MARITIME FEEDBACK

CHIRP

An independent and confidential reporting system for the Maritime industry

GENERAL MARITIME

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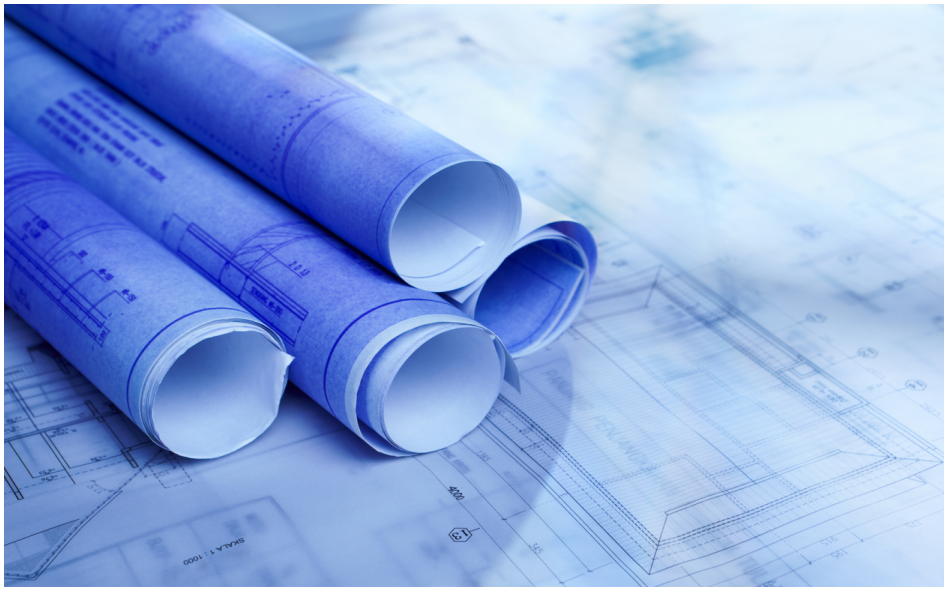

Built to break?

Contents

Adam Parnell

Design decisions shape safety outcomes at sea.

Once again, our excellent reporters have shared a wide range of incident reports, and we thank them all. In this edition, we move from 'traditional' incidents such as pilot boarding mishaps and enclosed spaces, to a cutting-edge report about the capsize of an Unmanned Survey Vessel (USV), and, as always, there are valuable lessons to be learned by anyone involved in shipping.

You will also find a worrying report about a ship which suffered a serious pest infestation and was subject to a botched fumigation, and another about aerial plans which were inaccurate. In a similar vein, another reporter tells us about an escape hatch which could not be opened if a mooring rope was turned up on the adjacent bitts.

The predominant theme in this edition is that mistakes made at the design and construction stages of a ship's lifecycle can have real-world

safety repercussions. It is therefore vital that practical mariners are involved at the building yard, so they can spot any practical difficulties and ensure they are corrected before the vessel enters service. It is normally more difficult, and more expensive, to correct mistakes later.

Murphy's law states, "anything that can go wrong will go wrong". This is not rocket science, although Mr. Murphy was an American rocket scientist who coined the epigram in the 1940s. It is worth bearing in mind as you go about your business on board, because if you think about what might go wrong in any set of circumstances, you have a much better chance of taking steps to prevent it and ensure you get safely home at the end of every voyage.

Until next time, stay safe!

Reports

M2459 – Pest infestation

Initial Report

What the reporter told us: "We are facing a severe infestation of pests on the ship, with cockroaches present throughout the vessel. They are found in food supplies, refrigerators, utensils, bedding, and other areas. This situation has caused significant psychological and emotional distress among the crew. We are unable to eat or sleep peacefully, constantly feeling anxious and stressed. The captain's behaviour exacerbates our situation. He behaves erratically, making threats to ensure our silence regarding these issues. There is fear among the crew, and speaking out feels unsafe. During recent inspections, port inspectors did not inspect the onboard condition closely. This same behaviour by port officials also occurred at the last port and during the current inspection. The captain has warned us against saying anything."

