MARITIME FEEDBACK

CHIRP

An independent and confidential reporting system for the Maritime industry

SUPERYACHTS

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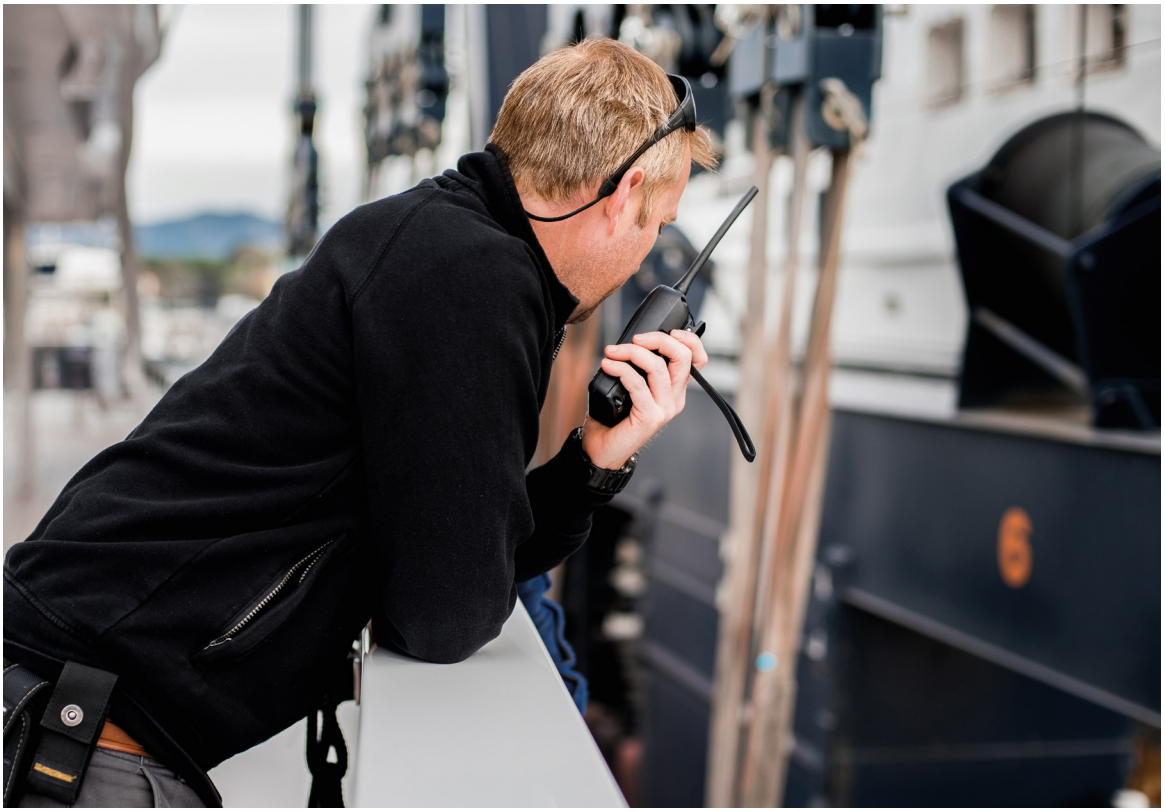

Silence isn't safety

Adam Parnell
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This edition contains interesting and varied reports, and we are grateful to all our contributors for their support. It is noticeable that most cases are concerned with routine operations – collision avoidance, bilge cleaning, shifting anchorage, bunkering and preparing to anchor – all things which we are familiar with, but perhaps this familiarity sometimes causes us to lower our guard at the wrong time.

Among the human factors we identify, inadequate communication appears most often. Whether it is communication between vessels or between crew members, we ignore it at our peril. The first two reports also raise the question of alerting, or speaking up when we see a potential problem. As we comment in one of the reports: 'while speaking up can be morally uncomfortable, the potential safety and legal consequences of staying silent can be far more serious.'

A lack of teamwork also appears in several reports, and in most cases could be avoided by holding proper briefings and discussion before a task is undertaken. Better communication is likely to lead to better teamwork.

We hope you will find the cases described in this edition useful and, until next time, be careful out there!

