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Arrogance, or Ignorance?



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Director (Maritime)

This edition of *Maritime FEEDBACK* contains a wide variety of interesting and often alarming reports, and we are extremely grateful to our reporters for sharing them with us.

We begin with an account of a company Head of Safety who led potential purchasers into an enclosed space without taking any precautions, and we ask whether this was arrogance or ignorance. We define arrogance as a result of people underestimating risk and overestimating their own abilities.

Arrogance may also have been present in reports about a master who ignored contractual requirements during a dynamic positioning incident despite the DPA advising against his actions and another master who opted to sail from a port despite a warning from the pilot.

Another worrying trend which emerges is that so many reporters did not feel comfortable reporting to their managers or senior officers, and came to us instead. The best companies strive for kind leadership and a just culture which ensures that all crew members feel empowered to speak up whenever

they see an unsafe situation developing, but it is apparent that there are still many companies where a robust safety culture is lacking. We feel honoured that people in such situations contact CHIRP Maritime when they feel unable to deal with situations through their own organisation, and we continue to support them to the best of our ability, without ever revealing their identities.

Fortunately, this edition also contains reports on how good teamwork averted a potential disaster and how crew members felt empowered to stop work and call a safety meeting when they saw an unsafe situation developing. We applaud everyone involved in those cases, which contrast sharply with another ship where the crew were unpaid and inadequately provisioned.

Our final report concerns a senior officer who was repeatedly observed to be asleep on watch. We suspect this was a severe case of fatigue, and if one officer was suffering, then it is highly likely others were also affected. If the company ran other ships with similar manning on similar routes then the problem could be widespread. We hope the relevant authorities will take action and crack down hard if our suspicions prove to be accurate because mariners deserve better.

Until next time, stay safe!

Are you interested in becoming a CHIRP Maritime Ambassador?

CHIRP and the Nautical Institute have an established ambassador scheme to raise awareness of our incident reporting schemes and encourage the submission of incident, accident and near-miss reports.

As an ambassador you will join an international network of over 50

seafarers (see map) who also share your passion for safety, and you will quickly gain a broad knowledge of current safety issues. These are great additions to your CV and increase your employability.

Together we can promote the development of a 'just' reporting culture across the maritime sector

to improve safety outcomes. The key attributes of a successful ambassador is a passion for safety and a willingness to speak up for CHIRP among your colleagues and contacts.

If this sounds like you, please contact us to discuss this opportunity at mail@chirp.co.uk



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M2276

Unauthorized entry into an enclosed space

Initial report

The company's Head of Safety was conducting a tour of a vessel which had been laid up for over a year, accompanied by potential purchasers. They were witnessed opening and entering a void space, which was correctly labelled as an enclosed space, despite not having a permit to work to do so. They were not carrying an atmospheric gas analyser. They had not completed pre-entry activities, e.g., venting the compartment, having crew and emergency equipment standing by, and an enclosed space entry checklist thoroughly completed and signed off by the master. The reporters approached CHIRP about this matter because any report raised through their company system would have gone directly to the Head of Safety, and they feared reprisals. They did not speak up at the time because they did not want to embarrass a senior company member.



Incorrect enclosed space entry can be lethal (Stock image for illustrative purposes only)

CHIRP Comments

Entering an enclosed space without completing the pre-entry activities is exceptionally hazardous. Last year, 16 seafarers were killed because they entered enclosed spaces where the air was not breathable.

Even if the Head of Safety did not have a seagoing maritime background, they ought to have been aware of these hazards and the safety protocols that should be followed.

We will not speculate on the reasons that led to this specific incident, but people generally deviate from safety protocols for one of several reasons. One is that they underestimate or are unaware of the risks or overestimate their abilities (arrogance). Another is that they feel (real or imagined) pressure to complete a task quickly or without the right resources (lack of time or equipment).

Officers and managers have a special responsibility to lead by example in safety. They set the standards for a company's safety culture.

