

**GENERAL MARITIME**Edition MFB 81
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Stand up, Speak out, Stay safe!

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**Adam Parnell*****Don't let silence endanger safety at sea.***

Maritime safety is built not just on regulations and procedures, but on the everyday courage of those who speak up when something isn't right. This edition contains powerful examples of moral bravery, from sounding the alarm on illegal waste disposal at sea, to challenging unsafe pilot transfer arrangements in harbour, to confronting bullying leadership ashore.

Each report reflects a deeper truth: safety culture is shaped by the actions of individuals, and sustained by the systems that support them. Whether it's a pilot refusing to board an improperly rigged ladder or a crew member resisting pressure to violate MARPOL rules, these stories remind us that compliance is not just about ticking boxes; it's about protecting lives, the environment, and professional integrity.

CHIRP depends on the voices of seafarers and maritime workers worldwide to raise safety concerns in their environments. Every report, regardless of size, helps us identify trends, challenge complacency, and foster learning across the industry. Your experiences are important; in fact, they can literally save lives.

If you have witnessed a safety issue, faced pressure to cut corners, or want to share a lesson learned, we encourage you to submit a confidential report. Together, we can maintain momentum and foster a maritime culture where courage is celebrated, compliance is standard, and safety is everyone's responsibility.

Reports

Report No1 - M2591 – Severe injury caused by a fall from pilot ladder

Initial Report

While descending a pilot ladder, a pilot fell approximately 5m onto the pilot launch and was severely injured. The standard operating procedure for this pilotage authority was for the pilot vessel to position itself at the foot of the ladder and remain there while the pilot or other personnel descended.

Our reporter was concerned that this procedure may conflict with best practice, as falls from even moderate heights onto a pilot vessel can be fatal. They prefer to be partway down a ladder before the pilot vessel approaches alongside.

CHIRP Comment

Pilot Transfer Arrangement (PTA) incidents often reflect broader systemic issues, such as inconsistent onboard training, insufficient supervision, or a lack of shared understanding of procedures. Ensuring all parties know what to expect and when is crucial for safety.

An [educational video](#) by the *Federation Francaise des Pilotes Maritimes* highlights that a fall from 3m onto a pilot vessel can cause serious injury, a fall from 5m can cause permanent disability, and a fall from 8m can be fatal.^[1] This underscores the importance of clear communication and coordination between the ship's bridge team, the pilot, and the pilot launch crew.

When a pilot is *embarking*, it is generally safer for the launch to move away from the vessel once the pilot is secure on the ladder and has started to climb. However, when the pilot is *disembarking* and still at the top of the ladder, the risk of fatal injury should they fall onto the pilot vessel is at its greatest.

This creates a conflict between 2 competing risks: that of falling from height onto a pilot vessel already at the bottom of the ladder, and the chance that the pilot vessel could snag the bottom of the ladder as it manoeuvres alongside, causing the pilot to be thrown off the ladder by the violent motion.

There is no 'best' answer that can be universally applied. However, the Standard Operating Procedures (SOPs) of many pilot authorities will favour the positioning of the pilot vessel at the bottom of the ladder before the pilot arrives at the top of the pilot ladder and begins their descent. CHIRP suggests that pilot authorities augment their SOPs by permitting the pilot some discretion if their dynamic risk assessment (conducted in coordination with the ship and the pilot vessel) indicates that, in that specific circumstance, the balance of risk favours the pilot descending partway down the ladder before the pilot vessel approaches the bottom of the ladder.

In all instances, the IMO guidance posters ([MSC.1/Circ 1428](#)) can reinforce good coordination and shared expectations. Clear communication, mutual awareness, and precise timing remain the most effective ways to ensure every pilot transfer ends safely.

Key Issues relating to this report

Situational Awareness – Be aware of the factors that can cause a pilot to fall. These include the weather and sea state, the relative movement of the two vessels, the height of climb and the efficacy of the 'lee' created by the larger vessel, among other factors.

Local Practices (Shortcuts/Deviation) – The operating procedures of this pilotage authority are contrary to global best practice. However, as written, this pilot's descent of the ladder before the pilot vessel is at the foot of the ladder is also a deviation from documented practice. The pilotage authority is encouraged to reconcile these different perspectives to ensure that risks are as low as reasonably practicable (ALARP).

