CHIRP Maritime FEEDBACK
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Editorial

This is the last edition of Maritime FEEDBACK which will be published under the leadership of our current Director (Maritime), Captain John Rose MNM, who has decided to step down in January 2018 after four years at the helm. During his time with ***CHIRP***, John has overseen a remarkable transformation and introduced numerous improvements. We are now more effective, are reaching more seafarers than ever before, and are financially more healthy, so we owe him a tremendous debt of gratitude.

The Trustees are fortunate to have recruited Captain Jeffrey Parfitt FNI, who is already working with John ahead of the handover. Jeff is an experienced mariner with wide experience, particularly in the offshore industry, who also worked for several years as a confidential investigator. He brings a very useful set of skills to ***CHIRP*** Maritime, and we look forward to working with him in the years ahead.

In this edition, we feature more reports about mooring and pilot boarding, and describe a few problems faced by pilots in the course of their duties. There are reports about dangerous practices when working aloft, and others referring to COLREGS, leisure vessels and ship design. There is an interesting section about passenger vessels, and one potentially explosive report!

Finally, we include a note about health-related issues, and ask for your support in helping us to shine a spotlight on an area which has been neglected. Recent international conventions have made this a legitimate area of concern for ***CHIRP*** Maritime and we will welcome your reports.

This is a varied and interesting edition and our thanks, as always, go to our reporters and sponsors for making it possible.

REPORTS ...

An illusion of safety

OUTLINE: A report outlining dangers with inertia-wire rope safety lanyards when not used correctly.

Lifejacket with safety lanyard.

What the Reporter told us:

Rigging the gangway, the crew were dutifully using inertia-wire rope safety lanyards clipped to the webbing straps of life jackets. There were a few issues of concern and I don't believe they are unique to this vessel.

- The lifejacket was not of a type designed for fall arrest. (Lanyard clipped around strap and strap around torso).
- There was no energy absorbing lanyard in use.
- There was no obvious rescue means on hand at the top of the work area.
- The inertia-wire rope unit was not directly above the worker. Should they have fallen they would have suffered the pendulum effect. The wire was passing over a sharp coaming.
- The inertia unit was secured to handrails that were in poor condition.

There are many factors here, including the design of a gangway area that seems to have no regard for how to rig safely. The idea that someone is expected to walk down a gangway with no rails and then lift those rails into place shows that good human-centred design has a long way to go in our industry.

Further to this, if we can't change the design we should at least consider how we make people safe carrying out this task? How do we get an unconscious person back to deck level when using a safety harness and stop them dying from suspension trauma?

Typical marine industry reaction will likely be more training for the seafarer to ensure he/she is blamed for what is, at root, a design issue not a behaviour/training issue.

CHIRP Comment

The Maritime Advisory Board agreed with all aspects of this report. It is good example of Human Centred Design not being applied, forcing crews to work around the problem. Designers take note!

REPORT ENDS

PLEASE NOTE ALL REPORTS RECEIVED BY CHIRP ARE ACCEPTED IN GOOD FAITH. WHILST EVERY EFFORT IS MADE TO ENSURE THE ACCURACY OF ANY EDITORIALS, ANALYSES AND COMMENTS THAT ARE PUBLISHED IN FEEDBACK, PLEASE REMEMBER THAT CHIRP DOES NOT POSSESS ANY EXECUTIVE AUTHORITY.

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Unmooring – Momentary Human Error – Wait for the splash... !

OUTLINE: Whilst unmooring, the forward breast lines were lowered by ships staff for release at the hook by the shore linesmen. The officer in charge (OIC), assuming that the ropes had been released, gave the signal to the winchman to heave the ropes home. The winch operator commenced heaving. The OIC realized, simultaneously with advice relayed via the pilot and master, that one of the mooring ropes had not released. He signalled to the winch operator to stop heaving, and to slacken the rope. The rope was then released by the linesmen and the unmooring operations continued. The pilot issued an incident report which was followed up by the company.

