MARITIME FEEDBACK

CHIRP MARITIME

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An independent and confidential reporting system for the maritime industry

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The *CHIRP* editorial

Drugs and the sea don't mix

Capt. Jeff Parfitt
Director (Maritime)

Fishing is dangerous enough without the effects of drugs

We think you will agree this is an interesting and varied edition of Maritime FEEDBACK, and we are extremely grateful to our reporters for sharing their experiences. Please do contact us if you have an incident to report.

We begin with an alarming account of drug abuse on some fishing vessels, but it is unlikely the problem is confined to only one sector of our industry. The problems which may result from impairment due to drugs or alcohol are obvious, so please let us know if you have had a similar experience. By alerting our readers to the dangers, you might save lives.

We follow this with another example of a failure to comply with Colregs, this time a simple crossing situation which could have led to disaster, then we consider the problems of fatigue in part of the towage sector, where traditional ways of manning the tugs have become inappropriate due to increasing workload and reduced manning. The report reminds us that, just because something 'has always been done this way', it may no longer be safe if underlying conditions have changed.

There is an interesting discussion about what constitutes a ship from the perspective of safe manning, and an article about suitable PPE for female mariners. This is a topic we raised in our Annual Digest for 2019, and it has now been taken up by Solent University, who are asking us all to complete a short survey. We hope you will contribute to this important study.

Changing tack once again, we discuss a classic case of improper slinging of a load, then learn about a case of poor communication and decision making – vital lessons we can all benefit from.

> The problems which may result from impairment due to drugs or alcohol are obvious

We conclude with our new section – 'Pilot's corner' – which contains an excellent article written by a senior pilot, and a report about a pilot ladder which was not even secured to the ship which rigged it. The story is almost unbelievable, but we have the photograph to prove it.

We hope you will benefit from the lessons in this excellent selection of reports and, until next time, stay safe!

Drug abuse on fishing vessels

Outline: *CHIRP* has received two reports from official sources highlighting the use of drugs on board commercial fishing vessels.

What the reporters told us:

Increasing drug abuse has been identified on several commercial fishing vessels operating in a specific area. Allegedly cocaine is being used by a number of crew members and it was reported that some are actually being paid in cocaine.

The above was backed up by witnessed incidents of irrational and violent behaviour, including verbal outbursts, to such an extent that another vessel was required to take avoiding action to prevent collision. Furthermore, there are recorded incidents of collisions between the reported vessels and fixed offshore structures and the tragic loss overboard of a crew member from one of the boats who was a known drug user.

CHIRP Comment:

The problem of drug taking within the global fishing industry is well known and *CHIRP* has been aware of it for some time. However, this is the first time *CHIRP* has received any reports on the subject. Since the reports are based upon illegal activity, the issues are in the hands of the local and national authorities – *CHIRP* cannot investigate further but can publicise the issue. The drug of choice varies from region to region, but all drugs have the same adverse effects on the users. Rational thought processes are impaired, leading to poor decision making on both an individual and group basis. This of course increases the risk of an incident or accident and is a cultural issue which requires addressing both at company and national administration level. A mandatory drug and alcohol policy may be considered a good starting point.

Some companies have introduced a "zero tolerance" policy for both drugs and alcohol. Many seafarers are familiar with some form of breathalyser used to detect alcohol in exhaled breath and they are often carried on board for self-regulation. However, *CHIRP* is not aware of any similar type of simple device on board vessels for detecting the presence of drugs. Such a procedure usually requires third party involvement, similar to the monitoring of sports personnel.

Whilst this article started with commercial fishing vessels, the same issues apply to all aspects of seafaring, including professional seafarers, offshore workers, recreational sailors and fishermen.

DRUGS AND THE SEA DON'T MIX

Fatigue in the harbour towage sector

Outline: The following report was received in response to the request in Maritime FEEDBACK 56 for seafarers with experience of fatigue at work to contact *CHIRP*.

What the reporter told us:

After reading your latest *CHIRP* Maritime publication where you requested examples of fatigue occurring in the maritime industry, I will try to explain the fatigue which is present in our harbour towage sector.