CHIRP Comment

CHIRP contacted the flag state, which in turn contacted the company, and arrangements were made to carry out fumigation of the vessel. However, the arrangements made to fumigate the ship did not follow the procedures outlined in the company's safety management system. CHIRP was allowed to review the relevant sections of the safety management system, and none of the risk assessment controls were implemented.

This report highlights a breakdown in safety culture and procedural compliance on board.

No safety meetings were conducted, and there was no explanation of the fumigant's chemical data sheet. Some crew members were reportedly asleep in their cabins when fumigation began; an unacceptable practice that exposed them to serious health risks. Video evidence supports the crew's account. The psychological effect on the crew regarding the infestation and the lack of support by the master and company until intervention by CHIRP led to very high stress levels, according to the reporters.

CHIRP managed to obtain the Safety Data Sheet for the fumigant used, and the risk of health issues associated with inhalation was high. The crew was instructed to conduct a second round of fumigation en route to their next port but was left without hazmat gear or proper masks, rendering the fumigation unsafe.

The master's behaviour reflects a person under severe stress and not capable of making informed decisions concerning the safety of the crew. The management company appears to be severely lacking in experience and support for the crew.

This case serves as a stark reminder that documentation alone does not guarantee safety. Procedures must be understood, implemented, and routinely verified. CHIRP has escalated this matter to the flag state and continues to engage with the crew to ensure their safety concerns are heard and addressed.

Superficial or weak auditing, whether internal or external, can miss serious risks, especially if the crew feel unable to speak openly during inspections. Such circumstances not only endanger seafarers but also erode trust in the regulatory framework meant to protect them.

The presence of procedures means little if they are not being lived and enforced on board. This case is a textbook example of "paper compliance", where documentation exists primarily to tick boxes rather than to drive real safety outcomes.

Factors relating to this report

Local Practices – management appears to have its own rules for managing the vessel, with no adherence to the safety management system, despite a specific reference to fumigation.

Culture – There is no authentic safety culture, except for the fact that you should not get caught!

Capability- The vessel's operational leadership appears incapable of operating a safety management system

Key takeaways

Seafarers: *Silence endangers safety—speaking up saves lives.*
A severe pest infestation, improper fumigation, and a captain's threatening behaviour created a psychologically unsafe and

physically hazardous environment. Despite formal procedures existing on paper, none were followed, placing the crew at significant health risk.

Managers: ***Leadership without listening breeds risk.***
The breakdown in leadership, procedural enforcement, and crew wellbeing in this case reflects deep-rooted safety culture failures. Procedures were ignored, risks were unassessed, and the crew was left vulnerable. Managers must ensure that documented systems translate into lived practice and that masters and crews are empowered and psychologically feel safe to raise concerns. Leadership accountability and visible commitment to safety are non-negotiable.

Regulators: ***Regulation fails when crews cannot speak freely.***
This case highlights how inspection regimes can overlook critical hazards when crews are too afraid to speak up. Despite clear procedural violations and health threats, port inspectors overlooked the issues on two separate occasions. Regulators must strengthen inspection protocols to uncover both technical noncompliance and suppressed reporting cultures, ensuring seafarers can safely disclose concerns and that just culture principles are allowed to flourish.

M2460 – Escape route blocked

Initial Report

During a routine inspection, the team found that an emergency escape hatch from the engine room to the deck could not be opened. The hatch, located near the aft mooring bits, was obstructed by the turned-up mooring lines. Just 2 to 3 centimetres of rope extending beyond the edge of the bitts was enough to prevent the hatch from opening — a small detail that could have had serious consequences in an emergency.

CHIRP Comment

This issue stems from the vessel's design phase. Mooring arrangements and emergency escape routes were developed using CAD software and approved as compliant with the relevant regulations. However, it seems no one physically checked how these systems would work together in real-life conditions. CHIRP is aware of several such incidents, as reported to the International Marine Contractors Association (IMCA) and has written to the International Association of Classification Societies (IACS) to raise awareness.