Extracts from the Company Report:

The company conducted a thorough investigation and analysis of the incident, focussed upon human factors rather than blame. The salient points are as follows;

- Mooring operations are covered by company's Safety Management System, including work control manuals with specific reference to mooring. Procedures refer to appropriate industry publications, cover familiarization/ training, job hazard analysis and proper operation/ maintenance of equipment.
- The mooring team consisted of the OIC and four ratings. All personnel were experienced, considered fully competent for the mooring operation, and had completed familiarization training prior to taking up any mooring duties. They were familiar with the terminal, and the communication practices between the linesmen and the mooring stations.
- Prior to departure a tool box talk was given to all mooring party members and reported to the bridge. Similarly, the unmooring plan was agreed between master and pilot, then communicated to all involved.
- Communications were supervised by the bridge. Standard practice is that the OIC communicates directly with the shore linesmen and vice versa using visual signals. There is no bridge intervention unless further clarification or guidance is required.
- The linesmen unhook the lines once slacked by the vessel. The OIC and the winch operator stand close to each other, so that effective verbal communication can be maintained. During critical verification times, the OIC stands in a location which ensures that both the shore and ship's teams can be seen. Following confirmation of release from the hooks, (by visual signal, which is acknowledged), the vessel heaves up the lines using the winches, initially at slow speed.
- This was effectively implemented whilst releasing the headlines. With the breast lines however, and at the critical point of release, the OIC was not standing at the proper location, and was not able to verify that all lines were released. Instead an assumption was made that the lines had been released, based upon the elapsed time from the last visual contact with the linesman. Although unintentional, this was a violation of standard practice. A further error was that the winch was operated at high speed, in contravention of standard practice. It was not clear why the winch operator acted that way.
- No contributory causes of the error have been identified. Fatigue was determined not to be factor.

Conclusions

- A review of the unmooring Job Hazard Analysis shows that there is no direct reference to the need to communicate with shore staff to prevent this kind of incident. (Procedural improvement indicated).
- The OIC had become involved in the releasing/retrieval of the mooring ropes and had momentarily assisted the crew instead of overseeing the operation. (Lack of situation awareness).
- The lines of communication, for handling the breast lines, were insufficient as the OIC had not received a signal from the linesmen ashore to verify that all was clear and the mooring rope tails had been released from the hooks. Additionally, this had not been acknowledged, and the OIC was not in a position to determine that shore linesmen were in a position of safety away from the hooks. (Lack of proper communication and improper position for the operation).
- A human behavioural issue was identified in the unintentional risk taken by using time elapsed to infer critical information related to mooring operation. (Performance of a practice without risk appreciation)
- Finally, the fact that the winch was operated at high speed at the initial stage of heaving up implies inadequate supervision. (Improper operation of equipment and lack of proper supervision)

Actions Taken

- The near miss analysis to be discussed with the terminal operator to improve existing mooring practices.
- Just Culture process was applied with regard to the OIC, and will include a training session.
- A Fleet Circular issued, sharing the lessons learnt and requesting a mooring operation evaluation review to be discussed on board and shared across the fleet. The review to include a mooring operation hazard analysis to ensure the lessons learnt from this near miss are incorporated, for use in future toolbox talks.
- The lessons learned are to be included in Fleet Training Officer material for on-board training.

CHIRP Comment

The Maritime Advisory Board emphasised that the person in charge should not get involved in handling ropes and should always maintain a full oversight of the operation. The company's effort to investigate the human factors is refreshing – it is only by doing this that root causes will be properly addressed, as opposed to simply saying "Did not comply with the SMS!".

Useful references – OCIMF *Effective mooring*, and the Nautical Institute *Mooring and Anchoring Ships Volumes 1&2*.

REPORT ENDS

The Charitable Trust CHIRP (Confidential Hazardous Incident Reporting Programme) reviews near miss and hazardous incident reports from seafarers around the world.

