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Safety takes time: Do we give ships enough time to stay safe?



Adam Parnell
Director (Maritime)

We have a wide range of reports in this edition, and we thank all our reporters for contacting us. It strikes me that, despite the variety of vessel types involved, most of these reports apply to almost every ship.

We learn of a momentary loss of concentration on a Search and Rescue craft, a fire in a cargo of charcoal and another on a motor yacht recently out of drydock. An inoperable CO₂ system was also discovered following a period of maintenance. Once again we learn about a pilot ladder which was improperly rigged, and we also have reports about a corroded walkway on deck and an eye injury caused by a caustic cleaning agent.

One report which should not apply to any vessel, ever, concerns unacceptable living conditions. We are following this up with the

Flag State, because contraventions of the Maritime Labour Convention are disgraceful, if sadly all too common.

On a brighter note, it is encouraging that several of the incidents reported in this edition were resolved successfully by the crews involved. The benefits of thorough training are readily apparent.

Among the most common factors identified in these reports are situational awareness, capability, culture, teamwork, alerting and communication. How would your ship manage if you found yourselves in similar situations? But the common theme in all reports is time: without it, many checks and preventative measures are missed, and safety gets compromised.

Finally, we commend the suggestion that vessels should adopt the use of 'REMOVE BEFORE SAILING' tags when equipment is rendered inoperative during maintenance periods. It is a simple and inexpensive idea which could potentially save many lives.

Until next time, stay safe!

Are you interested in becoming a CHIRP Maritime Ambassador?

CHIRP and the Nautical Institute have an established ambassador scheme to raise awareness of our incident reporting schemes and encourage the submission of incident, accident and near-miss reports.

As an ambassador you will join an international network of over 50

seafarers (see map) who also share your passion for safety, and you will quickly gain a broad knowledge of current safety issues. These are great additions to your CV and increase your employability.

Together we can promote the development of a 'just' reporting culture across the maritime sector

to improve safety outcomes. The key attributes of a successful ambassador is a passion for safety and a willingness to speak up for CHIRP among your colleagues and contacts.

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M2354

Non-compliant pilot ladder

Initial report

Our reporter sent pictures of a pilot ladder that did not meet SOLAS regulations. No handholds were securely fastened to the ship's bulwarks, preventing the pilot from stepping safely and comfortably from the top of the ladder onto the ship's deck. The accommodation ladder platform did not have stanchions, and the ropework and securing hitches were substandard. The pilot ladder was not correctly secured at deck level.

This was reported to the master when the pilot boarded the vessel. The master was informed about the proper securing of the combination rig and has given assurances that corrective action will be taken. Port state authorities were alerted to this incident.



CHIRP Comments

The quickest way to motivate the industry to address this common issue properly is to refuse to board. This also ensures pilots' safety. Do not take chances – there is no such thing as a 'safe' non-compliant ladder.

SOLAS requires that a responsible deck officer supervises the rigging of ladders. Unfortunately, there is some ambiguity in using the word 'officer' because ISO 799 says that a deck officer can be any suitably trained deck crew, and many companies thus delegate the role to a deck hand rather than a ship's officer. This has obvious safety implications.

CHIRP calls on Flag States to mandate that ladder rigging be supervised by a ship's officer and that this activity be included within the Permit to Work system because of the potential risk to life.

Factors relating to this report

Culture – A poor safety culture is evident, which is shown by the lack of care to a pilot boarding the vessel. Management must provide guidance and practical training to the crew.

Situational Awareness – There is a false sense of safety that the pilot can manage this transfer safely when it is clearly dangerous.

Capability – There are clear procedures for rigging a pilot ladder combination rig, but they were not followed in this incident.

M2310

Eye injury

Initial report

The ship's cook used an oven cleaner containing sodium hydroxide while cleaning the galley after a mealtime. The cleaner was sprayed onto all greasy areas, including the extractor hood over the cooker (which was above head height) and left for some time to dissolve the grease.