The problem only becomes evident when the vessel is alongside or under tow, but that is precisely when escape routes must be fully functional. Being unable to open an emergency hatch because of a few centimetres of mooring line is a critical design oversight with potentially severe consequences. Blocked emergency escape hatches have led to deaths in the past, e.g. the *Marchioness* on the River Thames.

This highlights the need for practical, operational checks during the design and approval stages of newbuilds, not just digital validations. Safety depends not only on compliance but on proven functionality. It underlines the need for integrated risk thinking across routine operations, design layout, and inspection regimes.

Emergency systems must be constantly validated against the realities of onboard work practices. Incorporating escape routes during your familiarisation process, particularly when joining a different type of ship, is vital. Additionally, emergency escape hatches and their access ways should be incorporated into contingency exercises so that their use can be part of both egress and access during an exercise.

During a vessel's quarterly inspection, the function and securing of escape hatches should be reviewed by an officer and crew from a different department.

Factors relating to this report

Situational Awareness – The design and approval teams failed to anticipate that the mooring operation would obstruct an emergency route. This suggests limited foresight regarding how the vessel would be used, particularly in an emergency scenario where every second counts.

Communication – There may have been insufficient communication between designers, builders, and operational stakeholders. Without input from those with lived experience on board, subtle but serious flaws like this can go unnoticed until it is too late.

Teamwork – The design process lacked interdisciplinary coordination. Engineers, naval architects, shipyard teams, and operational staff all play a role in ensuring systems function safely. Here, the lack of collaborative review meant a potential emergency hazard was built in from day one.

Key Takeaways

Seafarers – ***Don't assume safety systems work as designed.*** Regularly inspect and test escape routes under real-world conditions, including when the vessel is moored, to ensure they are functional and practical. Speak up if something isn't right, even if it complies with the ship's plans.

Managers – ***Engage operational staff early in the design process.*** Crews bring essential insight into how systems are used on a day-to-day basis. Build in practical walk-throughs

and validation steps to catch risks before they become built-in hazards.

Regulators – ***Verify compliance against reality – not just design.*** Design compliance must be matched by functional performance. Safety-critical access points must function reliably under all operational conditions, particularly in emergencies.

M2433 – Aerial errors: ships plans mislabelled

Initial Report

Indications and markings for the GPS 1 and GPS 2 antennas were incorrectly displayed on both the bridge antenna arrangement plan and the compass deck. Incorrect markings, in the event of specific issues, can lead to misunderstandings regarding which equipment needs checking and repair. A complete survey of the ship's antennae was conducted and the plans were updated accordingly.

CHIRP Comment

This report illustrates how a minor error, such as incorrect labelling, can lead to significant issues. The GPS 1 and GPS 2 antennas were wrongly marked on both the bridge plan and the compass deck. If a fault had occurred, the crew might have checked the wrong antenna, wasted time, and possibly overlooked the real issue.

The antennas were installed in the correct place, but the signs and drawings did not match. This indicates that no one properly checked the labels after installation was completed.

For something as crucial as GPS, all information, including markings and drawings, must be clear and precise. If the crew cannot trust what they see, it can cause delays or mistakes during fault-finding.

This case serves as a reminder that when antennae are installed during the new build phase or at dry dock, any new equipment must be rigorously checked. The area/antenna plan should also be updated and cross-checked to ensure accuracy.

On a critical and operationally practical note, an antenna position must be correctly marked and located so that the navigation system can apply the correct offset from the vessel's centre line. e.g. on a 60-meter beam vessel, a 20-meter error in recording can put you outside of a navigable channel!

It is essential that, during the annual or five-year radio survey, aerial verification of all bridge equipment is physically carried out. This also applies after any refits at dry dock, where bridge equipment is renewed or replaced.

Factors relating to this report

Situational Awareness – During technical troubleshooting, bridge teams rely on plans and labels to quickly isolate faults. Incorrect markings can easily mislead the operator and prolong a problem that requires urgent attention.

Communication – Poor information flow between design, installation, and operations teams likely contributed to this discrepancy. Without effective feedback loops, errors can persist unnoticed until they lead to failure.