Port arrival and berthing mishaps

OUTLINE: *CHIRP* has received several reports relating to port arrival and berthing. The following reports cover communication failings, maintenance issues, and operational concerns.

What the Reporter told us (1):

The ship arrived early at the pilot station but continued to proceed inside pilotage limits. When outbound in the pilot boat I saw the vessel was ahead of time, so called and told them not to proceed inside the pilot station and if necessary take a round turn until I arrived. The vessel took no action and continued inside the limit. Only after repeated calls and explanations did the vessel to go around to allow me to board in the correct position.

We do not send out written instructions about not proceeding inside the boarding ground via the agents, as this may not be actioned upon receipt. Our harbour radio (VIS) instructs vessels not to approach the boarding station until contacted by the pilot. We do not talk to the ship until we have the vessel in sight visually.

I'm sure that, with hindsight, I could have communicated better but it is clear that there was a lack of understanding about what was being requested. Once I got to the bridge the captain immediately asked why he needed to go around. Having explained, and established myself on the bridge, I was very conscious to establish a good rapport with the bridge team, since an overly critical pilot can create a barrier between himself and the master/bridge team. Whilst encouraging some small-talk to soften any tension, I was also able to get a better sense for the captain's level of English, which was moderate at best. It was confirmed he had never been to this port before.

CHIRP Comment

The Maritime Advisory Board emphasised the need for good communications between the port authorities, vessel and pilot. In general, the reasons for not proceeding inside port/pilot limits might be;

- **Any incident inside pilot/port limits might have legal ramifications.**
- **That the pilot needs time to familiarise himself with specific bridge equipment and also to conduct a thorough master–pilot information exchange.**
- **The pilot and master need to satisfy themselves that the vessels equipment is all in good order for the transit.**
- **Time may be required, for example to line up for a leads approach.**
- **The vessel may not be aware of any other ship movements in the vicinity which may or may not have priority.**

What the Reporter told us (2):

Sailed a car carrier this evening and noted a few issues for consideration.

- Bow thruster not available due to auxiliary engine issue. Master stated bow thruster could not be used without risk of blacking out the vessel. This was only mentioned when the pilot arrived on the bridge for departure. I called for a second tug.
- Unmooring was slow due to winch pumps requiring changing-over during the operations, both forward and aft. I recall this from previous operations with this vessel.
- Elevator not working, fourteen decks from accommodation level to pilot embarkation deck, resulting in a slower than expected transit time through the vessel.
- Ships VHF radio communications broken at times, could be a handset issue?

CHIRP Comment

The Maritime Advisory Board commented that many pilots do have the option to delay sailing, take the ship to anchor until faults are rectified, and to inform Port State inspectors (although the power to do so is unfortunately not universal). In this case there are several issues, all indicative of poor mooring equipment design, work preparation and maintenance failings – overall a non-effective safety management system. This is unfortunately not uncommon. Ship's personnel often live and work with deficient equipment for such a long time that it becomes the standard, and is not regarded as being deficient.

What the Reporter told us (3):

Whilst berthing the vessel a tug order was missed resulting in heavy contact with the berth. It appears that as an order was given to each tug in quick succession, the order to the forward tug may have been blocked by a response from the aft tug. This resulted in the tug continuing to push after the order was given to stop. There was no damage because the rubber fenders absorbed the load adequately. As the shoulder landed first there was no damage, however if it had been the aft tug continuing to push, there could have been damage to the quarter with this type of vessel.

CHIRP Comment

The Maritime Advisory Board commented that a vessel's speed must be fully under control when approaching a berth. The problem in this case was the rapid succession of orders given to the tugs. Any instruction to a tug should be considered before being transmitted. The view of the tugmasters and their means of communication is an additional consideration. A publication giving guidance on "Standard Pilot Orders for Tugs" by The International Tugmasters Association specifically discusses intervals between pilot orders for tugs and this becomes increasingly important when more than two tugs are utilised. The whole issue of tug orders and language is the subject of ongoing debate globally.

