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## Communication: the key to better safety



**Adam Parnell**  
Director (Maritime)

This edition contains a wide range of different types of reports, and we are grateful to all our reporters for the high quality of their submissions.

One theme which links the majority of the reports is the need for better communication at all levels, whether it is between ports and port users, between vessels, or between the various parties on board a ship. Our reports clearly demonstrate how a failure to communicate or a breakdown in communication can so easily lead to misunderstandings and accidents. On a positive note, there is also a report where good communication between the bridge team and the pilot prevented a potentially serious incident.

The role of port authorities is a factor in some reports, and failures of coordination and communication again feature prominently. Many mariners would probably be reluctant to criticise

a port authority, but the good ports will always welcome constructive comments. If you witness anything you think could be improved, it should be raised with your DPA or mentioned to the pilot.

Unfortunately, we also feature a report of a sub-standard vessel. We are seeing more of these types of reports, which indicates there must be a large number of vessels sailing in a totally unacceptable condition. Such vessels tend to be quite old, so somehow they have traded for years without being detected by port state or classification society surveyors. How is this possible? Are the inspectors spread too thin, or are there surveyors who do not care or look the other way? If you experience such vessels or cases where deficiencies are not acted upon, please let us know.

Until next time, stay safe!

**One theme which links the majority of the reports is the need for better communication at all levels**

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M2051

## Failure to challenge authority leads to a dangerous occurrence

### Initial report

A pilot boarded a tanker at anchor. When they arrived at the top of the ladder, they discovered that it was tied to a rotten railing, there were no suitable hand-holds nearby, and there were many trip hazards on the deck near the embarkation point.

When the pilot raised this with the master, he was told that the ladder was not usually rigged in that position but had instead been moved to accommodate the pilot station's direction to rig a 7m ladder. This was higher than the 5m maximum height at the normal embarkation point, so the ladder had been moved.



### CHIRP Comment

The master should have challenged the pilot station's request to move the ladder from its designated position on safety grounds. In many cultures, authority figures are not challenged, which might have been the case in this situation. However, the master and crew know their vessel best! If the request was made because of a high sea state or significant swell, CHIRP would question whether safe embarkation would have been possible in such conditions.

### Factors relating to this report

**Communication** – Vessels should challenge any direction that means a departure from authorised procedures, particularly where safety could be compromised.

**Situational awareness** – Before any activity, particularly one which deviates from normal procedures, a dynamic risk assessment is vital to ensure that the area is safe. Had this been undertaken effectively, the crew should have noticed that the ladder's fixing point was unsuitable.

**Culture** – The poor state of maintenance indicates that the vessel's safety and maintenance culture was inadequate. It also suggests a lack of external inspections and audits at the organisational level.

**Pressure** – The crew put themselves under self-imposed pressure to provide a pilot ladder at 7m despite knowing this would be less safe than the designated embarkation point.

M2048

## Bridge Resource Management - Issues concerning helm execution

### Initial report

A vessel was entering the harbour by day with a pilot on board. After settling on a course of 168°, the pilot asked for a new course of 170° to set up for a wide turn onto the next (160°) leg.

The helm correctly repeated back the 170° course to the pilot, who then looked down at their portable pilot unit (PPU). When they looked up, they saw that the ship had started to swing to port. The master and OOW challenged the error just as the pilot realised what was happening, and the swing was quickly stopped.

One possibility considered by the pilot was that the helm might have had the next (160°) course in mind, which was to port. Visually too, there was a shoal beacon fine on the starboard bow, and the helm might have intuitively turned to open the distance from that navigational hazard. The pilot put the incident down to being a human factor slip, which he felt reinforced the need to check the rudder indicator with all course changes.



### CHIRP Comment

The reporter (pilot) is commended for self-reporting, a sign of a strong safety culture at that port. Similarly, the use of closed-loop communication by the pilot and helmsperson and the swift challenges by the master and OOW indicate a strong safety culture among the crew.

Closed-loop communications are a good protocol for all safety-critical communications.

Several environmental stressors can affect how the helmsperson responds to helm orders. Creating the right communications environment with clear, concise communications will help the helmsman interpret the orders correctly. Providing advanced intentions of helm action at critical points in pilotage assists the bridge team in anticipating the pilot's action. In this instance, the clearest



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order would have been “Starboard wheel, steer 170°.” Some pilots augment their spoken orders with non-verbal signals, such as raising an arm or pointing in the desired direction, to minimise the risk of confusion. This is a good practice that CHIRP encourages OOWs and other pilots to emulate.