Teamwork – The eventual resolution required a coordinated review of all antenna locations and documents. This highlights the importance of collaboration across departments in identifying and addressing safety risks.

Key Takeaways

Seafarers – ***Check, do not assume***. Don't rely unthinkingly on diagrams or deck markings — especially during fault-finding. Visually confirm the actual installation and speak up if you notice any discrepancies.

Managers – ***Danger lurks in the small details.*** Include signage and documentation checks in post-installation and maintenance routines. Even minor labelling errors can cause significant operational delays.

Regulators – ***Test assumptions – not just systems***. Ensure that commissioning and inspection processes verify not only the functionality of equipment but also the accuracy of associated markings and plans, particularly for critical systems such as GPS.

M2392 – Pilot welfare when boarding

Initial Report

CHIRP received a report from a pilot concerning a non-compliant boarding arrangement and an apparent lack of care from the vessel's crew.

The pilot ladder was suspended from the deckhead and failed to rest flush against the ship's side due to hull belting—a setup that did not meet safe boarding standards.

Although a small shell door was available for safer access, large fenders had been rigged on either side. When the pilot requested that these be removed to facilitate safe boarding, the master refused, citing concerns about damage to the paintwork.

The pilot assessed the situation and stated that boarding would not proceed unless the obstructions were cleared. Eventually,

the fenders were removed, and boarding took place via the shell door. The event was filmed from the bridge wing and by crew members, which contributed to the pressure and unease the pilot felt.

During boarding, the duty pilot struck his head, sustaining a minor injury (see attached image). The crew did not inquire about the pilot's welfare or offer first aid. Instead, he was handed a pair of overshoes to protect the deck from being dirtied.

CHIRP Comment

Safety regulations around pilot boarding exist because failure to follow them can and does result in injury or worse.

Here again is a common design problem often reported to CHIRP. There appears to be a lack of integrated thinking when designing superyachts. Crews should not be placed in unsafe situations due to poor design decisions made remotely by those who will not operate the vessels. Collaboration is essential during the design phase for new builds, involving input from all stakeholders, including designers, owners, flag authorities, class societies, crew, contractors, and pilots.

This report reminds us that pilots are contractors and guests, yet they remain vital maritime professionals. The safe transfer of the pilot is not optional; it is compulsory, and their physical safety and well-being must be taken seriously. The revision to ISO 799, which specifies new requirements for ship's pilot ladders, comes into force in 2028.

Currently, owners are accepting vessels from builders that are not compliant, which places a greater burden on flag states and classification societies to ensure that they comply with SOLAS. CHIRP will raise these concerns with the flag states.

Factors relating to this report

Culture – The dismissive attitude toward the pilot's safety — prioritising paintwork over people — reflects a poor on-board safety culture. A culture that does not respect external personnel or reporting lines weakens trust and increases risk.

Communication – The Master's refusal to remove the fenders and the failure to explain or resolve the issue collaboratively suggest a lack of effective communication between the ship and the pilot. Effective communication is crucial for achieving shared situational awareness and making informed, coordinated decisions.

Alerting – The pilot raised a safety concern, which was initially ignored; this constitutes a failure to act on an alert. Ignoring or dismissing raised concerns discourages others from speaking up and undermines the effectiveness of safety systems.

Teamwork – Boarding a vessel is a collaborative effort between the ship and the pilot. Filming the event and failing to help shows a breakdown in cooperative behaviour and mutual respect, key elements of effective teamwork.

Situational Awareness – The lack of recognition that the pilot had been injured, combined with the absence of any first aid or welfare check, indicates poor situational awareness. The crew was not entirely focused on what was happening around them or the seriousness of the event.

Key Takeaways

Seafarers – *Every visitor is your responsibility.* Pilots and contractors are part of your extended team. They deserve the same duty of care as your crew. Ensure safe boarding arrangements, treat visitors with respect, and help without hesitation. A clean deck is no excuse for a dirty attitude.

Managers – *Safe access is not optional – it's the law*. Boarding arrangements must meet SOLAS requirements — every time. Pressure to protect paintwork cannot outweigh the safety of personnel. Set clear expectations with your crews: all visitors, especially pilots, must be welcomed safely and professionally.