What the Reporter told us (4):

On approach to the port whilst under pilotage, a vessel experienced a blackout approximately two miles NE of the inlet leading to the final port approach. The main engine stopped, although steerage and emergency electrical power was maintained. The vessel was proceeding inward bound with a speed of 5 knots. Both anchors were cleared away ready for use. The generators were restarted after

2 minutes, and all electrical power and systems brought back online. Main engine and bow thruster were tested at this time. In consultation with the master, it was agreed to resume the approach. The master advised the pilot that the reason for the blackout was the starting of an additional generator. The vessel then proceeded to berth without further incident.

CHIRP Comment

The Maritime Advisory Board mentioned the following lessons to prevent reoccurrence;

- Prior to standby it should be ensured that adequate electrical power is available with additional plant engaged as necessary before the pilot boarding ground is reached, to cover all anticipated operations e.g. electro hydraulic winches, bow thruster, lighting, main engine.
- Anchors should have been cleared beforehand - vessel only two miles off the beach.
- Are the pre-arrival checks appropriate – are they implemented correctly, who checks, and are they confirmed by the company? If the answer is in the negative, managers should then ask, why? (Potential management failings)
- Some companies conduct machinery drills, which are useful for training staff to respond to such incidents.
- The incident identifies potential causal factors including but not limited to;
  - Latent Failures - Design, Hardware, Maintenance Management, Procedures, Training.
  - Human Factors - Complacency, Local Practices, Pressure, Fatigue, Situation Awareness.

REPORT ENDS

Navigation lights – can you see them?

OUTLINE: An encounter between a yacht and a large passenger vessel, where navigation lights were difficult to distinguish amongst other deck lights.

What the Reporter told us:

My yacht was under sail progressing in a southerly direction. I saw the lights of another vessel off my starboard bow. At some distance, I made out what I thought was a green light and believed that the other vessel was a cross channel ferry heading north, well clear of my vessel. As we closed, it became clear that what I had thought was a green light was in fact blue, but another green light became visible, so I continued to believe this was a ferry heading north and clear of my vessel. However, the relative tracks didn't seem to make sense if I was seeing a starboard navigation light. Eventually, the vessel crossed my track about a mile ahead – it was a cruise liner going from west to east. I should, therefore, have been able to see the port navigation light but, even with hindsight, I could not convince myself there was a red light in amongst the multitude of other lights visible on the cruise liner. This is a common issue with cruise liners – and this one is no worse than some others.

On this occasion, there was no harm as the other vessel was a safe distance ahead and we were the stand-on vessel. However, because we only saw what seemed to be a green navigation light and, therefore, misinterpreted the situation, had my vessel been under power, we would not have known that we were the give way vessel until very much closer, and then only because the track wasn't making sense, not because we identified the red port navigation light.

The Collision Regulations specify the minimum visibility of navigation lights. However, the impact of other bright lights simply obscuring the navigation lights, (as was the case when the vessel was 1 mile ahead), or being positively misleading (as was the case initially when the only coloured lights I could see were green), is not appreciated. Vessels should ensure that their navigation lights are bright enough to be seen against the background of all their other lights, and avoid using coloured deck lights where this can cause confusion.

Very bright deck working lights obscuring navigation lights are often an issue on fishing boats as well.

CHIRP Comment

The Maritime Advisory Board highlighted the importance of taking a series of compass bearings in order to determine whether a risk of collision exists. Navigation light visibility – irrespective of other lighting – must comply with COLREGS Annex 1.

In addition, they queried why classification societies permit these designs where visibility is obscured. Technology exists whereby deck lighting may be adequately shaded - permitting safe movement on board yet not obscuring regulatory lights.