When CHIRP contacted the company, they immediately understood the seriousness of the incident and responded immediately to ensure that it could not happen again.

Factors related to this report

Communication – In this case, actions speak louder than words. The manager's actions destroyed any safety messaging the company may have communicated to its fleet.

Local practices – An enclosed space entry operation requires a significant number of crew members to be in attendance. Make sure that everyone knows that enclosed space entry is taking place. The permit to work must be distributed to all parts of the ship: the bridge, engine room, the master, and the entrance to the enclosed space. Is this what happens on your ship? How well are enclosed space entry work activities communicated?

Alerting – If you see a safety breach, even by a senior manager, speak up! It is better that they are embarrassed than dead!

Pressure – Be aware that real or perceived pressure can lead anyone to deviate from procedures if they think it will save them time. If you feel under pressure, pause for a moment, and re-evaluate the risks. If you see others taking shortcuts, call it out.

Complacency (under-estimation of risk) – Enclosed spaces can be lethal if incorrectly entered.

Culture – Managers' actions set the tone and standard of a company's safety culture. In this incident, the reporter did not feel safe raising this issue through the company's reporting system. CHIRP exists to capture these reports and advocate for improved safety while protecting the reporter's identity.

M2258

Good teamwork averts a serious incident

Initial report

Two pilots boarded an LNG carrier before making an approach along a fairway to an offshore LNG terminal. The weather was rough, with a long swell. Four tugs were made fast before proceeding at approximately 5kts.

As the chief pilot prepared to make a planned alteration of course, both engines of the tug attached to the centre lead forward failed within minutes of each other, and the tug was overtaken and pulled hard against the LNG carrier's bow by the towing line.

Because of the risk of damaging or capsizing the tug, the chief pilot could not conduct the planned turn while the stalled tug was still attached, but through a combination of good bridge teamwork and skilful control of the remaining three tugs, the LNG vessel was slowly manoeuvred alongside without further incident.

Throughout the incident, the co-pilot liaised with the stalled tug for regular updates and with two standby tugs in the vicinity, directing one to assist the disabled tug in detaching its towing line and pulling it to safety. At the same time, the second tug assisted in manoeuvring the LNG vessel. The pilots also provided regular updates to the port authority.

04

A combination of the sea state and the tug's ballast arrangement was found to have caused the sea chest to become starved of cooling water for the generators, which were automatically shut down to preserve the equipment.

CHIRP Comment

CHIRP is aware of 3 similar tug events published in 2024, and readers may be aware of the case in 2019 in which a large passenger ship lost propulsion and nearly foundered because the ship's motion in rough weather caused the oil pressure to drop, shutting down the engines.

In *Bow Tug Operations*, a manual by Henk Hensen, he writes, "Bow tug operations of a ship having headway are very risky." The International Harbour Masters Association recommends a 6-knot speed limit for such operations.

Tugs sometimes undertake bow-to-bow (reverse) towing because it keeps their propellers further away from the pressure fields around the towed vessel's bow. This method also ensures that if the tug propulsion fails (as in this incident), it is pulled alongside the towed vessel by its bow, which reduces the risk of capsizing.

However, when reverse-towing (as in this incident), there is a risk that the tug becomes trimmed by the bow, lifting the stern (and sea-chest water intake) out of the water and starving the sea chest of cooling water to the generators. This risk is lessened by towing more slowly, adjusting the vessel's trim, and ensuring that the sea chest vents are open so that any air trapped inside can be expelled to allow it to re-fill.

The automatic shut-down system protects the equipment from overheating and being damaged or even catching fire. However, many systems do not have a manual override for use in emergencies. Tug vessel operators are advised to investigate how their equipment would react in a similar scenario, whether it would alert the operators before shutting down, and then develop emergency procedures accordingly. A checklist that includes the operating area (open water, sheltered water), draft and trim, ballast arrangement, and type of towing for the job will ensure that the risks of a blackout are mitigated.