When the cook returned to inspect the sprayed area, the chemical cleaner dripped from the cooker hood into the cook's eye, causing severe irritation and a burning sensation to the eyeball.

A crewmember called the master who irrigated the eye with a sterile eye wash to flush the chemical from the cook's eye. The coastguard doctor was contacted as a precautionary measure; they advised that the crewmember be airlifted to a local hospital for further treatment.

CHIRP Comments

The correct PPE must be worn when working with caustic or other hazardous materials, especially above head height, as risks of personal injury significantly increase. The PPE should cover the entire body to prevent caustic burns. A full-face shield is better than eye goggles as it protects the whole face from caustic burns.

It was also inadvisable to leave the area unattended after the chemical had been sprayed onto the galley surfaces because another crewmember might have entered and suffered a severe injury.

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Factors related to this incident

Communications – The head of the department needed to be informed about this hazardous work so that proper safety precautions could be taken.

Overconfidence – Because cleaning the galley is a routine task and has been done many times before without incident, the risk of the chemical cleaner has been overlooked. If you routinely work with chemicals, be alert to any signs of complacency in yourself or others.

M2317

Unacceptable living conditions

Initial report

During a recent deployment, a temporarily embarked armed security guard reported that the ship's material condition and living conditions were deplorable. The potable drinking water system was inoperative, and the crew relied on outdated bottled water. The water used for showering, brushing teeth, and laundering clothes was rusty. There was no air conditioning, and the toilet system was broken. Additionally, the living quarters were unhygienic, and the crew experienced numerous bed bug bites all over their bodies.

Food was also unsatisfactory: meals were monotonous, with limited meat or fish options. Fruit was rarely available and tasted of rust.

**CHIRP Comments**

The armed guard is to be praised for raising this report because the crew were too afraid of reprisals to do so themselves. This raises worrying questions about the company's safety culture. Many seafarers are unaware of their rights, set out in the [Maritime Labour Convention](#), regulation 3.1 (page 43). The vessel in this report is breaching many of these legal requirements. CHIRP contacted the vessel's Flag State, which has a legal obligation to ensure that the vessel addresses these shortcomings immediately.

Factors relating to this report

Culture – Management has very little regard for safety, MLC compliance and contractor welfare.

Alerting – CHIRP notes that this report comes from embarked contractors, suggesting that the crew does not feel safe reporting these obvious failings.

M2329

Container fire

Initial report

While on passage, a container full of charcoal spontaneously ignited and a severe fire ensued.

A special exemption existed at the time of the incident, meaning that the cargo did not need to be declared dangerous goods. This significantly delayed efforts to identify the location of other charcoal-filled containers when the fire erupted.

Thanks to the crew's swift and decisive actions and exceptional teamwork during the emergency, personal injuries were prevented, and the ship sustained no structural damage. The crew's coordinated efforts in boundary cooling and fire suppression were critical despite the challenges posed by the fully enclosed containers, which made firefighting operations more difficult.

CHIRP Comments

This report echoes a similar incident ([M2253](#)) published by CHIRP in 2024. CINS (the Cargo Incident Notification System) has published their [Guidelines for the Safe Carriage of Charcoal in Containers](#) which is available online.

Charcoal is categorised as 'UN1361 CARBON animal or vegetable origin' and presents unique risks because it can spontaneously ignite if not stored or packed correctly.

From 1 January 2026, charcoal must always be labelled as dangerous goods, and transitional arrangements commenced from 1 January 2025. It is worth noting that 68 container fires were reported from 2015 to 2022, highlighting the potential risk to all carriers.

While this new requirement will promote the safer carriage of charcoal in containers, shippers must still exercise due diligence to ensure that all requirements are fulfilled before loading. Carriers are encouraged to review their cargo management and know-your-customer procedures. Ship management and chartering departments are crucial in ensuring that shippers comply with the new regulations.