#### Factors relating to this report

**Communications** – Ensuring that the spoken message has been received and understood and that the desired outcome is implemented is crucial during navigation manoeuvres.

Different pilots and different bridge teams will all do things slightly differently. Ensuring that there is closed-loop communication at all stages of pilotage for helm and engine orders creates consistency and will improve navigational safety.

**Alerting** – Keeping the bridge team informed of current and future intentions reduces the risk that others will anticipate or misinterpret orders. This is particularly useful in times of high or low workload.

**Teamwork** – The master and the OOW reacted swiftly to the error; this shows a commendably high level of teamwork. Pilots often have many jobs during the day that can result in them feeling tired and making the occasional slip, and it is at these moments that they need backup and support from the bridge team. When you are on the bridge of your next ship, consider how well you work as a team and what you can do to improve bridge teamwork. Does your bridge team ever conduct a post-arrival/departure debrief?

*M2028 (submitted by ISWAN)*

## Enforcement of safety regulations – is it adequate?

#### Initial report

A seafarer complained about awful working conditions on board their ship. The accommodation was unhygienic, food was insufficient, and the equipment was in disrepair: the main engine and gearbox leaked oil, and the seafarer claimed that oil and garbage were frequently discharged overboard. The air conditioning was also broken.

The reporter stated that the chief officer was blackmailing the crew by threatening that anyone who reported the poor conditions would be dismissed.



#### CHIRP Comment

The reporter initially contacted ISWAN with their concerns. Because of the obvious safety implications, and with the reporter's consent, these were passed to CHIRP. Shortly after CHIRP received this report, the coastal state detained the vessel when it next docked, and the crew were repatriated.

The photographs suggest that the vessel has not been compliant with minimum regulations for a considerable time, yet this was not detected by any external audit. This is not an isolated case, and CHIRP regularly receives similar reports. The number of vessels with unseaworthy or poor conditions remains stubbornly high, despite numerous international and national regulations regarding minimum safety, environmental and welfare standards. Flag states are obliged to enforce standards, but international law has few consequences if a flag state fails to do so adequately.

Capacity and resource limitations reduce the number of inspections a port state may conduct, so substandard vessels like this can operate for a considerable time before being identified and detained. Seafarers on board unseaworthy or non-compliant vessels are encouraged to contact CHIRP, who will advocate on their behalf.

CHIRP remains the confidential, independent and impartial voice of the mariner, whose safety remains our priority.

#### Factors relating to this report

**Alerting** – The ship's crew have been responsible for raising this matter to ISWAN and CHIRP, which is commendable. Alerting by the internal and external audit process has failed.

**Competency** – The management company does not have the necessary skills or willingness to run a ship conforming to the ISM code. There appears to be a total lack of adherence to the requirements of the Code, which is the minimum standard that should be applied. The Recognised organisation and Flag for this company must do more to achieve the minimum standard.

**Pressure (Commercial)** – The threats by the Chief Officer suggest that commercial considerations have contributed

to a culture where violations of environmental, welfare and safety standards are not just tolerated; they are expected.

**Capability** Do Flag and Port State have the ability to enforce minimum standards strictly? According to records which have allowed the ship to keep operating in this condition, the flag state appears to have not carried out any quality control inspection.

M 2033

## Collision between power-driven vessel and yacht narrowly avoided

### Initial report

Our reporter writes, "We were sailing in our yacht, with a flat sea, light wind, and perfect visibility, making about 4 knots on a course of 132° degrees. A very large motorboat came into view dead ahead several miles away and continued towards us on a reciprocal course. We observed this motorboat as it came closer, mainly because its bow pointed directly at us.

As it came closer, it showed no sign of changing course, even though it was motoring and we were sailing. When it was just a few seconds away, we started our engine and made a 90-degree course change to starboard to avoid being run down by it. We do not doubt that, had we not started our engine and turned out of its way, it would have run us down.