Communication/Alerting – The pilotage authority did not address the reporter's concerns.

Pressure – There was implicit pressure from the pilotage authority for the pilots to adhere to a rigid operating procedure, despite this being contrary to industry best practice.

Key Takeaways

Regulators: Enforce best practice before tradition becomes a hazard.

Strengthen oversight to ensure disembarkation practices comply with international guidance and address cultural tolerance of unsafe methods.

Managers: *Are risks “As Low As Reasonably Practicable” (ALARP)?*

Review and align local procedures with international best practice to prevent normalisation of unsafe shortcuts.

Pilots/Contractors/Seafarers: *Your safety comes first – don’t ascend or descend the ladder until agreed safety practices are in place.*

Always verify the launch’s safe positioning before committing to the ladder, and challenge unsafe instructions if necessary.

Report No2 - M2561 – Illegal disposal of waste at sea

Initial Report

A reporter informed CHIRP about the illegal disposal of oily waste and plastic while the vessel was en route to its next port. They provided photographs and videos showing oily waste from the engine room being discharged into the sea under the instruction of senior officers.

CHIRP alerted the flag state and, soon after, a flag state inspector arrived on board to conduct an inspection. The reporter and CHIRP maintained close communication throughout. The reporter’s primary motivation was simple: to stop environmental pollution and ensure accountability.

CHIRP Comment

The reporter initially raised the issue internally, with other crew members supporting concerns about the environmental impact. When no action followed, they contacted CHIRP to ensure the matter was adequately addressed. Their moral courage and sense of responsibility are commendable.

Although the experience left the reporter feeling isolated at times, they remained convinced that protecting the marine environment was the right thing to do. CHIRP shared the evidence with the flag state, the company’s designated person ashore (DPA), their insurers, and the classification society to understand why oily waste and sediment had accumulated and to help prevent similar incidents in the future.

CHIRP encourages readers to report concerns, even if feedback from authorities appears limited. Every submission helps reveal systemic issues and promotes positive change.

This case also illustrates that protection for those who speak up is not only a shipboard issue; it reflects the company’s safety culture ashore. The DPA, with both the authority and the moral

duty to act, plays a key role in ensuring that those who raise concerns are supported, not silenced.

CHIRP commends the reporter’s moral courage. This incident reinforces why CHIRP exists: to provide a safe, independent route for seafarers to speak up when something is wrong, and to drive learning that protects people and the environment.

Key Issues relating to this report

Culture – The vessel’s safety and environmental culture was weak, and it took significant moral courage from the crew to speak up and challenge harmful environmental practices.

Alerting – Alerting is a crucial skill, and it takes courage to speak up when there is a risk of emotional or professional retaliation.

Local Practices – Illegal dumping at sea had become normalised on board until someone spoke out and reported it to the authorities.

Key takeaways

Regulators: *Protect the sea, and those who also attempt to protect it.*

Flags and authorities should respond promptly to reports of illegal discharges and investigate thoroughly. Visible action, including meaningful sanctions, helps prevent recurrence and strengthens compliance culture. Guidance and enforcement must emphasise both environmental protection and protection for reporters.

Managers: *Protecting reporters ensures safety for everyone.*

When seafarers feel safe enough to raise safety and environmental reports confidently, it leads to positive safety changes. Managers have an obligation to champion a positive reporting culture. Clear procedures should ensure swift action and strong support for those raising concerns.

Seafarers: *CHIRP is here to help you.*

Reporting environmental violations is vital to protecting the marine environment. When you don’t feel safe reporting through your company’s normal channels, CHIRP is here to listen and help.

Report No3 - M2590 – Near miss between an uncrewed surface vessel (USV) and a large number of yachts

Initial Report

While departing from a fuelling jetty within a harbour, a USV and its support vessel were surrounded by a large number of

sailing vessels entering the harbour. Due to the high density of traffic, both vessels were unable to manoeuvre safely, resulting in a near miss. The situation posed a significant risk to life and property, as several vessels were at risk of collision or damage.

CHIRP Comment

This near miss highlights the challenges of operating uncrewed surface vessels (USVs) in busy ports alongside conventional craft. Even well-planned operations can create risk when there is limited room to manoeuvre and many other vessels are present.