M2612

Hull integrity compromised during refit

Initial report

During routine paint and corrosion repair on the bow, a hole was discovered in the hull plating approximately 0.5 meters above the waterline. Inspection revealed that the anchor pockets had not been properly sealed, allowing water ingress and corrosion to spread beneath the coating system over multiple seasons. This represented a clear compromise of hull integrity. Upon discovery, the defect was documented and reported to the permanent Masters, who were on leave at the time. The Chief Officer recommended formally notifying management, the class, and the flag authorities and following standard hot work procedures, including obtaining a permit.

The master instructed that the matter be handled internally and ordered a weld repair without a hot work permit, safety oversight, or post-repair testing. The repair was completed without verifying watertight integrity, hull thickness, or class approval. Despite these actions, the vessel was scheduled for an Atlantic crossing, with no assurance that the repair had restored the hull to safe operational standards.

Several factors contributed to this incident. The absence of the permanent command structure during the refit period resulted in poor oversight of shipyard activities. A culture of concealment and avoidance of reporting undermined procedural compliance and safety integrity. Conducting hot work without a permit exposed the vessel and personnel to serious fire and safety risks. Finally, the deliberate instruction to bypass reporting channels demonstrated a significant breach of professional and ethical standards.

The outcome of these events was a repaired hull with no formal verification or documentation, leaving uncertainty over the vessel's seaworthiness. The failure to follow ISM Code reporting requirements, the lack of class involvement, and the avoidance of established safety procedures exposed both the crew and the shipyard personnel to unnecessary risk. This incident highlights the need for vigilance, transparency, and adherence to reporting protocols, especially during periods when temporary command arrangements are in place.

CHIRP Comments

Undermining a vessel's safety culture is **not acceptable**. Creating situations where individuals carry responsibility without the authority to act, especially when they are deliberately undermined, significantly increases risk.

This report reinforces the importance of transparency and strict adherence to procedures, particularly during repair or yard periods when normal command structures may be disrupted. Bypassing reporting requirements and permit-to-work systems removes essential safety barriers designed to protect personnel and maintain hull integrity.

Treating yard periods as "low risk" is a dangerous assumption. During repairs, a vessel may be effectively out of class and uninsured if unrepaired or unreported damage later causes an incident. This risk is often poorly understood on board.

When vessels are under refit or managed by temporary personnel, obligations under the ISM Code remain unchanged. Any damage affecting watertight integrity must be formally reported, assessed, and verified by Class and Flag through established channels.

Unpermitted hot work remains a recurring concern in CHIRP reports. Regardless of intent, welding without a valid permit exposes crew and yard personnel to serious fire and explosion risk. It may also invalidate insurance cover should an incident occur. How hot work can be conducted in a yard environment without proper documentation should be questioned by all involved.

CHIRP encourages all mariners to maintain an open and professional safety culture, one where hazards are reported, not concealed. The integrity of the hull and the effectiveness of the safety management system depend on openness, accountability, and procedural discipline.

Factors relating to this report

Situational Awareness – The defect in the hull plating was not recognised as a serious threat to seaworthiness at the time. The absence of permanent command and limited oversight during refit reduced collective awareness of the vessel's true condition and the associated risks.

Communication – Although the Chief Officer raised a valid safety concern, the information was not passed beyond the ship. Communication became one-way, with no opportunity for open discussion or escalation. This breakdown prevented essential parties, management, class, and flag, from providing oversight, and led to them unknowingly carrying undefined risks in the long term.

Teamwork – The team dynamic was weakened by the absence of the permanent Masters and unclear authority among temporary officers.

This created uncertainty over roles and responsibilities, allowing unsafe decisions to go unchallenged.