Our AIS receiver gave the vessel's name and showed a speed of 12.9 knots. The motor cruiser is a 50-meter-long vessel. We called the vessel on VHF Channel 16 and immediately received a response. We said, 'we are the yacht off your stern that has just had to alter course to avoid being run down by you. The radio operator on the motor cruiser said three times that they had not seen us and seemed to be completely unaware of our presence or that they had nearly run us down.'

### CHIRP Comment

The power-driven vessel (PDV) should have maintained a proper lookout to "Make a full appraisal of the situation and the risk of collision" and then taken action under rule 18 to "keep out of the way of" the yacht. The yacht avoided a collision by her manoeuvre alone (rule 17). However, the moment it started its engine, it became a PDV; thus, this manoeuvre was required under rule 14 (head-on situations).

Both vessels had an obligation under rule 2 to 'comply with the ordinary practice of seamen', which, in layman's terms, means always using common sense. Although the yacht was strictly correct in maintaining her course and speed, CHIRP suggests that an early and bold alteration to starboard to stop a close-quarters situation developing could have been an equally valid course of action since both vessels have a responsibility (again under rule 2) to avoid a collision.

The yacht might also have considered sounding five short blasts (rule 34d) to indicate that it did not understand the intentions of the PDV. And notwithstanding the risks

that CHIRP has previously noted about 'VHF-assisted collisions,' it might also have been prudent to alert the PDV of their presence.

### Factors relating to this report

**Situational Awareness** – The yacht's crew displayed good situational awareness, which was lacking on board the motor cruiser. All vessels must keep a proper lookout at sea – there are no exceptions.

**Alerting** – When in doubt of another vessel's intentions, five short blasts on the whistle and at night, the flashing of a white light is an effective way to get another vessel's attention. The VHF can also alert them to your presence, but the message should be short, concise, and positive if used.

M2070

## Mooring launch crushed against the side of a container vessel

### Initial report

The port berthing officer was attending to a large container vessel's berthing when he received a radio message from the mooring team to quickly head aft to investigate a serious incident during mooring operations.

The aft mooring launch sat at the stern of the containership, waiting for the third line to be lowered to them. Instead, the two lines that had been run ashore and were fast on the bollards were slackened off by the aft mooring team and dumped into the water. The launch tried to move away from the lines to avoid getting tangled. When the launch was almost clear, the ship heaved up on the two lines again, only to catch the mooring launch, lifting it out of the water and crushing it against the underside of the ship's flare. The two launch crew considered abandoning the craft, as the prolonged shouting and blast of their horn did not succeed in getting the crew's attention. Finally, the ship's after mooring crew realised what had happened and slackened off the lines. Other than the boat crew being severely shaken by the incident, there were no injuries to the crew but some damage to the mooring boat.

### CHIRP Comment

This is an obvious case of miscommunication during a critical phase of the mooring operation.

Vessels often pay out lines to take the weight off them before transferring them to the working drums. The safest method is to do this only after all lines are ashore, then move one at a time to keep the lines and the vessel under control. CHIRP wonders if there was a real - or perceived - time pressure on the mooring party for them to take such a dangerous shortcut.

### Factors relating to this report

**Situational Awareness** – While launches or other vessels, such as tugs, often make line handling easier, it complicates

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the mooring officer's task because that officer must simultaneously be aware of what is happening on board and over the side. A vessel rarely has enough crew to dedicate one person to each of these tasks, although that would be ideal. Instead, additional care must be taken when working lines with vessels nearby.

**Pressure** – Mooring operations must never be rushed. Care is required by the master and pilot to provide timely messaging to the mooring teams to ensure that each order is carried out carefully and unhurriedly.

**Distractions** – The mooring team were distracted when they failed to hear the mooring boat crew's signals when they were trapped against the ship's hull. Keeping alert during mooring operations is vital, given the changing nature of the ship's movement and the strain on the mooring lines.

M2062

## Contingency action to avoid a close-quarter incident with a passenger ferry

### Initial report

Our reporter, a passenger ferry captain, writes: "As per the timetable, we arrived at the standby location for the port at the required time. It was daylight, with good visibility and a stiff wind. We worked, as usual, on the pre-arrival checks and verifications as we closed on the berth. When I called the port per the pre-arrival checklist, I was informed that a large passenger liner had just let go and that I might have to 'slow her up' (referring to my vessel). However, given the proximity to the berth, the other boat and the increasingly confined waters, it was clear that I would have to lose speed quicker than I safely could. So, I had to opt for a rapid turn upwind (to avoid being set onto the nearby lee shore). I continued my turn and completed a 360, and during this time, the passenger liner was clear of the port and the berth we were aiming for. Our distance from the breakwater was approximately three cables when we started the turn.