The quality of light bulbs used is another possible consideration. Take LED for example – are approved suppliers holding the introduction of these back due to a lack of any requirement in COLREGS?

REPORT ENDS

Close Call - Fishing Vessel and a Ro-Ro

OUTLINE: A report outlining a near miss in the Mediterranean Sea that almost resulted in a collision.

What the Reporter told us:

Whilst on watch during the night I heard an Italian fishing boat several times calling a ro-ro ferry on VHF channel 16, asking her to keep clear of him as he was trawling and displaying the required navigation and fishing lights. Italian was the language in use. The fisherman also provided his position and said he had been flashing a light for the last five minutes. As he did not receive any answer from the ro-ro ship, and considering that the vessel had not altered course and speed at all, he had to take evasive action and stopped his boat, ending up just 10 meters from the passing cargo ship. The fisherman contacted the nearest local Italian coastguard station shortly afterwards to report the near miss, and he was told that an investigation would be conducted upon his return to port the following day.

It's really shocking to still hear such conversations on VHF. In this case the lack of a proper lookout could have resulted in a collision - the actions of the fishing boat skipper prevented it.

What the Third Party told us:

CHIRP wrote to the ISM Managers of the vessel but they declined to respond.

CHIRP Comment

The Maritime Advisory Board commented that with the exception that the use of VHF should not be used for collision avoidance, the fishing vessel's actions were appropriate when raising awareness of the risk of collision. Additionally, whilst it is pleasing that the Italian coastguard undertook to follow up, it is disappointing that the Company in question did not respond, indicating a poor company management safety culture.

REPORT ENDS

Watch Your Step!! Poorly designed bridge wing platform

OUTLINE: Poor design – a tripping hazard with the potential for a fatal fall from height.

What the Reporter told us:

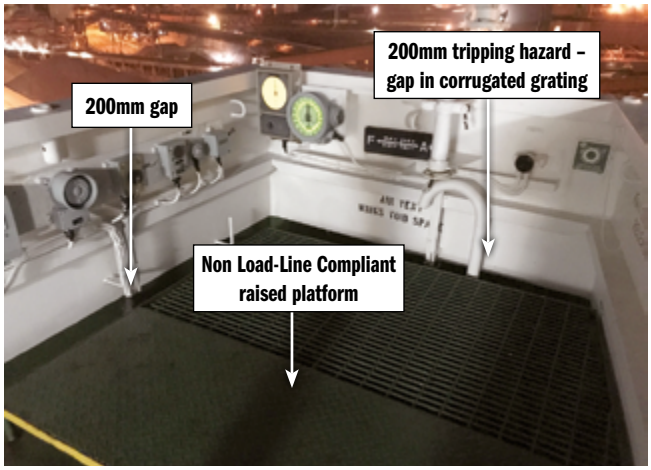
I piloted a vessel into port this morning. As I walked out to the bridge wing in the dark I was confronted by a platform approximately 200mm off the deck - despite the yellow paint on the edge it was almost invisible. Once on the platform I had the coaming of the bridge at mid-thigh level as opposed to hip level. Being some 26m above the wharf, this was quite unnerving.

Upon stepping off and proceeding to the bridge during berthing my foot slipped off the outboard edge. This was due to the fact that there was a gap off approximately 200mm between the platform and the solid upright part of the bridge wing.

I am not sure why the ship was built with this platform - the only thing it appears to do is make it easier for a person to fall off the bridge wing.

The reporter passed the incident to Port State Control who visited the vessel to follow up and conduct a scheduled inspection. They commented that, remarkably, this ship is some 13 years old yet the matter has never been raised. The International Convention on Load Lines 1966, Regulation 25(2) Protection of Crew states that a minimum bulwark height of 1000mm from the deck is required. With the addition of the deck platform the height was reduced to about 880mm which does not comply with this regulation. The vessel's classification society also stipulate that for bridge wings, freeboard decks and superstructure decks, the minimum height of bulwarks must be 1000mm.