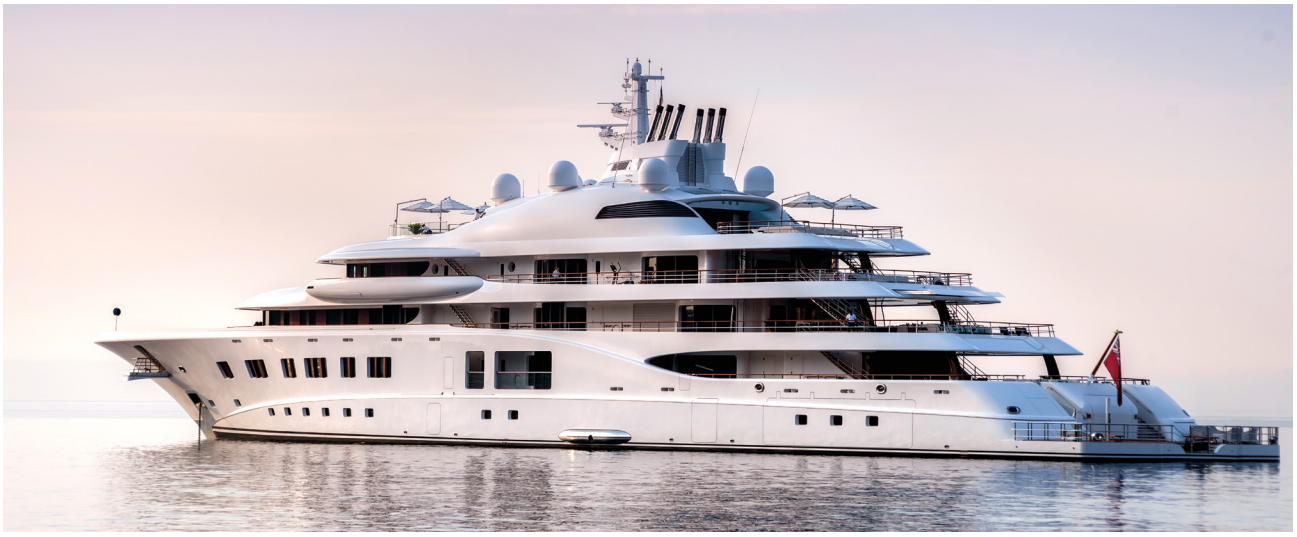
Capability – There was an apparent lack of competence in assessing the structural implications of hull corrosion and repair requirements.

Performing a weld repair without verification or class input demonstrated a limited understanding of safety standards and statutory obligations.

Alerting – Early warning signs—such as the discovered corrosion and the Chief Officer's recommendation- were ignored. This indicates a breakdown in the alerting process where individuals either did not recognise or did not act upon safety signals.

Local Practices – Poor repair yard practices were carried out, leading to fragmented refit and supervision and unevenly distributed workloads. Without the permanent Masters, key safety oversight functions were lost. Shipyard work continued without consistent monitoring or clear interface management.

Culture – A "keep it quiet" attitude discouraged transparency and reporting. This culture of concealment undermined safety management and trust and placed both personnel and the vessel at risk.



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Key Takeaways

Regulators – Culture is as important as compliance.
Regulators should look beyond paperwork and evaluate the culture that influences behaviour. When reporting systems are bypassed, the ISM Code becomes just a formality. Oversight during refits and temporary command periods should ensure that safety reporting, hot-work control, and class notifications are being adhered to. Promoting transparency and supporting confidential reporting will help uncover risks before they lead to incidents.

Managers – Leadership shapes the safety climate.
Management must set clear expectations that defects and safety issues are always reported, regardless of operational pressure. Temporary command arrangements require strict supervision and documented accountability. A culture that values honesty over convenience safeguards both reputation and personnel. Repairs impacting hull integrity must always involve class and flag—taking shortcuts risks far more than delays.

Crew – Speak out, even when it feels uncomfortable.
Every seafarer has a responsibility to protect the safety of the vessel, the crew, and the environment by questioning unsafe decisions and ensuring procedures are properly followed. If you find yourself in a difficult situation, take practical steps to protect both safety and yourself. Keep a written record of your concerns, either in an official logbook or by sharing them with a trusted person using email or another method that provides a clear time stamp. This creates an objective record if the situation later escalates. You can also contact CHIRP for confidential advice and support.

Raising concerns through the correct channels, even when they are not welcomed, is a mark of professionalism. Maintaining situational awareness, using the permit-to-work system correctly, and verifying that repairs are properly completed all help prevent a "temporary fix" from becoming a long-term hazard.

While speaking up can be morally uncomfortable, the potential safety and legal consequences of staying silent can be far more serious.

M2576

Close-quarter situation

Initial report

"I was aboard a large sailing super yacht, under power motoring on a south-westerly course at 9 knots and around 1.5nm from a navigational strait/passage. I noted a ferry steaming almost north, clearly visible, showing her starboard bow aspect. 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 (Rule15 ColRegs).