For each port of arrival, we plan two abort positions. We had passed the first, where 'Standby' is rung, the crew called to stations, the pitch response verified, and hand steering engaged. We had not yet reached the second abort position (approximately four cables from the first), so a direct abort was still viable.

Shortly after passing the first abort position and confirming the items mentioned, I called the harbour for permission to continue into the berth. I was given the all-clear whilst being advised of a departing cruise ship that might be leaving. The operator told me I "might want to slow her up a bit", but it was now clear to me that I would need to abort the arrival to avoid a close-quarters situation with the cruise vessel, which was manoeuvring off her berth. Given the proximity of the lee shore to starboard, I elected to turn to port upwind and gain distance from the shore, together with slackening speed to a minimum.

With the above avoidance measures well underway and having the desired effect, I communicated with the cruise vessel to establish which general direction they intended to take upon clearing the harbour to allow me to plan the rest of my manoeuvre and not result in additional unnecessary risk. With them advising a course to the east initially before turning to the north, I elected to complete a full 360, allowing time and space for the cruise ship to exit the immediate harbour area and for me to generally pick up the standard approach to our berth for arrival.

The main hazards were the proximity of the lee shore, with easterly winds, something that is factored into the passage plan to allow extra room, including the shoaling waters to the south of the berth; this knowledge allowed me to decide on early, positive and bold avoidance measures quickly, rather than allowing the risk to increase by proceeding onwards, even at a reduced speed, and allowing an unnecessary close quarters situation to develop.

As my vessel is on a timetabled service, we arrive and leave at the same time every day, weather permitting. Despite this, the cruise ship was allowed a departure that directly clashed with our arrival. A clash in movements such as this could have been avoided with a simple telephone call or email. After that, we could have timed our arrival later, thus preventing the situation above entirely.

It is worth noting that the bridge team worked well together in the initial arrival, the abort actions, the passage/arrival resumption, and subsequent safe berthing".



### CHIRP Comment

The ferry traded time for space and safe water and avoided a close-quarters situation. This was the correct course of action. Readers are encouraged to compare this with report M2036, published in our last edition of FEEDBACK, which highlights the perils of taking the opposite approach.

Port authorities are responsible for managing vessel traffic and would have been aware of the ferry's scheduled arrival time. Cruise vessels operate to an itinerary, but better coordination between the port and the cruise ship would have avoided this incident. This suggests either a breakdown in communication or the ferry's arrival was not correctly considered when the cruise ship planned its departure time. Radio procedure by the port authority was also ambiguous: was "You might want to slow up" a direction or a recommendation?

In smaller ports, particularly those not staffed 24 hours a day, it might be wise to publish notices to mariners directing specific sizes or categories of vessels to broadcast

their arrival and departure on the port's VHF working channel. This alerts other vessels in their vicinity and allows them to coordinate with each other. CHIRP encourages small ports to consider whether such a scheme would be appropriate in their harbour.

**Factors relating to this report**

**Local Practices** – Port management must not leave marine operations to chance. Establish clear safety risk measures and define procedures to understand what is required for arriving and departing vessels at this port.

**Communications** – Clear communications from the port authority, which prioritises incoming and outgoing vessel traffic, should be established, especially in ports with limited room to manoeuvre.

M2065

## Failure to communicate a change in the pilot boarding arrangement

**Initial report**

Combination ladders: Trapdoor Type Combination  
The pilot who reported this incident had reported the same non-compliant transfer arrangements on this vessel two months earlier. At that time, the master was advised and given drawings of the required modifications. The port state was also informed. On arrival at the port two months later, nothing had been done to rectify the situation.

The new master on board knew nothing of the previous non-compliance report. As part of the trapdoor combination, the pilot ladder could not rest against the ship's side. It was hanging free of the ship's side by 200mm. This time a formal notification was given to the Port State Control authorities to attend the vessel.



**CHIRP Comment**

This report highlights several issues in the reporting culture of the company.