All crew work 7 days on / 7 days off. The main issue is that crews can and regularly do work 14 hours in a 24-hour period with 10 hours of rest. This is not unusual, but twice a week the rest hours can be broken down into 3 separate periods e.g. 6,2,2 which is unusual. This is further exacerbated by the crews working to no recognised marine watchkeeping pattern. The routine is allowed under a long-standing agreement between the owners and a union. The agreement has been accepted by the flag state administration which has granted a dispensation to allow the rest hours to be split into three periods rather than the maximum two periods stipulated in the STCW Hours of Rest regulations.

Being a long-standing agreement over many years, the system we work was never analysed for the effects of fatigue and the long-term health consequences, even though the technology is now available and has been used on other agreements.

During the working week crews will work days, nights and a combination of both, with no scheduled rest periods. Instead we take rest periods at random times through the day and night between ship movements in a non-tidal-restricted port. Furthermore, meal preparation, cooking, eating and cleaning up is not classed as work time so is carried out three times daily within the random rest periods. This leads to unhealthy meal choices and due to the nature of the work schedules we follow, meals can be taken late at night.

Further dialogue:

In the past few years there has been a marked increase in the number and size of ships calling at our port which results in more tug movements, but there has been no increase in the number of tugs or crews.

When the agreement was first introduced there were enough crews and the system worked well - fatigue and stress were not issues - but since then the crew numbers have been reduced from 72 crew manning four tugs on a 1 day on / 3 days off rotation to the present 30 crew manning four tugs on a 7 days on / 7 days off rotation. Virtually all crew members struggle to get enough rest.

All crew members experience difficulties sleeping with the rotating day and night working, and experience the effects of fatigue whilst engaged in safety-critical operations. Crew members speak of experiencing headaches, feeling jet lagged and not feeling normal until after the 2nd or 3rd day of their week off as a result of the massive disruption of their circadian rhythms.

Crewmembers that have declared themselves fatigued have been met with a negative attitude from the company, with the crewmembers having to explain why they have declared themselves fatigued.

During a recent shipping medical after several crewmembers mentioned the situation, the doctor had serious concerns regarding the working conditions in our towage sector, prompting the doctor to notify the chief medical officer of the flag state administration. As yet there is no satisfactory outcome.

A local risk assessment on fatigue was carried out by a combination of lower management and crew representatives, as part of the company's required Fatigue Management Plan. However, none of the participants had any specific training or specialised knowledge about fatigue.

The problem described is not limited to a single port but is widespread wherever this work pattern is followed.

CHIRP Comment:

- A proper risk assessment, carried out by qualified people, would immediately identify the risks the current working arrangement presents to the health, safety and welfare of the crews.
- Use of modern technology and scientifically recognised programmes (see Project Martha – www.chirpmaritime.org/wp-content/uploads/2017/02/MARTHA-Final-Report.pdf) would readily identify and quantify the levels of fatigue and risk present.
- The company have a duty to reduce such identified risks to as low as is reasonably possible.
- The flag state administration has not granted any exemptions to trading vessels but for some reason is treating these tug and towage operations differently.
- While this long-standing agreement has been revalidated every 5 years, *CHIRP* would argue that due to changes in the workings of this port and others, the additional workload on the tugs renders the present agreement no longer fit for purpose and a full review needs to be carried out by all parties.
- The STCW Hours of Rest regulations set the internationally agreed minimum number of hours of rest for seafarers and the maximum number of periods those hours of rest can be divided into. *CHIRP* cannot see the justification for any exemption that is detrimental to the health, safety and welfare of the tug crews.
- *CHIRP* has written to the Harbour Master, as the responsible authority within the port, to share our concerns with him over the present situation. Furthermore, *CHIRP* has written to the national administration expressing concern at the consequences of the current dispensation arrangement.

When is a ship NOT a ship?

Outline: A report was received from an engineer, with 10 years' experience on the same vessel, who was concerned about changes to the vessels' status and the potential consequences.

What the reporter told us:

The vessel was built in 1997 and has always been registered in the same flag state – even when the name was changed the flag state remained the same. The vessel was purpose built for its role as a Floating Production and Storage Unit (FPSU) but has always been recognised and registered as a motor ship with multiple engines. As such it always had a Minimum Safe Manning Document (MSMD) and was crewed to STCW requirements with regards to certificates of competency and numbers.