Regulators – *Standards must protect people, not paint*. Incidents like this show how operational decisions can put reputations — and lives — at risk. Regulators must reinforce the message that the **duty of care extends to all personnel boarding a vessel** and that non-compliant setups or dismissive behaviour are unacceptable.

M2494 – Design flaw jeopardizes Pilot boarding

Initial Report

The Pilot Boarding Report read as follows:

"Weather Conditions (first attempt): wind: 33 knots SW; sea: 1.7 – 2.5m swell, Swell breaking over the lower deck, making it inaccessible.

First Attempt – Boarding aborted – The crew was observed standing on the hatch cover above a fixed yellow metal ladder (see attached image), appearing to expect the pilot to board via this structure. No pilot ladder was rigged. The pilotage act was aborted due to the absence of a compliant ladder. The Master was informed, and a second attempt was planned for the following morning.

Second Attempt – Boarding aborted – Weather conditions remained similar to those of the first attempt. The pilot was

directed to board near the accommodation area at the vessel's stern, at the lower deck level. However, this area was repeatedly overtopped by swell, making it unsafe for transfer. Two crew members were again stationed at the top of the fixed vertical metal steps. This arrangement is non-compliant and places both pilots and crew at unnecessary risk. The crew attempted to open a gate amidships as an alternative boarding position, but the vessel was shipping seas on deck and clearly unsafe (see image above).

Third Attempt – Boarding completed – Conditions had eased, and the pilot was able to transfer via the lower deck.

However, several safety issues were observed with the rigged pilot ladder: the ladder was not resting against the ship's hull, it was secured to the handrail, not to strong points on deck, and

there was an obstruction at the top – the ladder rope did not sit flush with the deck, creating a tripping and entanglement hazard."

CHIRP Comment

Boarding eventually took place some 48 hrs after the first attempt, and CHIRP commends the strong safety stance taken by the pilots. This report highlights a persistent issue: some vessels continue to be unable to provide safe and compliant pilot transfer arrangements, particularly in adverse weather conditions. In this case, two boarding attempts were aborted due to unsafe setups and the absence of a properly rigged pilot ladder. Crew members were seen using vertical fixed ladders and standing on hatch covers, neither of which is safe or compliant in dynamic sea conditions.

Although the third attempt succeeded in calmer weather, the pilot ladder rigged was still unsafe, with poor securing, gaps between the ladder and hull, and obstructions at the top. This raises serious concerns. Improvised boarding methods, however well-intentioned, expose pilots and crew to unacceptable risk. SOLAS and IMO regulations are not optional; they are the minimum standard.

If the lower deck is the only viable transfer point, this must be clearly stated in the vessel's pilot card and agreed in advance. It is not helpful to inform the pilot when they are on the bridge about the transfer arrangement. This raises the question: do ports have heavy weather boarding procedures in place, with weather and sea state limits established? Only those conditions that fall within the criteria should be allowed for pilot boarding to take place.

This case reminds us that if a vessel cannot provide a safe and compliant means of pilot transfer under expected conditions, it may not be suitable for pilotage operations without modification. CHIRP will raise this issue with the relevant authorities to explore whether further action or guidance is necessary to prevent recurrence.

The subject of creating a safe lee for boarding was discussed by our Maritime Advisory Board, and this will be published shortly in the 'Hot Topics' section of our website.

Factors relating to this report

Local Practices – The continued reliance on non-compliant methods implies that unsafe practices may have become informally accepted aboard this vessel.

Complacency – The crew appeared to accept unsafe methods (e.g., fixed ladders, hatch covers) as viable boarding options, indicating the normalisation of non-compliant practices.

Capability – Improper ladder rigging and repeated use of unsafe arrangements suggest a poor understanding of SOLAS Ch V Reg 23 and pilot transfer standards.

Communication – Unclear coordination between the pilot and vessel on boarding points and conditions led to unsafe or aborted attempts.