All vessels, whether crewed or uncrewed, must comply fully with the COLREGs. USVs are to be treated the same as any other craft, and other water users have an equal responsibility to maintain lookout and take early, effective action to avoid collision (Rules 2, 5 and 6). Likewise, USV operators must comply with Rules 8(e) and 8(f), as well as all other applicable regulations.

The master and remote operator of a USV must be formally nominated and are usually ashore. On small vessels, one person may hold both roles, but a remote operator can control only one vessel at a time, while a master may have several under command.

Seafarers should anticipate congested areas and maintain heightened awareness, particularly during arrival and departure. Port operators and vessel managers should ensure clear traffic management and communication plans are in place whenever USVs are active.

Port authorities may wish to review local regulations and consider guidance for USV operations in areas of dense leisure or commercial traffic, including requirements for signalling, monitoring, and coordination with port control.

Key Issues relating to this report

Situational Awareness – The traffic density overwhelmed the USV/support team's ability to maintain a clear mental picture of all contacts and their intentions.

Communications – With multiple vessels, tight spacing, and perhaps different operators (yachts, marina control), miscommunication or ambiguity in intentions could lead to misunderstandings.

Complacency – Because departures are routine, operators may have underestimated collision risk, assuming that vessels would "give way" or that traffic would self-resolve.

Local practices – In some ports, it is common practice to depart into busy traffic without clear sequencing or control. This local

habit can reduce safety margins and increase the risk of incidents.

Key Takeaways

Regulators and Authorities: *Regulate for future vessel types, not just the existing ones.*

Mixed crewed and uncrewed vessel operations demand updated procedures and oversight. Integrating USVs into port and VTS systems, strengthening coordination requirements, and refining training and guidance are essential steps to manage future traffic safely.

Managers and Operators: *Plan for the crowd — not for the calm.*

The event underlines the need for realistic risk assessment and pre-departure coordination that reflect actual traffic conditions, not just the operational plan. Human oversight remains vital, and effective workload management between USV control teams and support craft is key. Safety should never be compromised by schedule or commercial pressure.

Seafarers: *If the picture isn't clear, don't move.*

This incident highlights the importance of maintaining situational awareness when operating in congested waters and recognising that uncrewed systems may have limitations in perception and manoeuvrability. Clear, early communication remains essential, and it is always safer to delay departure than to risk escalation in confusion or congestion.

Report No4 - M2576 – Close quarters situation

Initial Report

"We are a large sailing yacht under power, motoring on a south-westerly course at 9 knots and around 1.5nm from a navigational strait/passage. I noted the ferry steaming almost north, clearly visible, showing her starboard bow. Visibility was very good, and both radars were operating with a lookout on the bridge.

The CPA was causing concern, and it was a clear crossing situation (R15 COLREGs).

In this situation, my vessel was the stand-on vessel, as confirmed by the lookout. I maintained my course and speed. I expected the ferry to turn slightly to starboard (about 10-15 degrees) as there was plenty of sea-room and no immediate traffic, and the ferry had cleared the strait, so there were no

depth restrictions. Then both vessels would have passed port to port.

The ferry maintained her course and speed, crossing my bow at a range of less than 2 cables. We then passed starboard to starboard, close enough (about 70 metres) that I could clearly see the master/watchkeeper on the bridge, who gestured that I was in the wrong, which surprised me, as there was no doubt about the situation, or which vessel should take what action.

Although ferries operate on regular routes, they must still comply with the COLREGs. This potentially close-quarters situation could have been avoided with better application of the COLREGs.”

CHIRP Comment

CHIRP followed up with the master of the motor yacht to clarify and obtain additional information.

The account suggests that both vessels failed to follow the appropriate rules (2, 7, 8, 16, and 17) of the COLREGs, leading to a close-quarters situation. Expectancy bias may have influenced their actions, as the ferry assumed the large motor yacht would give way, which is sometimes the norm in busy coastal waters.

A further factor may have been commercial pressure. Tight schedules and repetitive crossings can subtly influence decisions, sometimes leading mariners to prioritise efficiency over compliance. However, passing at only 70 metres is clearly hazardous, regardless of vessel type or familiarity with the route.

This event serves as a reminder that the COLREGs exist to remove uncertainty. Expecting other vessels to deviate from them introduces unnecessary risk. Challenging assumptions and maintaining situational awareness are critical, as is early and unambiguous communication; a timely signal of five short light flashes/sound blasts can often break the chain of misunderstanding before it leads to danger.