The crew's ability to prevent this fire from escalating largely depended on strong onboard emergency preparedness, which is founded on a robust safety culture within the company. This report highlights the outcomes of practical training provided both on board and by the company.

Factors relating to this report

Local Practices – When packing charcoal into containers, strong local oversight and supervision is required to ensure that the risks of oxidation and spontaneous ignition are minimised.

Alerting – Charcoal must now be declared a dangerous good. The local exemption has been revoked.

Situational Awareness – Packers are encouraged to provide photographs of loaded containers to shipping companies to improve their situational awareness of container contents in the event of an emergency.

Packers are encouraged to provide photographs of loaded containers

M2355

Corroded walkways over deck pipes

Initial report

While walking between holds 2 and 3 on a bulk carrier, the bosun observed that the platform made a crackling sound under load. The metal plate was found to be significantly worn and no longer capable of safely supporting the weight of a single crew member. The bosun reported the issue to the master, who ordered an inspection of other walkways, which were found to be in a similar state.

CHIRP Comments

Cross-deck walkways are often made of steel plates, but these can be corroded by seawater or chemicals carried as cargo. Although the upper surface of these plates is usually well-painted, the underside is frequently overlooked or inaccessible for painting, allowing undetected corrosion to develop until failure occurs, potentially resulting in serious injuries like leg fractures and lacerations.

CHIRP recommends replacing these steel plates with open grating made from composite materials, which are resistant to corrosion. An open grating also exposes the underlying pipework, making leak detection considerably easier.

Factors relating to this report

Situational Awareness – The condition of the walkway could not be assessed because inspecting the underside of the steel plate was difficult.

Design – Assessing the condition of the steel plate was difficult due to accessibility issues, so gratings are preferred.

M2319

Fire on a large motor yacht

Initial report

After a period of maintenance in dry dock, a motor yacht was moved to a repair berth. Shore power was unavailable, and one of the yacht's generators was started. The captain was not made aware that shore power was lacking, nor told that the generator had been started.

During a pre-sail survey, the engine room (ER) ventilation dampers had been shut by the contractors. In the haste to move out of the dry-dock, the crew did not have enough time to fully check the condition of these, so failed to notice that they were still closed. This raised the temperature in the ER, and an emergency escape hatch was opened to improve ventilation. A while later, the ER fire alarm sounded. The captain briefly checked the ER, observed haziness but no strong odour or visible fire source, and closed the door.

The engineer and deckhand donned breathing apparatus and entered the ER. They discovered smoke near the running generator, which was shut down to minimise fire risk. However, this left the vessel without power. The emergency hatch was also closed.

While attempting to respond to the incident, several issues were discovered: the emergency fire pump was difficult to operate, the emergency generator was inoperative, smoke detectors and atmosphere testing equipment were unavailable, and the fire system's uninterruptible power supply battery had failed. Unable to monitor the ER, the master activated the CO₂ system, which did not operate properly because it had been incorrectly configured. The captain and crew were unaware that the CO₂ cylinder valves had to be held open until they were fully discharged.

The local emergency services intervened and made the space safe for re-entry. Subsequent investigation revealed that hot exhaust gas leaking from a malfunctioning exhaust valve caused the fire, which was made worse because the closed ventilation dampers limited air circulation in the compartment.

CHIRP Comments

Taking vessels into and out of dry dock is a complex and high-risk operation that requires very clear communications between contractors, dockyards, and vessel crews. This is particularly true when the responsibility for maintaining or operating the vessel, its fixtures, and other equipment is transferred.

It is essential that the schedule for bringing a vessel out of dry dock allows sufficient time for the crew to conduct thorough inspections of their assigned equipment and spaces. They must also be able to re-check systems if external surveyors make modifications, as with the ventilation dampers.

While owners may prefer to prioritise hotel services, safety systems must take precedence. Beneath the polished exterior of a large superyacht, it remains a seagoing vessel where safety is paramount. A significant cultural shift in management is needed to ensure safety is consistently the top priority.