Further dialogue:

A few years ago, the owners took a corporate decision to move away from the requirements to have STCW certificated personnel onboard by applying for an exemption to the MSMD. This was granted by the flag state for a 5-year period which expired in 2019, but since that date neither a MSMD nor an exemption has been displayed. When asked, the flag state advised that the vessel did not need either as it was not self-propelled, (which came as a surprise to the reporter who had spent 10 years maintaining and running the engines and thrusters which are frequently used for heading control and on more than one occasion prevented a potential disaster when elements of the mooring arrangements failed in heavy weather). Instead the flag state issued a letter stating the vessel should be manned in accordance with IMO Res.1079.

IMO Res.1079 deals with manning requirements for Mobile Offshore Units (MOU). Flag states usually publish their own guidance based upon IMO resolutions but so far, the flag state in question has not done so.

There is a common argument that, as the vessel comes under HSE regulations (as an installation), the flag state rules do not matter. However, HSE regulations do not deal with manning requirements and the vessel is still floating and needs to be maintained to class requirements. It seems the IMO have long recognised the need for the manning on MOU's to be regulated, as all over the world these vessels seem to fall into a grey area between HSE regulations and flag state rules.

CHIRP Comment:

- This is a confusing problem that is also a global issue because these specialised vessels are in service all around the world.
- There are numerous vessels that fit into this category in the offshore industry from MODU's to FSU/FPSO's. What they have in common is that their respective flag states appear to have technical definitions that allow them not to be treated as a ship in the STCW definitions. Instead, their watchkeepers must have qualifications under the flag state definition, such as "MODU Master" and/or "OIM" qualifications. This even applies to MODU's using dynamic positioning, if they remain in the same location.
- A problem arises if they have to transit to another location, whereupon crew certification might dictate that the unit is towed. If they transit under their own propulsion, they would require STCW certification.

Failure to comply with Collision Regulations (Rule 15)

Outline: A 12m ketch on a night passage in the Mediterranean had to take evasive action to avoid collision with a 72m luxury motor yacht which failed to comply with the requirements of Rule 15.

What the reporter told us:

It was a clear night with good visibility, and we were approaching the outer reaches of our destination port, when we noticed a power-driven vessel approaching from our port side. We observed it visually and on our AIS unit (Note: the ketch's AIS was a receive only unit, not a transponder). We were making 5.8 knots under power and the approaching vessel was making 13 knots. The AIS showed a CPA of around 100m so we closely monitored the approaching vessel expecting it to alter course to starboard and pass astern of us. Our navigation lights were on and bright but the approaching vessel closed without altering course, so we turned on our deck lights to further illuminate our ketch and reduced speed to 2 knots. As the approaching vessel remained on what appeared to be a collision course, I altered course hard to starboard and eventually completed a full 360° round turn. Once the other vessel had passed, I

resumed my original course. I tried calling the other vessel on VHF Channel 16 to alert her to the near miss, but there was no reply. I then took a screen shot of the AIS.

Screen shot of AIS display after the round turn to starboard

A few minutes after this, the other vessel turned hard to port to enter the ports' inbound channel so there was clearly someone on the bridge. I have no doubt that if I hadn't altered course so dramatically, we would have either been run down or had a *very* close call.

Despite clear navigation lights, (and by all accounts usually creating a good radar echo), it appeared we were invisible, perhaps because of our lack of an AIS transponder? I will be fitting an AIS transponder soon.

Further dialogue:

In clear visibility at night with navigation lights on, a 12m ketch is as visible as any other small craft, assuming of course that a visual lookout is being kept on the other vessel. In a modern enclosed wheelhouse full of every kind of electronic device and screen, the light pollution can be such as to render a visual lookout almost impossible unless great care is taken with dimmer settings.

The reporter did not mention if the ketch was fitted with a radar reflector but even if it was, that would only aid detection if the other ship had its radar turned on and somebody was actually monitoring the radar screens.

Potentially the only additional thing that could have been done was to flash an Aldis lamp into the wheelhouse of the approaching vessel in an attempt to attract their attention.

The reporter did exactly what he should have done by following the Collision Regulations, and the system worked. Regardless of the failure of the other vessel to comply with the regulations, the actions of the reporter ensured the safe arrival in port of both the reporter's ketch and the other vessel despite the latter's demonstration of poor seamanship.

The 72m motor yacht safely at anchor the following day

At the end of the report the reporter stated that he would be fitting an AIS transponder unit which would be prudent, but even that is not infallible. On every voyage there is always a chance to encounter a rogue vessel which through poor seamanship fails to comply with the requirements of Colregs. Always hope for the best but plan for the worst.