In this situation, my vessel was the stand-on vessel. 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

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.

CHIRP followed up with the master of the sailing yacht to clarify and obtain additional information. The account indicates that neither vessel fully complied with the applicable COLREGs (Rules 2, 7, 8, 16, and 17), resulting in a close-quarters situation.

Expectancy bias may have played a role, with an assumption that the larger motor yacht would give way, as is sometimes seen in congested coastal waters. Such assumptions, however, undermine the clarity which COLREGs are designed to provide.

Commercial pressure may also have been a contributory factor. Tight schedules and routine crossings can subtly influence decision-making, leading mariners to favour efficiency over strict compliance. Passing at a distance of only 70 metres is hazardous, regardless of vessel size or route familiarity. In some areas with frequent ferry operations, local custom may develop whereby ferries maintain course with the expectation that other vessels will keep clear, even when this conflicts with the COLREGs.

Risk tolerance is another consideration. The ferry may have assessed 70 metres as an acceptable passing distance, which could explain the lack of avoiding action.

This event highlights the importance of adhering to the COLREGs to remove uncertainty. Expecting other vessels to deviate from them increases risk. Challenging assumptions, maintaining situational awareness, and using early and unambiguous communication are essential. A timely signal of five short flashes or sound blasts can often interrupt a developing misunderstanding before it escalates.

For ferry operators, there is also a wider organisational lesson. Operators working to demanding schedules should ensure passage plans and bridge practices are regularly reviewed, through marine manager visits or independent navigational audits, to confirm ongoing compliance with the COLREGs. Encouraging open, blame-free reporting and discussion of near misses helps identify trends and reinforce safe practices before incidents occur.

Factors 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 so not challenging 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

Monitor patterns of repeated close-quarters incidents involving scheduled ferries and other traffic. Encourage systematic use of human factors frameworks (MGN 520 Deadly Dozen and SHIELD taxonomy) in investigations. Strengthen oversight of operator practices, where local or habitual shortcuts undermine COLREG compliance, and consider promulgating additional guidance on proactive VHF use and bridge resource management for congested or routine routes.

Managers: Culture and training must take precedence over schedule pressure

Maintain strict adherence to the COLREGS, regardless of familiarity with local routes or schedules. Do not assume the other vessel will act correctly. Proactively monitor CPA/TCPA, using all available means (radar, AIS, visual), and clarify intentions early via VHF when the risk of collision exists. Always be ready to challenge, alert, and speak up if a developing situation does not align with expectations.

Crew: Don't assume – confirm and communicate to keep clear

Maintain strict adherence to the COLREGS, regardless of familiarity with local routes or schedules. Do not assume the other vessel will act correctly - proactively monitor CPA/TCPA, using all available means (radar, AIS, visual), and clarify intentions early via VHF when risk of collision exists. Always be ready to challenge, alert, and speak up if a developing situation does not align with expectations.

Representative image. Credit: AdobeStock

M2640

Grounding incident

Initial report

The vessel had been anchored for three days to support guest excursions. The owner requested that the vessel move closer to the dock to allow easier pick-up for a tour.

After weighing anchor, the vessel ran aground about 10 minutes later. It struck uncharted coral and was damaged, including the sacrificial rudder tip. One crew member sustained bruising after falling inside the vessel when it grounded.

The presence of uncharted coral was subsequently reported to the hydrographic office. The incident highlighted a degree of overconfidence, as the vessel had been anchored in the same bay for several days without incident.

CHIRP Comments

This report highlights the risks that can arise when a vessel changes from a prolonged period of static operations back into manoeuvring, particularly in areas where hydrographic data may be incomplete.

Short voyages decided at short notice and under time pressure can be just as hazardous as longer passages and require the same level of planning. In poorly charted areas, practical precautions may include using a tender to check depths, ensuring echo sounders are active, and avoiding assumptions that conditions will be uniform across an anchorage. The Master retains the authority to say "no" on safety grounds, and a clear explanation is often accepted.

The vessel had been safely anchored for several days, which may have reduced the perceived risk when repositioning closer to the dock. Experience shows that extended periods without incident can lead to overconfidence and assumptions about the safety of surrounding waters. The presence of uncharted coral demonstrates that hazards can exist over very short distances, even in familiar locations.