This incident was successfully mitigated without injury or damage because of the close integration of the pilots, effective bridge team management, and close coordination between the vessels and port authority. Everyone understood their role and responsibilities, and information exchanges were clear and effective. The speed of response of all parties demonstrated their readiness to respond to an unplanned incident.

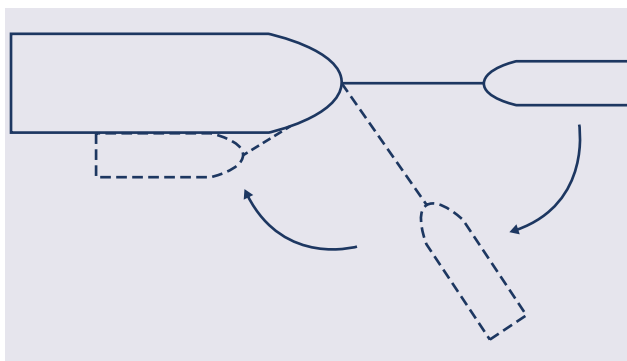


Figure 1: Likely response of a tug to engine failure

Factors related to this report

Situational Awareness – Tug crews should be alert to the changing dynamics operating on the tug hull, especially in open waters. A simple checklist for the type of towing arrangement would ensure an adequate draft for all tow stages, and that equipment is correctly configured.

Teamwork – The pilots and the bridge team worked excellently to manage the situation, highlighting the effect of adequate resources and training.

Alerting – From a technical perspective, there appeared to be insufficient warning concerning the generators shutting down. Temperatures would have risen quickly once the cooling water could not reach the generators.

Design – Given the nature of towing operations and the increasing use of ASD tugs in narrow channels, towing from the bow has considerable benefits concerning performance and girting safety. The change in trim that results if ballast is not correctly applied needs to be factored into design considerations.

M2286

OOW asleep on watch!

Initial report

CHIRP received a report about an officer who regularly slept on the bridge during solo morning watches (0400-0800) and relied on automated navigational alarms. Several crewmembers witnessed this behaviour over the course of a week.

CHIRP Comments

Sleeping while on a watch is a severe breach of the international collision regulations, and CHIRP contacted the vessel's Flag State, which is investigating.

Normally, no officer deliberately sleeps on a watch, especially a solo watch. In many cases, the onset of fatigue creates this desire to close one's eyes on watch and go into a deep sleep. CHIRP suspects that the individual is suffering from exhaustion to the point that their judgement is impaired, causing them to take unacceptable risks during their bridge watches.

CHIRP questions what working practices are taking place on the vessel operating without a dedicated lookout to create such a state of tiredness. Or is the officer deliberately ignoring their safety responsibilities and breaking the rules? Either way, the safety of the ship is severely compromised.

Factors related to this report

Fatigue – The incident report highlights the officer's lack of concern about the severe lapse in navigational safety. Clearly, the officer is suffering from sleep deprivation and has reduced mental capability and decision-making. Fatigue kills: the company must take steps to manage it.

Alerting – CHIRP was alerted to the issue, but why was the master not alerted? This serious safety situation affects everyone on board - speak up or contact CHIRP. The officer

should be able to speak with the master and inform them of their fatigued state. This may likely apply to other officers and crew on the same ship.

Culture – There appears to be a very poor safety culture on the ship, which may be reflected within the company. Does anyone care about safety? This issue would not have happened if the company operated a just culture and senior officers demonstrated kind leadership.

Teamwork – Good teamwork by the officers and crew can assist everyone in challenging, unsafe situations. Looking out for each other and feeling confident about reporting personal well-being issues is a sign of good teamwork. This takes time to achieve and is driven by a good company safety culture.

M2267

Rotating shafts create a lethal hazard

Initial report

While on passage, the crew was tasked to clean and paint the engine room tank top. One crewmember was seen working near the vicinity of the tail shaft and narrowly avoided hitting their head on the revolving shaft.

Another crew member stopped work, and a safety meeting was convened to remind the crew members about the hazards and to wear hard hats.

