tugs in attendance as a precaution.

Once the main engine had started the pilot asked the captain how it was possible for the engine to have been tested as stated but then fail to start. The captain's reply of "engine too powerful," which confused the pilot, was not elaborated upon.

CHIRP comment

After discussion, our Maritime Advisory Board members noted the following points.

- The Master / Pilot exchange must reflect the actual situation with regards to equipment status and operability rather than what should be or what we hope it to be.
- The meaning of testing the main engine should be clarified. A lot of engines are tested ahead and astern on fuel. However, some engines are only tested on air whilst alongside because of the excess thrust when fired on fuel with the potential to damage moorings. Perhaps this is what the Captain meant with the phrase "engine too powerful".
- Port arrival and departure passage plans should always have a plan "B" in case the first choice becomes unavailable. In this case plan "B" worked perfectly with the already secured tugs easily capable of towing the ship from the confined basin to a safe anchorage.
- A lot of modern engines have a reset mode that stops them starting. On the first physical start of the engine, it can be 20-30 seconds before the propellor starts to turn. This would be a matter of system familiarity by the engineers and electrician and good communications between the engine control room and the bridge.
- Furthermore, regarding system familiarity, check lists are great aids to highlight any link or commonality between remotely located machinery (main engines / bow thruster etc.).
- Finally, problems can occur, even after the most rigorous checks and physical tests, in which case early

and good communications are the answer to minimise the problem's effects. It is also necessary to overcome any cultural reluctance for the control room to volunteer that there is a problem.

PILOTS CORNER

Why do we get so many pilot ladder reports?

Most seafarers will join and leave different ships two or three times a year and on most occasions via a gangway whilst the vessel is tied up alongside in port. Spare a thought for the marine pilots who guide your ship safely in and out of ports, who regularly embark or disembark from 2 or 3 ships (or more) in a single shift, normally via an arrangement of hairy rope and wood called the 'pilot ladder'.

Pilot ladders must be important equipment because they come under the SOLAS regulations. For those who might have forgotten, the SOLAS regulations concern **Safety Of Life At Sea**. With that said, *CHIRP* questions why we continue to receive a steady stream of reports about non-compliant pilot ladders and pilot boarding arrangements .

Initial report

Combination pilot ladder with trap door non-compliant.

Further dialogue

The brief initial report was accompanied by a photograph (figure 5) which clearly illustrated the non-compliance. Whilst *CHIRP* received the basic report, a more extensive report was sent to the port state maritime administration by the reporter's professional association, which resulted in two PSC officers attending the vessel on the following day at its next port.

CHIRP contacted the ISM managers and corresponded with the DPA regarding the report.

Previously, in 2019, *CHIRP* had engaged with the ISM managers regarding a non-compliant pilot boarding arrangement (PBA) report for another of the company's vessels. On that occasion details had been passed to the DPA, but no further engagement had taken place . On this occasion the DPA volunteered that the vessel reported most recently was a sister ship of the previously reported vessel and both were fitted with the same pilot boarding equipment.

In later correspondence the DPA confirmed that the PSC inspection had taken place but stressed that no deficiency was logged by the PSC officer. However, the email went on "*Although we are of the opinion that the PBA is complying with SOLAS requirements, we have decided to make modifications to the PBA. We have instructed the technical department to approach the class & flag to carry out necessary modification*".

CHIRP comment

CHIRP was surprised to learn that no deficiency had been logged by the PSC officers following their inspection of this vessel.

- There are known issues with pilot boarding arrangements on pre-existing vessels of a certain age.
- Some maritime administrations seem to apply "grandfather rights" in this situation – *CHIRP* would contest there is no such thing with regards to pilot boarding arrangements. This is clearly a non-compliant arrangement.

- Pilots should be operating to a set of standard operating procedures.
- Not having a set of SOPs puts pressure on the pilot to make do. A pilot should not have to make a decision at the bottom of the ladder.
- Is there a difference between a non-compliant ladder and an unsafe ladder? – CHIRP would argue not. Although some elements of non-compliance are minor, it is a matter of law. The ladder *will* be compliant to the regulations and if it does not comply it should not be used – it's law.
- More and more ports and pilotage authorities are refusing to use non-compliant pilot boarding arrangements with more and more ships being turned away until a compliant PBA is presented.
- Ships that continue to present non-compliant PBA's will be delayed.