CHIRP Comment:

This report is an example of both bad and good application of Colregs. Taking into account that AIS is not intended for collision avoidance, the members of the *CHIRP* Maritime Advisory Board (MAB) noted that there was no mention of any bearings being taken to ascertain if a risk of collision did exist, which might suggest an over-reliance being placed upon the AIS. They also noted that when undertaking night voyages, an Aldis lamp or similar high intensity signalling light is a prudent addition to any craft's equipment inventory.

It was also noted that the visibility of navigation lights can be adversely affected by the movement of a small vessel and can easily be lost in the background lights of the shore. Furthermore, there is some suggestion of "confirmation bias" on ships' bridges so that even if a light is seen, if there is no confirmation by AIS or radar the visual sighting may be ignored or given a lower priority than a visual sighting corroborated by AIS.

That said, the reporter's assessment of the situation and the actions that were taken to avoid a potential collision were completely correct. The MAB members were also pleased to note that VHF communication was only attempted once collision avoidance action had been taken and proven to be effective.

Unsuitable PPE for female seafarers

Outline: *CHIRP* was invited to comment upon ill-fitting PPE for female seafarers and initiated a survey to determine the extent of the issue.

What the reporter told us:

In an effort to encourage females to take up a career in the maritime sector, certain administrations have prepared a number of articles giving practical guidance. One such article related to female-friendly PPE which among other things points out that asking female seafarers to wear over-sized PPE isn't safe, and that simply giving them a small man's size doesn't do the job. For example, goggles designed for the male face, which is typically larger and broader than a woman's, would not fit a female face as closely, leaving gaps with greater potential for foreign bodies to enter and cause injury.

Further Dialogue:

The *CHIRP* Maritime staff were initially unaware that a problem existed. However, the question having been asked, *CHIRP* investigated further and initiated a very small-scale basic survey with the assistance of a female seafarer to promulgate our questions to other female seafarers.

The response was rapid and enthusiastic, and the results showed overwhelmingly that there appears to be an issue with women's PPE and also with regard to fireman's outfits and LSA equipment.

The original findings were written into an article which was posted on the *CHIRP* website. https://www.chirpmaritime.org/wp-content/uploads/2019/11/20191119-PPE-for-female-mariners-Fit-for-Purpose-1.pdf. It also appeared in our Annual Digest 2019.

There are manufacturers who supply female-specific personal protective equipment – all BS, EN, and ISO compliant as applicable (although they may lack company logos on helmets and boiler suits). Nevertheless, the correct equipment is available on the market. The challenge is to increase awareness in order that it will become readily available on board merchant vessels.

CHIRP Comment:

- While there may be a limited requirement on any single commercial vessel there is clearly a requirement for all mariners to have appropriate personal protective equipment
- It is not a gender issue - the regulations give a minimum requirement irrespective of gender
- Regulations state that PPE must be suitable and **must fit**
- Shipping companies have a duty of care
- The ships safety committee should be consulted on PPE and should be the conduit to the company
- There is a direct correlation between safety culture and the provision made by the company

Following on from the original article, Solent University contacted *CHIRP* to advise us about a new research programme that is being undertaken into the issue of PPE for seafarers – which encompasses all seafarers, male and female. Solent University has requested *CHIRP*'s assistance to promulgate the research programme and the associated questionnaire to the wider seafaring community and on completion of the research to further promulgate the findings to seafarers who may not normally be aware of or read academic research.

The following paragraphs highlight the reasons and need for the research and *CHIRP* would encourage as many readers as possible to participate.

The Seafarers' Personal Protective Equipment project explores seafarers' experiences of using personal protective equipment (PPE) on board. PPE is vital in reducing the risk of workers experiencing injuries, yet we know anecdotally and from our own experience that PPE at sea is not always fit for purpose. For some workers, boiler suits can be much too large, causing a safety hazard in itself, for others safety boots are ill fitting resulting in painful blisters and cuts. We know that when PPE is not comfortable or practical to wear, workers are less likely to use it. So, finding out about seafarers' day-to-day experiences of using PPE is really important.