CHIRP Comments

The rotating tail shaft poses a lethal entrapment or snagging hazard, even if wire guards are present. Better planning would have eliminated this hazard by ensuring that maintenance was only carried out when the shaft was stopped, i.e., in port. However, for commercial reasons, there is a move across the industry to conduct as much maintenance at sea as possible to reduce time spent alongside. Engineers are already fully tasked with other roles when in port.

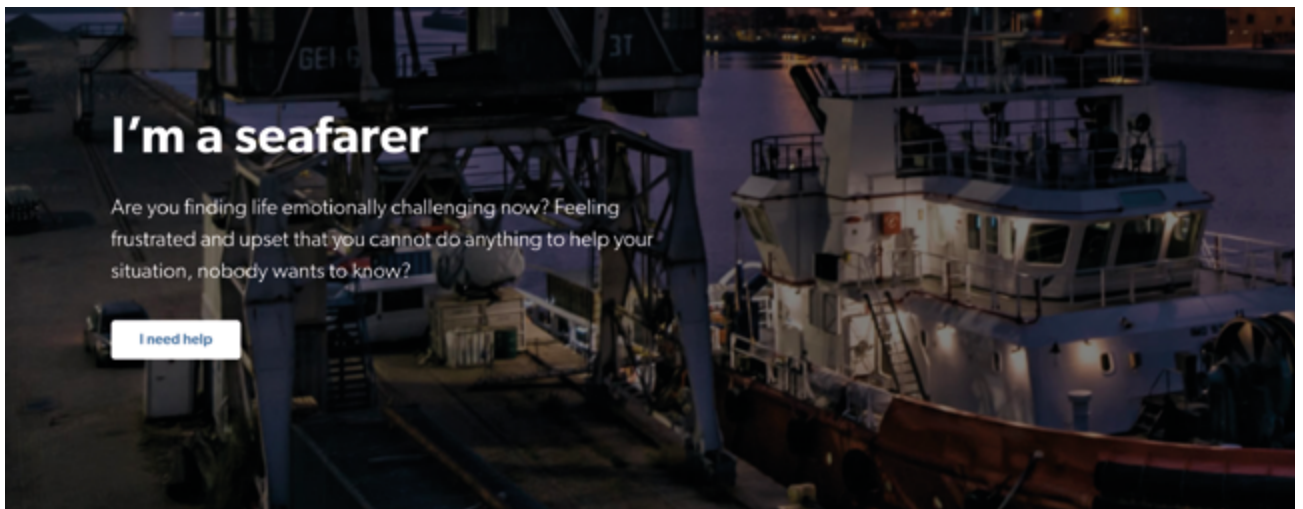
Was this incident the unintended consequence of a management decision?

CHIRP applauds the crewmember who alerted others to the danger and stopped the work from progressing until a safety briefing was held. We encourage all companies to empower their crews with similar ‘Stop Work’ authority when safety is in doubt.

Factors related to this report

Alerting and Teamwork – Both were demonstrated in this incident: alerting others to the danger and calling a halt on safety grounds is good teamwork.

Situational Awareness – Consider all aspects of the work, including your proximity to hazards, and consider the consequences.



Befrienders Worldwide (BW) is an emotional support charity whose mission is global suicide prevention. BW has operated for 50 years and has over 400 centres in 48 countries.

The main aim of the centres is to give confidential emotional support to people when they are suicidal. The centres also alleviate misery, loneliness, despair and depression by listening to anyone who feels they have nowhere else to turn.

The people who run the centres – Befrienders – are volunteers who have all been specially trained. The work is non-political and non-religious; volunteers do not try to impose their convictions on anyone. They listen.

Contact with a centre can be by telephone, letter, email, internet chat, SMS text message, or face-to-face meeting. It is strictly confidential, as is everything that the person tells a Befriender. Some callers prefer to remain anonymous, and that's fine.

Befrienders Worldwide has a dedicated seafarers' page recognising the emotional challenges seafarers face while working at sea.