A deficiency was raised with a direction to comply with the regulation as soon as practicable. Until then a risk assessment must be completed with appropriate measures taken to ensure there is no risk of falling or tripping hazard to any persons occupying the area. The company's port captain, on board at the time, agreed to follow up accordingly.



Tripping hazards on a bridge wing – height to coaming must be a minimum of 1000mm

CHIRP Comment

The non-compliant design should have been identified in a flag state survey. A risk assessment should have been undertaken and a Management of Change process applied at the design stage. This should have been approved by the ship managers. This report should raise the awareness of all mariners about the need for a minimum bulwark height of 1,000mm, and the inherent dangers of tripping over obstacles at night.

REPORT ENDS

Passenger vessel safety

OUTLINE: *CHIRP* has received several reports regarding both domestic and international passenger vessels outlining failings in safety management.

What the Reporter told us (1):

I was on a cruise earlier this year. As an ex-mariner I was shocked by the occasional unseamanlike behaviour of the deck crew. The following was noted – small things possibly, but indicative of the culture on board. I contacted the onboard ship management but their response was less than helpful so I wrote to the company. Their comments are in italics.

- Mooring crew left a stairwell gate swinging even though it had a securing device. The next six crew-members who went through that gate left it open, swinging gently. They all knew the vessel was proceeding to sea
- Personnel painting cable runs in the deck-head. On one occasion a safety harness was worn but was not used, the second time, a safety harness was not worn. *The photograph shows the crew member up a ladder and being supported below by another crew member. Whilst the Code of Safe Working Practices does allow for this control measure to be used, this is still 'working at height'. The Code lists the control measures that should be in place and the approved onboard risk assessment allows for ladder use in such a reduced height task such as this. Note the ladder is supported below. In this instance the practicality of securing a safety harness in a confined place such as this would have likely been more hazardous than the fall.*

- I watched an AB sharpening his scraper with a disc grinder. The disc was facing upwards and turning whilst he laid the scraper on it. Guests were walking past while this was going on but rather than go down to a workshop, put the scraper in a vice and do it properly, he put himself and passengers at risk. *This was likely very isolated and will be brought up at toolbox talks with the deck crew to ensure power tools are used safely.*

What the Reporter told us (2):

Whilst moored and carrying out administrative tasks on the bridge, I noticed a crew member on the ferry docked nearby, working (painting) on a scaffolding at approximately three to four metres above the deck, without wearing any PPE at all (no safety harness, helmet, safety goggles or gloves). Not only this, but when the scaffolding was moved a few metres by other crew members, the worker stayed on top of it holding onto the rails. A shocking sight indeed!

CHIRP Comment

The Maritime Advisory Board commented that in both reports the hazards do not appear to have been managed, indicating a poor level of safety culture and leadership. It was questioned whether the "two metre rule" is detracting from the use of a permit to work (which should take into account the specific location of the work, and potential hazards). CSWP Chapters 8, 11, 17 refer. MAIB have investigated several fatalities caused by falls from height, whilst MARS and *CHIRP* both have reports related to working aloft, so the issue still requires close attention.

What the Reporter told us (3):

On passage between the mainland and an island aboard a domestic passenger vessel, no safety briefing was provided although the public-address system was used by tour guides to broadcast information of general interest in five languages. Time on passage was approximately 50 minutes. On the return passage on a similar company vessel, no safety briefing was provided.

The only exit marked with an "EXIT" sign on the middle deck was at the aft end. Doors located towards the bow on this deck were not marked and were not seen to be used. The deck plan of this vessel, according to the company website, depicts these doors as being capable of use, each opening onto an exterior passage.

Railings on the gangway, once lowered to enable passengers to board and to disembark, left a significant gap to the fixed railings at the stern of the vessel. When schoolchildren were seen to walk across this area, a crew member standing on the deck extended an arm to ensure that there was no gap between the rails, but this protection was not provided for adult passengers.