We need you to help by taking the Seafarers PPE questionnaire. Your individual results will contribute to important research, helping researchers at Solent University understand the issues seafarers are currently facing in regard to PPE. The more seafarers who complete the questionnaire, the more we can learn about the PPE provided to those working at sea today, and the difficulties seafarers are experiencing and how these could be addressed to improve working conditions for seafarers in the future.

Please get involved, go online, visit the Solent University website and complete the questionnaire.

The website is:
https://www.solent.ac.uk/research-innovation-enterprise/rie-at-solent/projects-and-awards/seafarers-ppe-project.
Alternatively go straight to the questionnaire at:
https://solent.onlinesurveys.ac.uk/ppe

Lost crane load during cargo operations

Outline: *CHIRP* was amongst a list of organisations to receive a completed accident investigation report from a port authority with the sole purpose of promulgating the findings to a wider audience so more people can learn from the issues highlighted.

What the report told us:

The vessel involved was a small Lift On / Lift Off general cargo vessel engaged on a regular container freight service. On arrival the ship had been unloaded of the containers and 'flats' (see photo below) destined for the port and back loading was in progress. The lower level of the hold had been 'boxed out' with containers leaving no gaps, and the loading of flats had begun. As normal, the flats were being placed directly on top of the containers.

With the intention of leaving no gaps, the loading of flats had started forward, working aft. The first flat, containing a red van, was landed facing astern parallel to the ships side. The next flat, containing a white van was landed athwartships. The following lift was the flat containing the 4x4 vehicle involved in the incident.

Cargo operations were being carried out by a shore crane operator and contract stevedores; no ship's crew were involved. All personnel engaged in the loading were suitably experienced and were in date for training with regards to their respective roles, there were current certificates where applicable and all lifting equipment used was in date within a six-monthly inspection routine. A six-monthly inspection routine was carried out by a third party contractor instead of a more normal annual inspection.

The 4x4 after the incident

The 4x4 vehicle concerned had been placed on the flat and secured using tensioned webbing straps and a standard lifting plan was then used by the stevedores and crane operator. There are normally three lifting options for such a flat bed and light vehicle combination using the shore crane and spreader bar arrangement, these involved a combination of open or safety hooks and chains, side lifting lugs or top lifting lugs with webbing slings.

In this case slings were chosen in order to avoid any risk of damage to the vehicle by chains. Lack of space in the

hold precluded the use of side lifting lugs or hooks. Top lifting lugs were therefore chosen in combination with 5m webbing slings for the vehicle lifts.

The crane pre-start-up and pre operations check procedure had been properly signed off by the crane operator. However, unknown to anyone until after the accident, the CCTV in the crane cab, whilst working, was not recording so no direct coverage of the incident was available after the event. None of the port CCTV cameras were covering the area over the vessel's hold (one camera covered the lift from the quay but not the lowering into the hold)

The flat involved in the incident was to be placed athwartship, parallel and close to the white van. Whilst lowering down into the hold, the forward right-hand side of the flat struck the track of the moveable bulkhead. The contact was enough for the 'top lock' lifting equipment to become detached. This corner then dropped, causing the second 'top lock' on the same side to become detached, which caused the flat to tip over. The lashings attaching the vehicle to the flat then failed, and the vehicle dropped into the hold on its roof.

In the hold was the 'hatch man' – in constant radio contact with the crane operator – and two other stevedores. All were at a safe distance and no-one was harmed. No ship's crew were in the hold.

During the investigation it was found that although care is always taken to avoid standing under suspended loads, particular care is taken by stevedores with this type of "flat" due to perceived risk with the top-lifting attachments. **Such concerns had not been passed on to the management**. The process for operating the top lifting lug involves inserting each corner into the socket then turning the lug through ninety degrees and manually depressing the locking bar to hold it in place as weight is taken on the strops. If the locking bar is not fully located then, if weight comes off the lug, it would be possible for the lifting lug to rotate in the socket and for the lug to disconnect from the "flat". Port CCTV coverage showed that, just prior to the incident, two attempts were made to lift this particular "flat" from the quay with adjustments to the lugs being made in between.

Inspection of the flat involved showed that the top plate thickness of the lifting socket of this type of unit is (at approximately 20mm) some 8mm thinner than the standard fittings on other more modern flats and the industry standard (approx. 28mm). Given that the top of the plate is chamfered, only a parallel plate thickness of 8-10mm is available for the tab to connect with. This increases the risk of the tab on the lug moving enough to enable the lug to twist and disconnect especially if there was a twist in the strop. the light rain at the time may also have lubricated the surfaces.