Please look at the website.
www.befriender.org

If you need to contact a dedicated seafarers' centre, please click on the link: <https://befriender.org/befrienders-worldwide-seafarers/> which will take you to the seafarers' page. Thank you.

06

M2266

Rationed food

Initial report

A vessel was provisioned with a month's supplies for a two-month passage and planned anchorage, and the crew was instructed to ration its provisions. Since they had not been paid for three months, they could not purchase additional provisions, so they approached CHIRP for assistance.

CHIRP Comments

The shore management company claimed they did not have enough money to provide sufficient provisions. CHIRP contacted the vessel's Flag State, which immediately intervened, directing the company to supply adequate victuals and water and to pay the outstanding wages.

The Maritime Labour Convention regulation 3.2 requires vessels to ensure that sufficient food and drinking water of appropriate quality is on board. It also states that pay arrears of more than two months can be considered crew abandonment.

Factors related to this report

Capability – The shore management company lacked the financial ability to operate safely and thus put the crew at risk.

Culture – The company does not respect the workforce employed to operate its ships. Crew welfare is inextricably linked to safety, and the safety of the vessel's crew was compromised. Have you experienced anything similar?

Local practices – Keep local practices from becoming established norms. Report them!

Crew welfare is inextricably linked to safety, and the safety of the vessel's crew was compromised

M2279

Commercial pressures placed before safety concerns

Initial report

Our reporter informed CHIRP about contractual requirements for a recent operation involving an Offshore Supply Vessel (OSV) and Floating Production Storage and Offloading vessel (FPSO).

The OSV was a DP 1 vessel and did not require a follow-target function for normal operations. However, given the FPSO's movement in the operating environment, having one was a contractual requirement.

According to the agreement between the contractor and the charterer, the contractor had to equip the vessel with two reference systems: a Differential Global Navigational

Satellite System (DGNSS) and either a laser or microwave system capable of 'Follow Target' functionality. These systems are essential for FPSO operations. They ensure that a specified distance is maintained between the vessel and the FPSO and adjust the angle between their longitudinal axes to match any horizontal rotation of the FPSO.

Under pressure from the client's schedule, the master proceeded with the operation despite his vessel not having the required 'Follow Target' function. This decision led to potentially unsafe conditions, requiring the crew to manually adjust the vessel's position against visual references for a 12-hour fuel oil transfer. The Designated Person Ashore (DPA) cautioned against operating under such precarious circumstances, but the master continued anyway. The crew realised safety was being compromised to meet client demands and reported this to CHIRP.

CHIRP Comments

The agreement between the contractor and the charterer stipulated specific technical requirements for the OSV, including having a 'Follow Target' function and being capable of dealing with the expected movement velocities of the FPSO, which can be considerable. This function is crucial for maintaining a safe distance and alignment with the FPSO. The OSV in question was only equipped with a DP 1 (Dynamic Positioning Class 1) system, which typically does not include a 'Follow Target' capability. This discrepancy meant that the OSV did not meet the contractual requirements necessary for safe operations with the FPSO.

Despite not meeting these requirements, the OSV's master proceeded with the operation under pressure from the client's schedule. This decision led to potentially unsafe conditions because the vessel lacked the automated capability to maintain safe proximity and alignment with the FPSO. The crew recognised the compromised safety conditions during the operation, particularly during a critical 12-hour plus fuel oil transfer. They resorted to manual adjustments based on visual and radar references, which are less precise and more prone to error compared to automated systems like 'Follow Target'.

The crew's awareness of the compromised safety and their decision to report this to CHIRP indicates a responsible approach to safety reporting and an understanding of the potential risks involved. The Designated Person Ashore (DPA), who is responsible for ensuring compliance with safety and environmental standards, ensuring adequate resources are applied, and providing a vital link between the vessel and the company, cautioned against proceeding, given that the "follow target" function was required. This caution from the DPA underscores the seriousness of the safety concerns. Despite this explicit advice, the master proceeded with the operation, disregarding the DPA's recommendations. This decision not only heightened the risk involved but also called into question the company's safety culture and organizational structure. The master's choice to ignore the DPA's advice raises significant concerns about the prioritisation of safety within the company and highlights potential flaws in its risk management and communication practices.