Key Takeaways

Seafarers – *Know the rules, do not improvise.* Unsafe boarding improvisations aren't just non-compliant — they endanger lives. Always use properly rigged pilot ladders, never fixed ladders or hatch covers. If in doubt, stop and escalate the issue.

Managers – *Not compliant? Not ready.* Vessels must be physically and procedurally capable of safe pilot transfer in the expected weather conditions. Ensure that pilot cards accurately reflect the actual boarding arrangements and that crews are trained to meet SOLAS standards.

Regulators – *Unsafe boarding is still too common.* Persistent non-compliance shows the need for enforcement, not just guidance. Strengthen oversight of pilot transfer design and onboard practices, and ensure unsuitable vessels are forced to change their poor practices before incidents occur.

M2517 – Unmanned survey vessel (USV) capsizes

Initial Report

An unmanned survey vessel capsized while returning to its home port. Despite concerns from the marine team about worsening weather, the mission at sea was extended due to commercial pressure. This extension pushed the operation beyond the vessel's planned limits, and while returning to port the USV capsized in a busy area of navigable water. The USV was eventually recovered.

CHIRP Comment

This capsize highlights the dangers of operational decisions that override environmental limits, particularly under commercial pressure. Weather risks were known, but the operation was continued despite this, pushing the vessel beyond safe operating parameters.

As USVs and MASS become more common, there must be clear lines of responsibility. It is essential to identify who has ultimate authority over their deployment and recovery. Without this clarity, confusion or misjudgement could have serious consequences.

Both the owner and operator are legally responsible for the safety of their vessel and any other vessels nearby. Going beyond documented operational limits could make them legally liable. Moreover, a recent IMO decision confirms that state-funded rescue services are not required to recover unmanned vessels. This raises important questions about the environmental damage and navigational risks posed by disabled or capsized USVs left adrift.

Damaged USVs may also present a physical hazard. They can behave unpredictably, may have moving parts, or contain active electrical systems. Without specific knowledge of the vessel, approaching it could be dangerous. This incident also raises the question of whether the owners and decision-makers accepted a higher risk of an incident simply because the vessel was uncrewed. While there may be no immediate human risk, the broader operational, legal, and environmental consequences remain significant.

Current training and certification standards are struggling to keep pace with technological advancements. Remote operations teams often consist of highly experienced professionals with qualifications such as OOW Unlimited, Chief Mate, Master, and Yachtmaster. However, there is an urgent need to revise STCW and related regulatory frameworks to reflect the operational realities of USVs and MASS. Regulations also vary considerably between countries, which adds further complexity when these vessels operate across borders or in international waters.

This event acts as a warning to the maritime industry: as autonomy advances, so must foresight, training, and responsibility. Commercial pressure must never outweigh safety. The maritime community, regulators, and operators must collaborate to ensure that safety standards evolve in tandem with innovation.

Factors relating to this report

Pressure – The decision to extend the mission, despite known weather risks, was driven by commercial considerations rather than operational safety.

Situational awareness – Going beyond the USV's operational limits exposed the vessel to unnecessary risks. This was understood by the operations team but not by the commercial team.

Communications – Transmitting to the entire team the risks associated with this operation should have made the dangers apparent to everyone.

Key Takeaways

Seafarers – *Speak up, even when no one is on board*. This incident shows the value of professional judgement, even in remote operations. Seafarers and marine teams must remain confident in raising concerns, especially about weather and risk. The absence of crew does not mean the absence of responsibility.

Managers – *Commercial pressure sinks safety*. Management's decision to extend operations beyond safe limits – despite the marine team's input – was a direct contributor to the capsize. Safety decisions must be based on risk, not revenue, with operational teams empowered to act without interference.

Regulators – *Remote vessels still need rules*. The growing use of USVs and MASS demands a clear legal framework and updated training requirements. STCW must evolve to include remote operations, and accountability for the safety of these vessels must be unambiguous and enforceable.

M2518 – Enclosed space inspection leads to crew injury

Initial Report

The crew scheduled a routine 6-monthly inspections of void spaces A, B, and C, including testing bilge suctions and alarms. Due to the vessel's operational timetable (0600 to 2100, inspections were planned after service completion or before the first service of the day.