Figure 5.
PBA as presented:
 Pilot ladder presented in two sections. Both sections are secured solely to the accommodation ladder platform instead of to the ship. Yellow horizontal frame sections are impeding access during ascent or descent.

Changes can be made

The following information was passed to CHIRP by a pilotage authority to illustrate the extent of the problem and the success that can be achieved.

Regarding trap door pilot boarding arrangements and combination arrangements, over the past few months we have had some success in non-compliant unsafe arrangements being adapted to comply with the regulations and made safer. This is mainly due to the tenacity of our Harbour Master's department in following up on pilot ladder defect reports.

In 2020 we had 114 pilot ladder defect reports generated on 9512 acts of pilotage, this figure was an increase on 2019.

Case Study 1. Container Ship 304 m LOA, built 2008.

The vessel arrived at pilot station at night, pilot refused to board on arrival as ladder appeared to be non-compliant. (Figure 6).

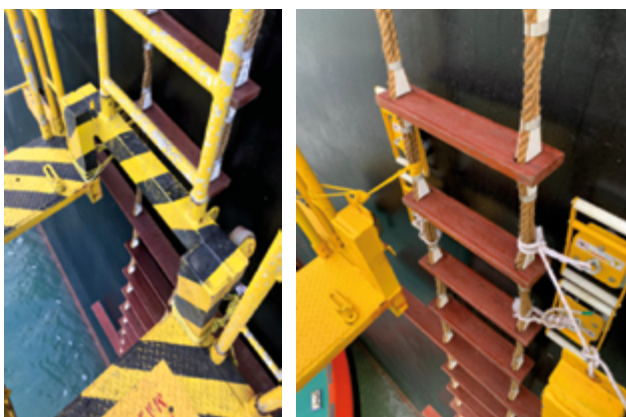


Figure 6 (left) original arrangement as presented.
 Figure 7 (right) after modifications

A second pilot did board in daylight and the vessel came in, it was reported to local Port State control who, after viewing pictures, deemed it compliant but not safe. Port Authority issued the vessel with notice that the arrangement was to be rectified before next visit otherwise vessel would not have a pilot. Dialogue took place over several weeks and on return the vessel presented a modified configuration (figure 7) as the boarding arrangement. Vessel was served on arrival and the pilot confirmed arrangement was safe.

Case Study 2. Container Ship 259m LOA, built 2013.

A trap door arrangement with the pilot ladder secured to the underside of the platform, so the ladder did not pass up through the hatch. Dialogue took place but no adjustments had been made, on arrival at port limits the vessel was refused pilotage until boarding arrangements were compliant and safe. After 3 days at anchor the arrangements had been adapted to a combination arrangement with the pilot ladder secured to strong points on the main deck.

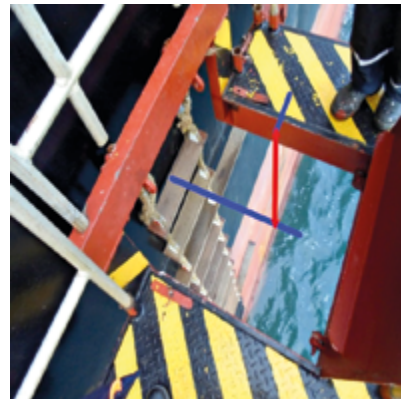


Figure 8 (left) What was presented originally (rejected)

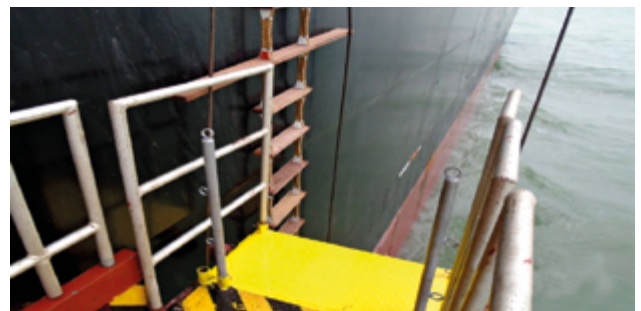


Figure 9 (below) This was the final arrangement (minus the securing magnets which were in place when used by a pilot).