At ≈20mm the top plate thickness was 8mm thinner than more modern "flats" and the current industry standard, ≈28mm

Chamfer on the lifting socket can be clearly seen.

CHIRP Comment:

- LoLo cargo operations are considered high intensity cargo handling and are being replaced by RoRo operations in some ports and routes. However, that option is not always suitable. Small vessels going to small ports will still be using LoLo for many years to come.
- This accident could have been avoided if just one of the many layers of risk had been rectified.
- If you are aware of an issue or potential issue don't keep it to yourself - always tell someone. Pass it on to your supervisor, put in a Hazard Observation Card or whatever method is available to notify management. Raise it at the next safety meeting.
- If there is an issue, don't try to work around it, address it and eliminate it for your own and everyone's safety.
- **This report clearly demonstrates why we should never stand under suspended loads.**

Poor communication and lack of command decision

Outline: Poor planning and even poorer communication put crew members in potential danger.

What the reporter told us:

On 4th December two offshore vessels arrived at the port, the lead ship having been a frequent visitor whilst the other vessel was on a first visit. Their berths had been booked directly with the berth operator, and the Harbour Master had been given no information about their visit. The reporter, a duty pilot, learned while bringing the ships in that they would both be sailing the next morning in order to test life rafts.

Both vessels duly departed and a (different) duty pilot learnt that they were testing 500-man life rafts needing about 3m of swell to test them. This was all the information that was given.

In the early afternoon the lead ship called the VTS, indicating it would require a pilot to return to the berth, but that things had not gone 'completely to plan'. The reporter spoke to the master of the inbound vessel who advised that there were still evacuation chutes attached to his ship's starboard side, "*but it wouldn't be an issue as they didn't effect manoeuvrability and the ship would berth port side to. However pilot boarding would not be possible on the starboard side*". The pilot expressed doubts at the vessel being able to berth at all in the prevailing conditions with a 40kt wind directly on the beam when approaching the berth, since it was known that the vessel had a very large forward windage and a single bow tunnel thruster. The master agreed and it was decided to wait until the wind speed reduced before berthing.

Enquiries were made as to the situation regarding the

second vessel. The captain stated that she was towing the 2 life rafts, so it was pointed out that she would not be able to enter until daylight slack water the next day. Port procedure is for all tows to enter at slack water as there are strong tides across the entrance.

After the reporter had sailed another vessel, he returned to the VTS. The Harbour Master was speaking by telephone to the project managers. They were unhappy that the second vessel could not enter the port. At this stage the Harbour Master was told that their fast rescue craft had broken down and 4 persons were still in the life rafts, but "they had survival suits on so that is all right". The telephone call ended shortly afterwards.

Within the VTS, it was suggested that the Coastguard needed to be aware of the situation, as it would be dark shortly and the 4 men needed to be removed from the life rafts. A few minutes later the Harbour Master called the project managers and said they should get the men out of the life rafts. He asked if they had informed the Coastguard. They said they had, but the reporter heard them call the Coastguard immediately afterwards.

The Coastguard took control of the situation and established that 1 man was possibly injured. Within a short time, the local lifeboat was tasked to rescue the 4 men. They successfully did this.

When the men were brought ashore (one with a broken ankle) one approached the Harbour Master and thanked him, as he had heard it was the port that had insisted that they were rescued. He stated that conditions in the life rafts were horrendous.

The duty pilot safely berthed the lead vessel at about 21:00 when the wind had eased. The reporter was on duty again the next day and managed to board the second vessel outside. Once through the breakwaters the 2 life rafts were transferred to harbour work boats which allowed the second vessel to berth safely followed by the two life rafts. Note: Each of the life rafts was 28m x10m.

Further Dialogue:

Apparently, there was a flag state surveyor on board the lead vessel to witness the test / trial of the life rafts.

CHIRP Comment:

Regarding this report, the members of the MAB considered that there were some details and other information that *CHIRP* was not privy to, namely the purpose of the test. Was it a prototype test, a product function test or an acceptance trial?

While none of the MAB members had encountered a 500 man life raft before, the basics of good seamanship, proper planning and risk assessment apply to any maritime undertaking and this report highlighted several shortfalls in those areas.