CHIRP is very surprised that the ship manager was not informed, so plans using the drawing provided by the pilot were not utilised to make the arrangements compliant. What is equally worrying is that the next master (who would

visit this port because it is on a liner service) would have the same non-compliance matter raised against the vessel. From a pilot's safety perspective, this deficiency is very dangerous, and the ship's staff seem to have given scant regard to the deficiency.

Pilotage and port state authorities are generally considerate when genuine first mistakes are made, and advice is given to rectify the problem. They are not so receptive when the advice is completely ignored. Port states or individual port authorities are strongly encouraged to empower their pilots with "stop work" authority - to refuse to board vessels with non-compliant or unsafe pilot ladders. They could make this clear to visiting vessels in their pre-arrival documentation.

**Factors relating to this report**

**Alerting** – Alerting the company of deficiencies seems to have been a difficult thing to do. It is unclear why, but it is likely that management does not react well to bad news, and therefore, such news is not delivered. The new master is left with a more severe deficiency, and the company's reputation is damaged.

**Culture** – There would appear to be a poor communication culture in the company where bad news is not encouraged. Have you experienced similar issues on your ship? Does nobody want to listen to your concerns? Contact CHIRP if your safety management process is not working and you are not being heard.

M2069

## A sailing yacht grounded at the entrance to a marina

**Initial report**

The skipper and five crew of a 17m sailing yacht with a draught of 2.5m were on passage in a large sea area. They approached a port with charted depths that should have presented no difficulties. However, a chart note stated that the marina entrance was prone to silting and that vessels should proceed with caution, keeping a close eye on the depth sounder.

Sails had been lowered about a mile from the marina entrance, and the engine engaged. The crew used up-to-date paper charts and the pilot book for the area. This warned of reports of shallow spots extending up to 50m from the marina breakwater and advised giving this a wide berth.

As they approached the entrance, the following sea became more pronounced as the depth decreased. Mindful of the pilot book's warning, they kept clear of the end of the breakwater and expected to see the three starboard-hand lateral beacons and four port-hand lateral buoys to guide them in.

They began their turn to starboard, having seen a single set of port and starboard lateral buoys inside the entrance and made a course between them. The depth was monitored but reduced quickly, falling below 1m under the keel.

In the belief that this was one of the shallow areas noted on the chart, they continued but grounded shortly afterwards. The engine was put hard astern, but the swell



was driving them further towards the beach. They were able to bring the boat head to sea using the bow thruster, and the anchor was deployed.

Fortunately, the vessel re-floated, and they were able to motor into the marina, taking a course much closer to the breakwater than that advised by the pilot book but which they had observed in the previous hour being successfully used by vessels of a similar size.

When the boat was lifted out of the water and inspected, nothing more than superficial damage was found to the keel bulb.

The reporter clarified that mistakes had been made by not referring to the chart notes and acting on their information concerning silting at the approaches. The reporter had become too focussed on the advice in the pilot book, which was four years old, regarding the shallow patches extending from the harbour breakwater.

When the depths began to reduce, instead of stopping and going astern, the yacht continued with the approach, resulting in the grounding.

The reporter also informed CHIRP that the yacht's engine was not working at full efficiency due to an, at the time undiagnosed, broken turbocharger. While it could propel the yacht at between 6 and 7 knots in calm conditions, there was insufficient power when needed in an emergency.

#### CHIRP Comment

This report highlights the dangers of using older sources of navigational data. The discrepancy between the actual and expected depth should have been a 'red flag' to the crew that they were not necessarily where they thought they were. Although they turned at what they thought was a safe distance, they had turned too soon because they did not see

the expected number of lateral buoys. There is evidence of confirmation bias in the report – they felt they were in the right place and explained away the rapidly shoaling ground as the 'shallow patch'. The correct action was to turn around and confirm their position.

CHIRP wants to reinforce the requirement that a fully performing engine on a sailing yacht should be considered an essential safety item, not only for the circumstances experienced at the time of grounding but also for collision avoidance, MOB situations, and executing crash stops in close-quarters cases.

#### Factors relating to this report

**Situational awareness** – The pilot book was several years out of date, and it is likely that it no longer described seabed depths accurately. The expected number of lateral buoys was not visible before the course alteration around the breakwater. Although the second entry into the marina was successful, this was mainly based on guesswork by estimating the route other vessels had followed.