Case Study 3. Container Ship. 190m LOA, Built 2020.

Combination ladder, the gap between the pilot ladder and the lower platform was greater than 20cm (when measured it was 50cm). Dialogue took place with the vessel who originally stated this could not be modified. Sorry captain, but there will be no pilot boarding your vessel. They found a solution on board and reduced the gap to 20cm. A pilot boarded.

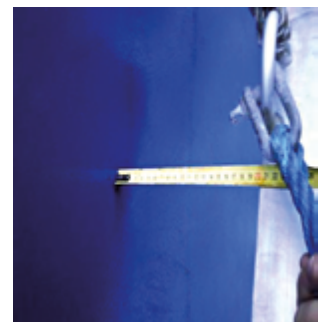
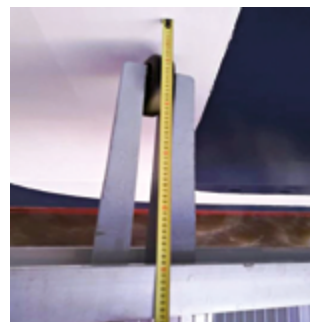


Figure 10 Before modification Figure 11. After modification

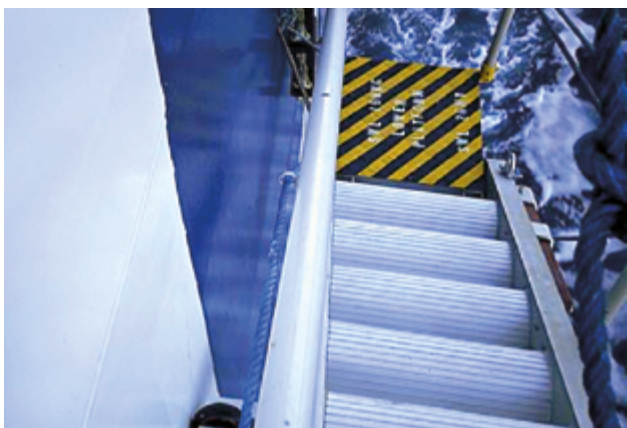


Figure 12. Compliant combination pilot boarding arrangement ready for use.

CORRESPONDENCE RECEIVED

1) Regarding the article published in MFB61, **Superyacht – crew working outboard without PPE.**

Within the article it was noted that *CHIRP* attempted to contact the PYA (Professional Yachting Association) to establish a dialogue, but sadly the PYA had not engaged.

At the time of writing the article and going to press that was correct.

Happily, that is no longer the case with the new CEO of the PYA contacting *CHIRP* Maritime recently when a fruitful engagement took place. *CHIRP* Maritime is now looking forward to further engagements and collaboration with the PYA.

2) Regarding accident prevention.

To enhance safety on board and as a proactive action against willful disregard, sabotage and recklessness

caused on a ship I am looking for an organization to report some events where the local flag did not show a positive reaction toward some actions that could cause a fatal accident in the future.

Please advise if there is any specific organization or International Branch.

CHIRP Maritime responded.

With regards to accidents, incidents and near misses on board any ship, the suggested normal chain for reporting, investigation and engagement about such things would be:

- Safety Officer/ Chief Officer / Chief Engineer
- Captain
- Company (ISM Manager's) DPA
- Classification Society – depending on the issue.
- Port State – if vessel is in a foreign country.
- Flag State

We stress that the normal chain of safety reporting is per your company SMS.

Beyond that, should the flag state not positively address concerns, there are no international authorities with statutory powers to investigate safety issues, incidents, or accidents on board ships. *CHIRP* Maritime does operate on a global basis, but we have no statutory authority or investigative powers, we can only attempt to correspond with the relevant ISM managers (DPA), classification society or flag state administration to bring issues of concern to their attention but we must stress there is absolutely no obligation for any third party to engage with *CHIRP* Maritime.

Reading your mail again, it is disconcerting that you mention wilful disregard, sabotage, and recklessness onboard ships.

If you feel *CHIRP* Maritime might be able to help, please send full details of the safety incident by e-mail to reports@chirp.co.uk, or through our online reporting system.

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