Operational or guest-driven requests can introduce subtle pressure to act quickly. This underlines the importance of pausing to re-establish situational awareness and conduct a fresh risk assessment before manoeuvring, particularly after a period of inactivity.

The injury to a crewmember during the grounding reminds us that sudden vessel movements can create secondary risks to personnel, even at low speed.

CHIRP commends the reporting of the uncharted coral to the hydrographic office. Mariners are encouraged to treat manoeuvring after extended anchoring as a new navigational task, to challenge assumptions formed during benign operations, and to adopt a conservative approach when operating close to shore or reef systems.

Factors related to this report

Situational awareness – Failure to re-assess conditions before manoeuvring; uncharted hazards not anticipated.

Teamwork/communications – Decision-making may not have been challenged; lack of cross-checks reduced safety margin.

Capability & Culture – Risk assumptions influenced by prior experience; organisational norms may have reinforced shortcut thinking

Overconfidence/Complacency – Extended anchoring without incident led to an underestimation of risk near uncharted coral.

Key Takeaways

"Even after safe anchoring, familiar waters can turn into hazards—pause, reassess, and navigate cautiously."

Regulators – Embed human factors such as complacency, fatigue, and communication in regulations and inspections—safety isn't just about charts and machinery.

Managers – Encourage a safety culture where crew pause, reassess, and speak up; operational convenience should never override risk awareness. Management companies could greatly assist vessels by developing a 'quick plan' procedure for short passages that retains all the key elements required for any passage.

Crew – Treat every manoeuvre after inactivity as a new navigational task—assume nothing, verify everything, and safeguard yourself and others.

M2639

Poor fuel handling causes blackout

Initial report

The vessel received poor-quality fuel during bunkering, which was not detected in the supplied samples. After departure, the ship lost propulsion in the middle of the night. This occurred because the fuel oil was supplied directly to the fuel oil service tank (FOST/day tank), bypassing the bunker, settling tanks, and purifier.

As a result, several fuel injectors required replacement, and all fuel had to be processed through the purifiers. This caused five hours of downtime during which the vessel was unable to manoeuvre. Fortunately, the vessel had ample sea room and calm conditions; under different circumstances, the situation could have led to serious consequences.

CHIRP Comments

This incident was a fuel-handling failure not a fuel-quality issue. Fuel was delivered directly to the service tank—bypassing the bunker, settling, and purification systems—resulting in a complete loss of propulsion. Several injectors had to be replaced, and all fuel had to be reprocessed through purifiers, causing five hours of downtime. CHIRP recommends the use of third-party fuel analysis to verify fuel quality, with a representative sample (e.g., a drip sample) taken at the point of custody transfer where the bunker hose connects to the ship's flange. Fuel should never be added to service tanks or supplied directly to machinery except through the fuel-purification or equivalent filtration systems. Fortunately, calm conditions and ample sea room prevented more serious consequences. The event underscores the need to follow correct fuel-handling routines, take proper samples rather than relying solely on supplier samples, and maintain readiness to respond promptly to engine issues.

Human Factors related to this report

Communications - Fuel quality issues were not communicated effectively to relevant personnel. This can vary significantly from port to port, where supplier quality can vary.

Teamwork - Decisions appear to have been made without cross-checking or consultation.

Capability - There was a lack of training for those handling the fuel.

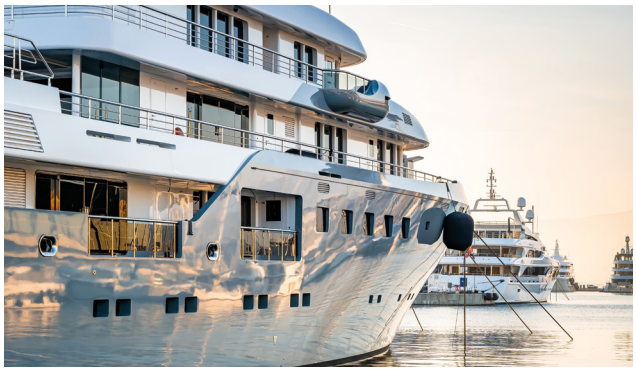
Key Takeaways

"Check, comply, communicate—every hand matters for safe fuel at sea."