The mooring eye, placed over fittings on the quay, had a hook attached that might be viewed as a trip hazard for passengers waiting their turn to board.

It is suggested that the company's Safety Management System might usefully consider:

- Requiring safety briefings to be broadcast on all passages.
- Reviewing the emergency exit plan for all vessels to ensure that doors capable and intended to be used for this purpose are marked with "EXIT" signs.
- Devising an effective means of bridging gaps between the gangway and fixed rails - a barrier that can simply and quickly be put into place and removed - to prevent passengers and crew from falling through these gaps with the associated risks of injury and/or drowning. Crew members were observed not to be wearing life jackets.
- Reviewing their policy for ensuring that methods employed to moor company vessels do not create trip hazards.

CHIRP Comment

Having established that the vessels had no IMO number, *CHIRP* concluded that they fell under domestic legislation. *CHIRP* wrote to both the vessel managers and flag state but neither responded, which is indicative of safety management and cultural failings at a local and national level – the perfectly reasonable concerns of the reporter could easily be addressed if they chose to do so.

REPORT ENDS

Pilot boarding arrangements

OUTLINE: *CHIRP* continues to receive many reports relating to pilot ladder boarding arrangements which are non-compliant with SOLAS. The following is a selection of some the issues reported.

What the Reporter told us (1):

Manropes were secured to handrails rather than strong points on deck as required by SOLAS. This ship may well be in compliance as built, but looking at the rails I would not be happy for them to be protecting me from plummeting to my death. They were quite bent out of shape.

CHIRP Comment

The correct arrangements, including the critical point of transfer from the ladder to deck are fully described in the IMPA – Boarding Arrangements Poster and SOLAS V/23 7.1.1

What the Reporter told us (2):


Non SOLAS compliant modification

I went to disembark from the ship when my attention was drawn to a device that was clipping the ladder to the hull, arguably to prevent the ladder from sustaining excessive rotation. The ship had been flagged before for an unsafe pilot ladder arrangement. The solution does not fully comply with SOLAS. The ship (and its Class) need a SOLAS compliant definitive solution to hold the ladder firmly to the hull.

CHIRP Comment

The Maritime Advisory Board noted that the report should have included the need for a full risk assessment before applying a Management of Change process for improvement – the arrangement put in place does not comply with SOLAS. *CHIRP* wrote to the vessel's ISM Manager but they declined to respond. We also discussed the photo with UKMPA who highlighted the following:

Ref paragraph 7.2.2 (IMO Resolution A1045). Unfortunately, the resolution is not well written as the securing requirements for combination rigs somehow became entangled in the winch reels section during editing - something the MCA picked up earlier this year. However, on close reading of the whole section, it is obvious that the requirements for both the ladder and the accommodation ladder to be secured to the ship's side apply regardless of a winch reel being utilised.


Examples of compliant fitting – magnetic (left) and vacuum (right). Any boarding arrangements for pilots must be in accordance with SOLAS Regulation V/23 & IMO Resolution A.1045(27) as amended by A.1108(29).

REPORT ENDS

Do Not Touch! – Discovery of live munitions

OUTLINE: A report from a vessel engaged in treasure hunting where unexpected treasures were discovered.

What the Reporter told us:

The vessel was engaged in treasure hunting, scanning and recovering wrecks with a remote submersible vehicle. On this occasion munitions were brought on board in addition to the treasure being hunted. The reporter wrote to CHIRP querying the handling of such potentially hazardous materials without proper protective equipment.

CHIRP contacted the Royal Navy bomb disposal unit and their advice is quite clear. Under **NO** circumstances are any munitions to be handled. Wherever you are in the world, if suspicious materials are discovered then immediately contact the local authorities in order for their experts to assess and deal with the hazard.