For ferry operators, there is also an essential organisational lesson. Companies operating to tight schedules should ensure that management regularly reviews passage plans, either through marine manager visits or independent navigational audits, to confirm that bridge practices remain compliant with the COLREGs. Encouraging crews to report and discuss near misses openly and without blame helps to identify patterns and reinforce safe behaviour before incidents occur.

While both vessels had clear obligations to act to avoid collision, this case reinforces a simple truth: being righteous and right is not the same as being safe and compliant.

Key Issues relating to this report

Local Practices – The ferry’s failure to alter course reflects a potentially ingrained local practice of prioritising routes and schedules over safe crossing protocols.

Communication – No VHF call or signal exchange occurred, even when intentions were unclear, which denotes a breakdown in clear communication.

Situational Awareness – No/wrong/late visual detection: The close crossing suggests the ferry didn’t adequately gauge the yacht’s trajectory in time. Even though radars were operating, the impending crossing wasn’t detected or acted upon sufficiently early.

Complacency – Familiarity with regular route traffic may have led to underestimating the risk, assuming no deviation or hazard would arise, and failing to challenge the crossing scenario.

Alerting – Despite the yacht’s clear expectation of port-to-port passing, there was no challenge or signal to the ferry indicating concern, nor was there any cross-check or speaking up.

Pressure – Operational pressures, such as maintaining schedules, could have influenced the ferry crew’s decision-making; insufficient personnel or workload management may have contributed.

Key Takeaways

Regulators: *Spot the patterns, close the gaps, enforce the COLREGs.*

Track recurring close-quarters incidents involving scheduled ferries and other vessels. Apply human factors frameworks (MGN 520 *Deadly Dozen*, SHIELD taxonomy) to identify systemic issues. Strengthen oversight to address shortcuts or local habits that undermine COLREGs compliance, and promote clearer guidance on proactive VHF use and bridge team management in congested waters.

Managers: *Culture and training must take precedence over schedule pressure.*

Ensure bridge teams are empowered to follow the COLREGs, even under time pressure or on familiar routes. Build a culture that values challenge and open communication. Reinforce that safety decisions are supported, even when they delay schedules.

Seafarers: *Don’t assume, check, communicate, and act early.*

Use every available tool, radar, AIS, and visual bearings, to confirm other vessels’ intentions. If in doubt, clarify via VHF before the situation escalates. Never rely on what “should” happen; anticipate, question, and take early action to stay clear and stay safe.

Report No5 - M2558 – Pilot transfer arrangement (PTA) - significant safety concerns

Initial Report

A pilot raised serious concerns about non-compliant pilot ladder arrangements on board. When attempting to embark, the pilot found that the ladder was not rigged in accordance with SOLAS requirements. Specifically, no heaving line was readily available, a tripping line had been incorrectly fitted, and the embarkation point on deck was obstructed. Most worryingly, the ladder itself was poorly secured. It had been fastened outside the vessel using improvised knots and was not secured to strong points on deck. Instead, crew members were standing on the bitter end of the ladder to stop it from slipping.

When challenged, crewmembers stated, “There is no problem, pilot, this is how we always rig it.” The pilot requested that the ladder be re-rigged. On making a second attempt to board, the ladder dropped while the pilot was on it. A third attempt, supervised by the vessel’s chief officer, resulted in the ladder being rigged correctly and the boarding being completed safely.

The pilot was unable to confirm the presence of lifesaving appliances such as a lifebuoy at the embarkation point due to the time and circumstances.

CHIRP Comment

This report emphasises the importance of maintaining full compliance with SOLAS and IMO requirements for pilot transfer arrangements. Even when PTAs are rarely used, for example, when the master has a pilotage exemption certificate (PEC), crews must stay competent and confident in rigging and checking pilot ladders correctly. Regular training, drills, and supervision are essential to keeping this competence, especially on vessels operating under a PEC. Masters and senior officers should actively ensure that all personnel understand the correct rigging procedures and recognise the safety implications of any deviation. A proactive safety culture – where concerns are raised, discussed, and promptly addressed – remains the most effective safeguard against recurrence.