Regulators - Ensure comprehensive fuel quality checks, standardised procedures, and vigilant oversight of vessel monitoring and risk management systems.

Managers / Operations Leaders - Enforce strict fuel-handling compliance, thoroughly train crews, conduct risk assessments before deviations, and maintain supervision and feedback to prevent unsafe practices.

Crew / Engineers - Follow fuel handling and purification procedures strictly, communicate clearly, double-check work, and report anomalies promptly to prevent operational disruptions and safety risks. Raise a Letter of Protest if the supplied fuel is sub-standard.



Representative image. Credit: Shutterstock

M2642

Near miss - potential poisoning and asphyxiation of a crew member using a chemical for cleaning a confined space

Initial report

"I was on a MY during an extensive refit, responsible for cleaning and painting the engine room bilges. The main bilge sump was 6ft deep, just barely enough to crouch in, and I was at the bottom, using acetone to degrease the surfaces in preparation for painting. Unbeknownst to anyone on the crew, acetone expands to over 300% of its original volume and is heavier than air. Therefore, as I was down there, oxygen was rapidly being displaced, and the vapour had nowhere to escape. I was wearing a VOC (Volatile Organic Compound) mask, per SOPs, so I had no way to sense what was happening. I didn't have a ventilation system set up, a body-worn gas detector, or a lookout posted. The first sign of trouble was not light-headedness or nausea, but a deep sense of 'fight or flight' in my chest, and I managed to scramble out of the bilge sump and just caught my breath enough to call on the radio. Luckily, I escaped without needing medical treatment, but it could have been much worse. It's a lesson I've carried throughout my career."

CHIRP Comments

Bilges are enclosed spaces as defined in CoSWP Section 15, MGN 659, and MSC A.1050(27). Vessels should clearly identify and record which compartments onboard are considered enclosed spaces (ES), and ensure this information is reflected in the SMS and risk assessments. While the reporter was following the vessel's SMS, the VOC mask used was not suitable for the hazard encountered.

This report highlights an important and often under-appreciated chemical hazard associated with routine tasks such as bilge cleaning. The reporter was working during a refit period, when ventilation arrangements and system configurations may differ from normal operations. The use of acetone in the confined geometry of a bilge sump, combined with poor ventilation and no atmospheric monitoring, created a potentially life-threatening situation. It is commendable that the reporter recognised the symptoms early and exited the space promptly, thereby preventing a more serious outcome.

A key learning point is that many common solvents produce vapours that can rapidly displace oxygen due to having a higher vapour density, particularly in enclosed or poorly ventilated spaces. VOC masks protect against inhalation of certain substances but do not supply oxygen and may give a false sense of security where oxygen depletion is occurring. Carrying gas-detection equipment is essential, not only for formally designated enclosed spaces but also when using oxygen-displacing chemicals in any restricted area.

Task risk assessments should explicitly consider the chemical properties of substances being used, their vapour behaviour, ventilation arrangements, and the need for atmospheric monitoring. Standard enclosed-space precautions — including portable gas detectors, effective mechanical ventilation, and a designated standby person — should be applied whenever there is a risk of vapour accumulation. This is particularly important during refit or maintenance periods, when non-routine tasks are undertaken.

This report also underlines the importance of crews having access to, and understanding, Safety Data Sheets (SDS). Pre-task planning should ensure that all personnel are aware of the risks of vapour expansion, oxygen displacement, and the limitations of PPE.

CHIRP strongly recommends that solvent cleaners such as acetone are **not** used for bilge cleaning.

Factors relating to this report

Safety Culture – The organisation had not fully identified or communicated the atmospheric risks linked to solvent cleaning during refits.

Capability – The task lacked a specific assessment that considered chemical behaviour, confined-space characteristics, and the required controls. Knowledge of solvent-related oxygen displacement was not part of regular training or toolbox talks.

Communication – The crewmember was isolated from other crew members, so no communication could take place.

Teamwork – No designated standby person or two-way check-in process for potentially hazardous work. The crew is working independently without support.

Design and engineering control – Lack of integrated ventilation/gas detection for small, confined compartments.

Local Practice – Procedures and work-as-done did not align with the real risks and relied heavily on PPE rather than higher-order controls.