- The members of the MAB found it difficult to comprehend that berths can be booked for ships arriving in a port without advising the Harbour Master, who is the responsible authority for the port
- Accepting that a 3m swell height was required for the trial, planning should have included facilities and redundancies for dealing with foreseeable problems bearing in mind that sea states can deteriorate as well as moderate
- Either the life rafts were always going to be towed back into harbour or it should have been a planned eventuality, but in either case the port requirements and restrictions for tows entering the port should have been ascertained by the project managers
- The tendency for managers to overrule or otherwise usurp the master's responsibility and authority is quite common within the offshore sector
- The masters of the two vessels involved in the trial had a duty of care for the 4 persons in the towed life rafts, even more so because one person was injured. They should have notified the shore authorities and requested assistance as soon as it was apparent that normal methods of recovery had failed or were no longer available

Pilot's corner

This inaugural article in our new section has been written by a senior pilot

Pilot ladder incorrectly secured to the deck using D-shackles to choke the side ropes.

For pilots one of the hot problem topics is pilot ladders and access. How do we tackle this? Locally my own port authority has a robust system for reporting and investigating non-compliant arrangements and are very supportive of pilots who refuse to board when they observe a non-compliant arrangement that cannot be rectified in a timely manner.

Last year a pilot boarded an inbound vessel at night and, on climbing, felt that something appeared to be out of place with the step spacing of the pilot ladder. On inspection, the steps were too far apart at over 40cm. The port would not allow the vessel to sail until a new ladder was sourced, which involved a delay of over 24 hours.

Last year I initially refused to board an inbound cruise ship as there were no stanchions at the head of the pilot ladder. Returning 10 minutes later after dropping a colleague at another ship, the stanchions had magically appeared. On another vessel, I observed a dangerous practice – whilst rigging a combination ladder only one of the crew was wearing the correct PPE out of the three crew members involved in the task. When I pointed this out to the captain, he was reluctant to stop the task until I insisted.

Unfortunately, we are still seeing accidents and in 2019 a number of pilots were killed whilst boarding or disembarking from vessels. Clearly, we need to continue working harder in trying to eradicate non- compliant boarding arrangements. Internationally, IMPA is working hard at the IMO and each year report the findings of the annual global "Pilot Ladder Safety Survey".

Going forward we need to continue educating masters, crews and ship owners on how the ladder should be rigged. I personally carry a supply of laminated cards that I can leave with the master illustrating how the ladder side ropes should be secured with rope using a rolling hitch which is then secured to an approved strong point with another hitch. No choke shackles over the side ropes, and no wedging a step behind a piece of angle iron. These practices have been outlawed by the MCA, AMSA and the New Zealand marine authorities. Surveyors, both port state and classification society, must also play a greater part in assisting with this ongoing problem. We are still frequently seeing new ships, built and certificated with non-compliant access areas and boarding arrangements.

Unsecured ladder

Outline: This is not what you want to find after climbing the pilot ladder.

What the reporter told us:

I boarded the vessel and noticed that the ladder had been put under a steel platform. I asked the crew to lift the platform because I wanted to know how this ladder was secured to the deck. After they lifted the platform, I found out that **the ladder hadn't been secured at all**. It ran under the platform, and this platform alone held it down. The ladder came from an electrically powered winch reel, which also wasn't mechanically secured.

Lessons Learned:

Check exactly how the ladder is secured before boarding the vessel. This example shows a complete neglect of pilot safety.

CHIRP Comment:

- The above isn't a shipboard modification, the ship came out of the builders' yard like that
- Shipyards don't do things randomly, ships are built according to the plans the yard are given, so this ladder arrangement was designed that way. **Non-compliant by design *again***.
- Possibly it has never been inspected by a class surveyor - whilst pilot ladders are not a class item, they are a specific part of the Safety Certificate. Every 5 years they are supposed to be looked at, but they rarely are
- With more surveyors having an engineering background rather than a seafaring one, they may not be trained in what to look for or what the requirements are
- The issue of pilot ladders and boarding arrangements being non-compliant by design is a flag state issue and *CHIRP* has raised the issue with more than one flag state administration

They say a picture paints a thousand words – this clearly demonstrates the appalling lengths that some mariners will go to with respect to endangering life.

We are grateful to the sponsors of the *CHIRP* Maritime programme. They are:

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