Time is also needed for the crew to become familiar with the operation and maintenance of the equipment and to become proficient in routine and emergency modes of operation.

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Equally important, they need time to learn how to function as a team. The fact that the captain was not informed of the power issues or the running of the generator suggests that they had not had the opportunity to work as a single, efficient crew. This includes reviewing (or developing) suitable risk assessments for every stage of the vessel's emergence from dry dock and return to seagoing operations.

Factors relating to this report

Capability – After any maintenance period, the crew need time to identify emergent defects, ensure that equipment is configured correctly, and they are correctly trained to operate it safely.

Communications – Defects and changes in operational readiness must be reported to the captain.

Teamwork – Teams need time to gel as a coherent and effective unit. Management should plan so that the drydock crew have sufficient time to establish good teamwork.

Alerting – Given the situation on board with non-operational essential safety appliances, would you have alerted your head of department.

Beneath the polished exterior of a large superyacht, it remains a seagoing vessel where safety is paramount

M2311

Near miss: poor configuration of CO₂ firefighting system

Initial report

Following a period of maintenance, a pre-sailing inspection revealed that the safety pins which prevented the CO₂ firefighting system from operating were still in place. A contractor had inserted the safety pins to prevent accidental discharge while maintaining the system but had not removed them once the work was completed.

Had these remained in place, the system could not have been used in the event of an engine room fire.

CHIRP Comments

There is always a pressure to get vessels out of dock and back to operational service as quickly as possible. However, similar to report M2319 (Fire on large motor yacht), this pressure resulted in several important steps being missed. Whenever equipment is handed over to or from a contractor, it is best practice that a suitably qualified crewmember and the contractor jointly inspect the equipment so that both agree on its material condition and out-of-service status and operational readiness configuration at the start and end of a job.

The design of the pins is a contributing factor: they are a similar colour to other nearby items and CHIRP suggests that if they had been painted, or had a label like the 'Remove before Flying' tags used in the aviation industry, it would have been much easier to identify that the pins had not been removed.



Factors relating to this report:

Pressure – Are your crew adequately qualified and resourced to withstand additional pressure that can come at the end of a drydock?

Teamwork – It is crucial to have a shared mental model when re-entering service after a drydock period, as this encourages facing challenges together.

Situational awareness – Actively seek input from other crew members and update your awareness. Never assume other people's intentions- ALWAYS CHECK.

Local practices – Equipment hand-over checklists can be a valuable tool in these circumstances and should be used.

Communications – 'Remove before sailing' tags are useful to help crew and contractors identify the state of the system.

M2333

Lifeboat capsize during a capability demonstration

Initial report

During a capability demonstration as part of a fund-raising event, two differently sized Search and Rescue (SAR) craft carried out a series of manoeuvres very close to one

another. The wake of the larger vessel caused the smaller vessel to lose steering control and it capsized.

The crew managed to right it within three minutes, with no injuries to the crew or damage to the lifeboat. All personal protective equipment operated correctly, and the kill-cord functioned as intended.

The reporter noted that the crew had recently completed an emergency procedures course, and the lessons from their training were effectively applied, particularly in fostering the confidence necessary to manage the situation safely and promptly. Another factor that aided the crew's recovery was the thorough briefing conducted before the drill.

CHIRP Comments

High-profile public events can lead experienced operators to push towards the limits of safety due to self-imposed pressure. This subconscious urge to perform can increase risk-taking behaviours that are usually avoided. At the same time, focusing on pleasing the audience can reduce situational awareness. Given the infrequency of such events, proper rehearsal and risk assessment may not have been thoroughly practised.

These factors quickly escalate risks in situations involving high-speed and close-quarters manoeuvres, where even minor errors can lead to incidents. Fortunately, the team was trained to recover from a capsize and managed to self-rescue without further problems.