Key Takeaways

"You can't smell missing oxygen—so plan for the hazard you can't sense."

Regulators – this report reinforces the need to ensure that guidance on confined-space entry and hazardous-substance use explicitly covers the oxygen-displacement risks of common solvents such as acetone. Regulatory frameworks may already mandate atmospheric testing and ventilation for enclosed-space work, but this incident shows how everyday maintenance tasks can fall outside formal definitions while presenting identical hazards. Clearer expectations around gas detection, task-specific risk assessments and solvent-handling protocols during refit periods would help close this gap.

Managers – the key takeaway is that work planning must account for both the environment and the chemical properties of the substances being used. Procedures that rely solely on PPE, without ventilation or atmospheric monitoring, create a false sense of security. Ensuring that Safety Data Sheets are incorporated into pre-task briefings, making gas detectors readily available and verifying that confined-space precautions are applied even in small spaces like bilge sumps are essential steps. Refit periods require heightened vigilance because non-routine work often involves equipment isolation, restricted access and chemical hazards that may not be part of everyday operations.

Crew - the lesson is that familiarity with a product does not guarantee safety. Solvents can behave unpredictably in confined areas, and symptoms of oxygen depletion may be subtle until they become dangerous. Relying on PPE alone is not enough; ventilation, monitoring and having someone aware of the task are critical safeguards. Trusting instinct and acting early, as the reporter did, can prevent severe outcomes.

M2638

Yacht's anchor damages hull

Initial report

Approaching an anchorage, the first mate rushed to prepare the anchor but accidentally released it while the vessel was doing 10 knots. With sufficient water, it didn't hit the bottom; however, when the mate engaged the brake, the anchor swung and struck the hull, causing minor damage that was repaired during the next haul-out.

CHIRP Comments

Apart from emergencies, never carry out anchoring procedures hurriedly. Heavy gear and high kinetic energy leave little room for error. Preparing the anchor to be let go is a deliberate process and should not be rushed, nor undertaken while the vessel is navigating at speed. Did the first mate experience real or self-perceived time pressure to rush?

Keep clear, closed-loop communications on the bridge, and always confirm brake engagement before releasing. Anchors should be held on the brake, plus guillotine or chain stopper, until vessel speed is reduced and the vessel is close to the anchorage. Ensure the vessel is at a safe speed and in suitable water depth before handling the anchor. Releasing the anchor while moving at 10 knots carries a high risk of damage to crew, anchor, machinery, and hull.

This incident highlights the importance of controlled anchoring methods and strict compliance with standard operating procedures to avoid unnecessary risks.

Factors related to this report.

Pressure - The approach to an anchorage often creates time pressure. The first mate may have felt rushed to "get the anchor ready" before the vessel reached the drop position, increasing the likelihood of an error.

Complacency - Anchor preparation is a routine task. Familiarity with the operation can reduce vigilance, particularly regarding the risk of premature release while the vessel is still making way.

Lack of Communication - There appears to have been no clear confirmation between the bridge and forecastle on vessel speed, readiness, or the command to let go. This is a critical barrier that failed.

Lack of Teamwork - Safe anchoring depends on coordinated actions between the bridge and the deck. The incident suggests the operation was not being managed as a shared task with clearly defined roles and checks.

Distraction - The premature release may indicate the first mate's attention was divided, possibly by concurrent tasks, environmental factors, or monitoring the vessel's approach.

Lack of Situational Awareness - Releasing the anchor while the vessel was still making 10 knots shows a breakdown in awareness of vessel speed and the consequences of letting go at that moment.

Key Takeaways

"Rushing routine work leads to accidents—slow down, focus, and follow the steps."

Regulators - This incident demonstrates how routine anchoring operations can become dangerous when workload and time pressure are poorly managed. It emphasises the need for regulatory focus on how procedures are practically applied during arrival phases, not just their existence.

Managers - The event highlights the risk of starting safety-critical tasks too early under perceived time pressure. Managers should ensure anchoring procedures, training, and supervision clearly align with vessel speed, task sequencing, and workload during approaches.

Crew - This incident shows how rushing and distraction during routine tasks can cause unintended outcomes. It highlights the importance of avoiding time pressure, staying aware, and ensuring conditions are safe before handling.

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