As part of the inspection, the company's technical manager arrived on board to inspect a series of void spaces as part of the planned maintenance system. Complete enclosed entry procedures were followed, and a thorough permit-to-work system was completed. The entry teams consisted of the supervising officer, the company technical manager, the duty AB covering the night shift, the leading AB, and the assistant AB, each with a designated specific role for tank guarding and watch.

Entries into void tanks A and B proceeded without incident, following the standard practice of entering through the port-side access. After completing the inspection with the technical manager, the supervising officer and the technical manager exited void space C. At the same time, the night duty AB continued testing the bilge alarms and suction systems, communicating with the engine room. To reduce the amount of radio chatter, the night duty AB switched to another channel to communicate with the engine room. The supervising officer informed the night duty AB that they would close the starboard access lid and that the AB should exit through the port side on completion of the bilge testing, as previously carried out on void tanks A and B. The night duty AB did not hear this information as they had switched to another channel.

The night duty AB's multi-gas detector then signalled a low battery alarm, which was mistaken for a gas alarm. He donned an Emergency Escape Breathing Device (EEBD) to exit the void space, and whilst donning the hood, dropped the radio. The EEBD hood started to mist/fog up.

Confused, the night duty AB attempted to exit via the starboard hatch, which was closed. He struck his head on the closed cover upon ascending the ladder, requiring immediate removal of the cover for his exit.

Four days later, the night duty AB reported feeling unwell with a sore head, attributing symptoms to the impact on the tank lid.

CHIRP Comment

This incident demonstrates how a single missed communication, resulting from a radio channel change, can undermine even well-planned procedures for enclosed spaces. A critical instruction about the designated exit route was not received by the lone crew member still inside the void space. This led to confusion and a dangerous attempt to exit.

The AB acted sensibly when their multi-gas detector issued a low battery warning, thinking it might be a gas alert. However, a Permit to Work and toolbox talk could have helped clarify the types of alarms, ensured the device was fully charged, and confirmed that the correct PPE, such as a hard hat, was worn.

The unexpected alarm caused a moment of panic, a "startled effect". While putting on an escape hood, the AB's visibility was reduced, and they dropped their radio, leaving them disoriented and unable to communicate.

Meanwhile, the team outside began closing one of the exit hatches, while someone was still inside. This action should never happen during entry operations. It delayed the AB's escape and caused a head injury when they struck the closed hatch.

The root issue appears to be a lack of a shared mental model among the team. Other activities, such as bilge testing and ongoing engine room communications, added to the distraction, as a conflicting work activity was taking place, thereby increasing the AB's cognitive workload.

Although procedures and permits were in place, this case shows why they must be supported by clear, confirmed communication and effective task coordination. Most importantly, exit routes must never be blocked while anyone remains inside an enclosed space.

Factors relating to this report

Communication – A critical verbal instruction about the exit route was missed due to a radio channel change, with no confirmation sought or given.

Capability – Conflicting tasks (void inspection, bilge testing, and engine room communication were scheduled simultaneously, increasing the risk and complexity in a confined space.

Situational Awareness – The AB became disoriented due to misinterpreting an alarm, impaired visibility from the EEBD, and a dropped radio, leading to an attempted exit through a sealed hatch.

Teamwork – The AB was left alone inside the void space while others topside began securing an exit, demonstrating a lack of active team coordination and monitoring.

Key Takeaways

Seafarers: *Use closed loop communications.* Ensure that all safety-critical communications are confirmed and understood, especially during entries into enclosed spaces. Don't rely solely on assumptions or past patterns—situational awareness can be the difference between safety and serious harm..

Managers: *Effective planning involves the human element.* Task planning must consider human-system interactions, equipment limitations, and communication redundancy, especially under time or operational pressure. Even well-trained teams need safeguards against miscommunication and confusion. Good planning includes the human factor.

Regulators: *Regulations must reflect reality.* Standards should mandate fail-safes for communication, equipment functionality, and emergency egress in enclosed spaces. Procedures must reflect real-world conditions, not just ideal ones.

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