Munitions discovered whilst treasure hunting

CHIRP Comment

The Maritime Advisory Board, whilst fully endorsing the advice above, commented that discovery of munitions is also common in the dredging and fishing industries. Since the severity of the hazard is unknown, maintaining a safe distance until assistance arrives is prudent.

REPORT ENDS

Swamping of a RIB and subsequent beaching of a yacht

OUTLINE: A yacht gets into trouble and requires assistance but it all goes wrong.

What the Reporter told us:

A yacht suffered engine problems while on passage and the skipper requested a tow from the mouth of the river to his berth at the yacht club. The club launched a rigid inflatable boat, (RIB), crewed and helmed by persons holding RYA Powerboat Level 2 and RYA Safety Boat certificates to perform the tow. A considerable swell in the entrance of the river had developed due to wind against the ebbing tide. This resulted in the RIB and the yacht being pulled apart and back together with quite some force. The RIB became swamped and subsequently capsized. The crew on the RIB entered the water, thus turning off the engine with the kill-cord. Following their training they climbed on top of the overturned craft which was still tied alongside the yacht.

The helmsman of the yacht made a mayday call to the local coastguard and all persons were rescued from the RIB. The RIB's anchor had deployed upon capsizing so once the crew had been rescued from the overturned vessel the yacht helmsman released the RIB. However, due to continued engine problems the skipper had difficulty in making headway

against the ebbing tide and deployed the anchor. This subsequently dragged, resulting in the yacht being beached on the shore. Rescue was safely coordinated by the rescue services stationed locally.

All persons were given first aid for hypothermia, and subsequently returned to the yacht club, where first aid observations continued. All persons, although wet and in shock, have made a full recovery from the incident.

CHIRP Comment

It is important to recognise when there is an emergency and how to act accordingly. In this case, a position of relative safety rapidly became an emergency. This report demonstrates the importance of contacting the correct rescue organisation and in good time. The effective use of the "kill cord" undoubtedly shortened the rescue timespan, and is a very positive aspect of the report.

It was also noted that the reference to hypothermia might have been cold shock, which can necessitate separate treatment so expert assistance should always be sought.

REPORT ENDS

Correspondence Received

Health Matters!

The majority of reports coming to ***CHIRP*** Maritime, as well as most of the emphasis in our publications, have been on risks to vessels and to personal safety. Injury risks are featured, but shortcomings in the prevention or management of illness have rarely been covered.

Our close collaboration with the International Seafarers Welfare and Assistance Network (ISWAN) and our continued support for the fishing industry, indicate there is an increase in health related incident reports that ***CHIRP*** could usefully consider.

CHIRP now encourages reporters to contact us when they identify shortcomings in the management of work related health risks, especially where there is non-compliance with the health requirements and recommendations derived from ILO Maritime Labour Convention, 2006 (MLC), and the Work in Fishing Convention that will come into force from 16 November 2017.

We plan to feature articles and presentations to inform and encourage reporting of work related health risks and to include examples of non-compliance with health provisions listed in the Conventions. Reporters are invited to use the customary method of reporting to ***CHIRP.***

Best Practice – Muster Stations

Muster Station with hooks for hanging survival suits and lifejackets.

With reference to ***CHIRP*** issue No.47 Best Practice – Muster Stations, I attach a picture of my muster station with fixed hooks on the bulkhead to hang each individual's survival suit and lifejacket when they muster. This ensures each seaman collects his designated equipment in an abandon ship situation, bearing in mind that if the equipment was left on deck with the vessel rolling, it would surely get mixed up. We also re-assess the seating arrangements in the freefall lifeboat after each crew change as the joiners might not fit the designated seats of their predecessors. ***CHIRP*** *note – lifejackets are not worn for freefall lifeboat launching due to the use of body seat belt straps, (hence the hooks for lifejackets in this case).*

When I receive the *Telegraph*, I first look at the Health & Safety section to update my notice board. Your "Best Practice" section is now very interesting and we have already adopted the anchor chain suggestion.

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