This report raises significant concerns about the safety of PTAs on board the vessel. The ladder rigging was non-compliant with SOLAS and IMO Resolution A.1045(27), creating a serious risk to pilot safety. Unsafe improvisations and a lack of procedural understanding indicate weaknesses in training, supervision, and compliance oversight. CHIRP contacted the pilotage authority to understand how such poor practices had developed and persisted. Following receipt of the pilot’s report, the ferry’s master took prompt action to rectify the failings, and other pilots

have since noted improvements in PTA safety. While this response is positive, CHIRP questions how such deficiencies went undetected for so long and whether similar issues reported elsewhere have led to effective corrective action.

The national maritime authority was notified, but it is unclear if any follow-up occurred at the management level. CHIRP has raised the matter with the Flag State and requested that management be informed of these failings.

It is to the pilot’s credit that they persisted in their attempts to board safely. The fact that the master and chief officer appeared aware of the correct method of rigging, while the deck crew were not, highlights a gap in competence assurance and supervision. This incident underlines the need for regular training, active oversight, and verification of crew competence – particularly on vessels operating under a PEC, where pilot ladders may not be rigged frequently. Ensuring full compliance with SOLAS and IMO standards, supported by an open and proactive safety culture, remains essential to prevent recurrence and safeguard pilot boarding operations.

Key Issues relating to this report

Local Practices – Deviations and shortcuts become the norm. “This is how we always rig it”: noncompliance institutionalised.

Culture – Culture erodes when leadership fails to challenge deviations.

Alerting – No speaking up or challenging unsafe practices. Only the pilot challenged; the crew did not.

Communications – Communications were unclear and did not provide a closed loop of information. It was dismissive: “No problem, pilot”.

Complacency – The crew assumed that nothing would go wrong with an unsecured pilot ladder.

Key Takeaways

Regulators: *Paper safety does not save lives.*

Rules on paper mean nothing without verification—oversight must ensure that the work done matches the work as imagined.

Managers: *What you permit becomes the standard.*

Unsafe shortcuts become habits—leaders must enforce standards, strengthen training, and build a culture where compliance is standard.

Seafarers: *Your safety depends on how you act today.*

Complacency kills. Know the procedures, speak up, and never accept unsafe practices as “the way we do it around here.”

Report No6 - M2613 – Bullying ship manager – safety and leadership culture ashore?

Initial Report

“The vessel’s manager consistently behaves aggressively, intimidating and humiliating the crew.

He insists on illegal actions, such as MARPOL violations, pumping out engine room bilge water without using the oily water separator (OWS), and several other things. When we said that it was unlawful, he started shouting and threatening that we would lose our jobs. We don’t want to commit a crime or breach the regulations, but we also need to work to support our families.

We are seeking your assistance to stop this harassment, intimidation, and abusive behaviour by the vessel manager. We have already approached company DPA, but they are trying to hide the issue and are not helping us.”

CHIRP Comment

This report raises serious concerns about crew welfare and regulatory compliance. Aggressive, intimidating, or humiliating behaviour by a vessel manager can significantly affect morale and safety. Seafarers should never feel pressured to engage in illegal acts, such as bypassing MARPOL regulations. When internal reporting channels fail, it is essential to be aware of other options, including flag state authorities, port state control, and independent safety organisations. Maintaining detailed records of incidents is crucial, and seafarers should seek support from professional welfare or legal bodies if necessary. The main lesson is that safety and compliance must take priority, and a respectful working environment is essential for everyone on board. CHIRP has contacted the management company for a response.

Fear has no place at sea – compliance, respect, and safety must guide every decision.

Key Issues relating to this report

Communications – The vessel manager’s aggressive and intimidating behaviour prevents open communication, making the crew feel unsafe to report concerns and blocking proper feedback and reporting channels.

Pressure – The situation promotes “fear-driven compliance” rather than safety-oriented behaviour.

Teamwork – The manager’s behaviour creates a hostile environment and erodes trust within the team, especially towards the engineers. Effective leadership is absent, and intimidation prevails.

Key Takeaways

Regulators: *Promptly address harassment and illegal practices.*

Effective oversight and support for safe reporting are essential for vessel safety.

Managers: *Leadership through intimidation endangers everyone.*

Respect, communication, and adherence to regulations are non-negotiable. Kind leadership implemented across the company will ultimately eradicate poor management behaviours.

Seafarers: *Be aware of the options for help globally when communications with your management company are difficult*



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