**Communications** – Contacting the port authorities to ask about the latest seabed changes should have been considered to plan a safer approach to the port. Is this something that you would do if you were approaching a port for the first time?

**Local Practices** – Although most charts and pilotage books are issued annually, many yacht owners admit to only updating their copies every few years to save on costs. This is a false economy compared to the potential costs of an incident. Similarly, engine maintenance can be costly but could be the difference between an accident and a near-miss.

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## Demonstrating the link between working conditions and safety

### Dr Jess Sparks

In June 2022, the International Labour Organization (ILO) of the United Nations adopted “safe and healthy working environments” as their fifth category of Fundamental Principles and Rights at Work, demonstrating the intrinsic links between safety and decent work and unsafe and indecent work.<sup>1</sup> As fishing is notoriously one of the world’s most dangerous professions,<sup>2</sup> recognition of these links is also embedded in the ILO’s (2007) Work in Fishing Convention (c188) – which establishes minimum standards for decent work on board fishing vessels.<sup>3</sup> Decent work is just one end of the spectrum of working conditions on board fishing vessels, with egregious violations of human rights constituting forced labour, human trafficking, and modern slavery at the other end. In between decent work and forced labour are a range of conditions that may be exploitative and discriminatory but not in violation of labour laws (e.g., unequal pay for migrant fishers for equal, shared work with national fishers) or conditions that violate labour rights and protections, but may not amount to forced labour.<sup>4</sup>

Bidirectional linkages between (un)safe working conditions and (in)decent work across fleets globally have also emerged in research. First, exploitative labour practices

make the work on board vessels even more unsafe. For example, many exploited fishers working in fleets from Thailand<sup>5</sup> to the UK<sup>4</sup> to China<sup>6</sup> report excessive working hours in contravention of ILO C188; denial and sometimes falsification of rest hours; and tied immigration schemes that blur the lines of what constitutes work – compelling some fishers to perform unvalued work (e.g., mending nets and vessel repairs) onboard the vessel while in port on their ‘rest’ days, or this may involve the denial or withholding of food and water until a certain amount of fish has been caught; as punishment for a poor catch.

Both scenarios compound the dangers already involved when working on a vessel as fatigued and malnourished fishers are more prone to making mistakes with serious consequences to their health and safety, and potentially the health and safety of others on board the vessel through no fault of their own. In research from the UK, migrant fishers in the sample were significantly more likely to incur injuries than national fishers.<sup>4</sup> Further, since many exploited fishers globally are transnational migrants, their precarious immigration status may deny them access to medical care, including routine medical care that could offer early detection of illnesses associated with extreme and chronic fatigue and malnourishment.

Safety matters may also influence working conditions. There is some speculation, though it has yet to be empirically tested, that safety violations may be an early indicator of future exploitative labour practices, as these violations may be an early warning sign of a tipping point into decreasing profitability and the associated 'corner cutting' that often underpins the exploitation of crew.<sup>7</sup> And increasingly, the fishing industry needs to anticipate and plan for future scenarios where climate change will also likely exacerbate these links between safety and decent work, such as extreme storms, extreme heat, and wave and wind changes that may lead to occupationally hazardous work, longer trips at sea, longer working hours, and the need for more safety equipment. Suppose these impacts are not mitigated, and the industry is perceived as becoming more dangerous due to climatic changes. In that case, it could intensify crew labour shortages that are known to increase reliance on migrant fishers and drive exploitative practices.

The industry must also grapple with how to understand and frame these interconnections. On the one hand, contextualising working conditions within a more significant reference of safety offers the potential for greater stakeholder buy-in as it is frequently less divisive of a topic than the treatment of migrant crew. On the other hand, such contextualisation may also risk overlooking the systemic drivers of fishing crew exploitation and fair washing exploitative practices that do not reach the threshold of forced labour as decent work.

Dr Jess Sparks is a Research Assistant Professor at the Friedman School of Nutrition Science and Policy at Tufts University and a Research Fellow at the University of Nottingham Rights Lab. She has almost ten years of experience researching working conditions in the global fishing industry.

**Fatigued and malnourished fishers are more prone to making mistakes with serious consequences to their health and safety**

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