This incident underscores the importance of thorough risk assessments and rehearsal drills before undertaking new or infrequent activities. It also emphasises the need to

recognise and manage self-induced pressure and monitor oneself and others for increased risk appetite or risk-taking behaviours.

Factors relating to this report

Pressure – Be aware that self-induced pressure to give an impressive demonstration can lead to additional risks being inadvertently taken, resulting in such incidents.

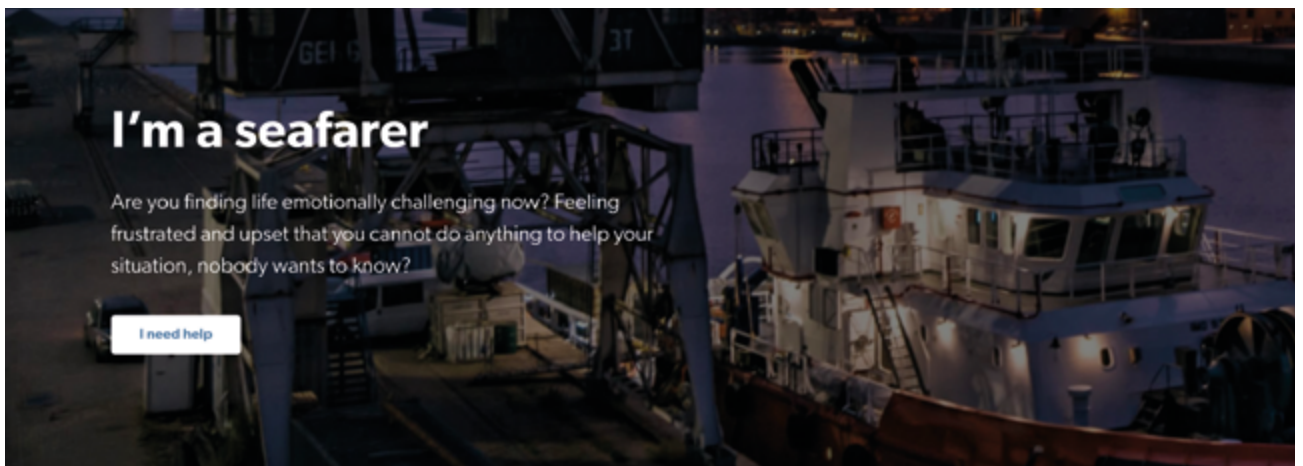
Situational Awareness – The helm of the smaller vessel did not recognise that they had entered a potentially dangerous area concerning the other boat's wake and their dynamic stability. His vessel capsized as a result.

Capability – When undertaking new activities, extra preparation is needed.

Culture – Management is encouraged to provide additional oversight when novel or infrequently undertaken tasks are planned and performed.

Teamwork – Well-trained crews are more resilient to unexpected events and can better respond positively to rectify the situation.

This incident underscores the importance of thorough risk assessments and rehearsal drills



Befrienders Worldwide (BW) is an emotional support charity whose mission is global suicide prevention. BW has operated for 50 years and has over 400 centres in 48 countries.

The main aim of the centres is to give confidential emotional support to people when they are suicidal. The centres also alleviate misery, loneliness, despair and depression by listening to anyone who feels they have nowhere else to turn.

The people who run the centres – Befrienders – are volunteers who have all been specially trained. The work is non-political and non-religious; volunteers do not try to impose their convictions on anyone. They listen.

Contact with a centre can be by telephone, letter, email, internet chat, SMS text message, or face-to-face meeting. It is strictly confidential, as is everything that the person tells a Befriender. Some callers prefer to remain anonymous, and that's fine.

Befrienders Worldwide has a dedicated seafarers' page recognising the emotional challenges seafarers face while working at sea.

Please look at the website.
www.befriender.org

If you need to contact a dedicated seafarers' centre, please click on the link: <https://befriender.org/befrienders-worldwide-seafarers/> which will take you to the seafarers' page. Thank you.

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