In recent years, several collisions have occurred aboard vessels undertaking DP operations near mobile assets, such as drilling vessels and FPSOs. While having a relative position referencing system fitted, such as the "Follow Target" function, training on its use is essential.

CHIRP would like to acknowledge the Information note provided by the *International Maritime Contractors Association (IMCA) No 1650- November 2023*, which details the Important Position Reference Systems (PRS) considerations when operating close to an asset that is not rigidly fixed to the sea bed.



Does your equipment fit meet contractual spec?
(Stock image for illustrative purposes only)

Factors related to this report

Pressure – Pressure to meet commercial objectives overruled safety considerations regarding the crew, the FPSO, and the environment. What would you do in the same situation, given the request by the DPA to stop the operation from being carried out due to a lack of safeguards?

Teamwork – The master's behaviour does not indicate teamwork. The master is acting alone, and the crew do not appear empowered to exercise 'stop work' procedures. What would you have done in this situation?

Culture – Company culture applies to everyone, and the master has a responsibility to demonstrate the company culture through actions.

Capability – Would you operate outside the requirements if your vessel lacks the capabilities to meet dynamic positioning standards? In this case, are DP safety standards being disregarded?

Local Practices – Keep local practices from becoming a new standard. Ask the company to install the necessary equipment to meet compliance requirements.

M2265

Difficulties leaving port in strong winds

Initial report

A passenger ship was due to depart port at 2150. This was the master's first time sailing from the port, and during the master/pilot exchange, the pilot had suggested delaying departure due to the forecast strong winds of up to 25 knots.

The passage plan required the vessel to reverse out of the harbour and then turn in one of 2 charted turning areas – one just outside the breakwater and the other a few miles out. The master chose the closer turning point against the advice of the pilot.

As the vessel passed the breakwater, the ferry commenced its turn with tug assistance. The wind gusted up to 50 knots, pushing the passenger vessel leeward onto a navigational buoy.

Despite the tug pushing on full power and the passenger vessel increasing speed, it was blown within 10m of the rocks before it could make headway to windward and regain the planned nav track. There were no injuries or pollution on the vessel, but the tug sustained minor damage.

CHIRP Comments

This report emphasises the need to prioritise the safety of the vessel, passengers, and crew rather than the scheduled timetable. Still, CHIRP recognises that because organisations rarely set wind guidance for vessels, masters are subject to considerable implicit commercial pressure to carry on, even in marginal conditions.

The best practice is for companies to provide weather guidance rather than limits, empowering masters to exceed the guidance if it can be justified by a risk assessment that considers local circumstances (including any advice provided by the pilot).

Factors related to this report

Pressure – A master operating on a tight schedule must never be placed in a situation where safety is compromised for commercial expediency. Does your company provide guidance to the master, especially when the master is calling at a port for the first time or during a different season?

Local practices – In this case, the pilot has experience, and their advice should have been heeded. Local knowledge can improve the interpretation of area weather forecasts.

Situational Awareness – If there was any doubt, the master should have consulted the ship's staff and shore management. The pilot's doubt should have been sufficient to register with the master that the departure would be challenging. Prudent overreaction should have been applied, and the vessel should have delayed departing.

Capability – The vessel's ability to manoeuvre under high wind conditions with exposure to high sides was not assessed. The wind forces acting on the hull must be understood when designing passenger vessels with high sides. Simple rules for calculating wind force exist. Were these rules used during the master pilot exchange?

E.g. Length overall (m) x Max freeboard in (m) = windage area

An approximate wind force in tonnes per 1000 sq. m can then be calculated using:

V wind speed (meters/second) = wind speed (knots) / 2

The Force (tonnes) per 1000 sq. meters = $V^2 / 18$

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