



## Take care when going forward



**S**eamariners will be familiar with the need to have the anchors cleared and ready for use while vessels enter or leave a port. A standard procedure for an outward-bound vessel is for the anchors to be secured for sea passage on dropping the pilot.

However, a recent report from the Australia Transport Safety Bureau (ATSB) serves as a reminder of the need to ensure the safety of those working forward when a vessel experiences adverse weather on departure.

In that case, faced with rough conditions at the pilot station, the master appears to have manoeuvred the vessel and reduced speed to assist the pilot's departure, but then resumed the passage course and speed.

Although the vessel was thought to have settled well on the course, a

solid green sea was shipped over the port bow shortly after three crew members went forward to secure the anchors. One man was killed and another badly injured

as they were swept across the forecastle head.

The ATSB has recommended that, faced with similar circumstances, "Masters should carefully plan the course, speed and/or position of their vessel to minimise the risk to crew members working on exposed decks." Further details can be accessed at [www.atsb.gov.au](http://www.atsb.gov.au)

A similar lesson could be drawn from a second accident, reported to the Club, in which a crew member was hurt while working forward in bad weather. In that case, as the weather deteriorated on the second day of a short passage, the master became concerned that a guillotine cable stopper had not been closed properly on departure. The master altered course in order to reduce the vessel's pitching, but a crew member was hurt when a wave broke over the bow while the anchors were

being checked. The master's analysis of the incident for ISM purposes concluded that he could have further reduced the risk to the crew sent forward if he had put the weather on a quarter and also reduced speed.

### The mobile menace

A recent casualty investigation by the UK Marine Accident Investigation Branch concluded that a cause in the grounding of a laden chemical tanker was the use of a mobile phone on the bridge, while the vessel was trying to transit a narrow channel. (see [www.maib.dft.gov.uk](http://www.maib.dft.gov.uk)). The MAIB's resulting recommendations included the introduction of constraints on the use of mobile phones in restricted waters.

Further, the UK Maritime and Coastguard Agency has recently issued a Marine Guidance Note which strongly endorses the MAIB's recommendation, and encourages owners and operators to incorporate appropriate procedures into their vessels' Safety Management Systems. And the MCA adds that consideration should also be given to the prohibition of all mobile phones from the bridge when navigational requirements demand the individual attention of each member of the bridge team. More details can be accessed at [www.mca.gov.uk](http://www.mca.gov.uk)

### IN THIS ISSUE



**Augment your bridge team**

**Holds and hatches**

**Beware when rigging pilot ladders**

**Malaria alert**

**Lifeboat safety warning**

**Beware enclosed spaces**



## Augment your bridge team

**T**he Club has received news of casualties occurring when officers have been standing navigational watches alone, in circumstances where they should have been assisted by at least a lookout - and probably another officer.

Such lone watchkeepers have been involved in several recently reported collisions and groundings, and in a case in which a vessel caused very significant damage to chartered fish farms. This casualty occurred at night, while the vessel was on a coastal passage through an area in which the master expected to meet a high concentration of fishing vessels.

Repeated alterations of course had been necessary to avoid the nearby fishing craft. But, when the fish farms were struck, the second mate was alone on the bridge, having allowed his look-out to stand down for a break.

The master's standing orders made it clear that he was to be called whenever necessary. But the second mate subsequently explained that it was only after the accident that he properly appreciated the extent to which his preoccupation with collision avoidance manoeuvres had detracted from the attention he was able to pay to the vessel's navigation.

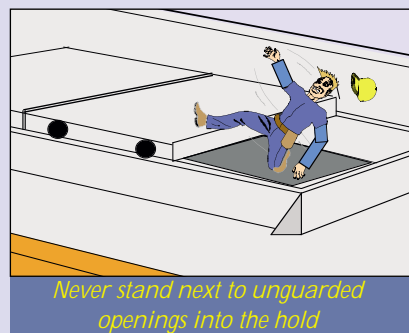
'Bridge Team Management' by the Nautical Institute addresses this issue. The publication notes that, "It is very easy for the Officer of the Watch to fall into the mental trap that he is able to cope with anything that watch-keeping presents to him. This may be a result of misunderstanding; an assumption that it is quite normal for a watchkeeper to do it all himself; or even a fear that he may be seen to be inadequate by calling for assistance."

Members are reminded that careful passage planning may identify circumstances in which it is preferable to take a decision to augment the bridge team in advance, rather than rely on the officer of the watch to call for assistance.

## Holds and hatches

Very serious accidents resulting from failure to observe safe practices while working in and around holds and hatch covers continue to be reported to the Club.

In one recent case, a seaman fell to his death while climbing a vertical hold ladder. Witnesses reported that he had been unable to grip the ladder with both hands because he was attempting to climb while holding a chipping hammer.



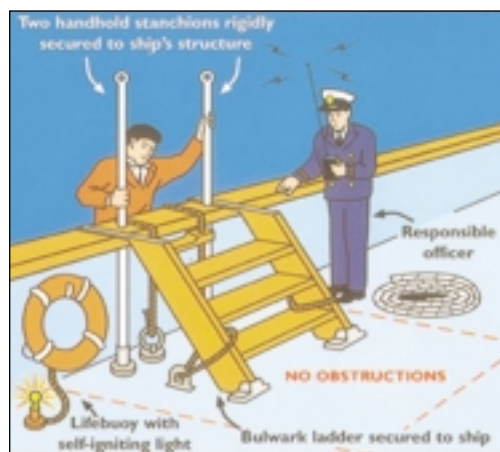
This tragic loss could have been avoided if those working in the hold had followed the simple practice of carefully lowering and raising tools and equipment on a line. In another case, a seaman fell as he operated a

mucking winch which was being used to lift lashing materials through the open hatch of a bulk carrier. Although the man could have watched the load ascend while remaining safely on the appropriate platform on the side of the hatch coaming, investigations suggest he lost his balance after he climbed on top of the coaming.

The London Club publication, 'Holds and Hatch Covers', contains guidance on safety procedures, and members are also referred to such publications as the UK MCA's Code of Safe Working Practice for Merchant Seamen.



## Beware rigging pilot ladders



**T**he Nautical Institute's Marine Accident Reporting Scheme has recently featured details of an accident in which a pilot fell onto a pilot boat, while disembarking a vessel.

Access to the pilot ladder was by means of a bulwark ladder, which had been fitted with handrails. On reaching the top of the bulwark, the pilot turned and began to descend the pilot ladder while gripping the handrails on the bulwark ladder, rather than the handhold stanchions, which were fixed to the bulwark itself. Unfortunately, the officer responsible for ensuring that the pilot ladder arrangements were securely rigged had failed to ensure that the bulwark ladder was properly secured.

As a result, when the pilot pulled on the handrails to steady himself, the bulwark ladder tipped and the pilot lost his balance and fell. Cases such as this serve primarily as a reminder of the importance of rigging pilot ladders safely and in accordance with SOLAS Chapter V Regulation 23.

The SOLAS requirements - including the lashing of bulwark ladders - are illustrated in an IMO approved 'boarding card', which can be downloaded from the website of The International Maritime Pilots' Association at: [www.internationalpilots.org](http://www.internationalpilots.org). A further issue for members' consideration, meanwhile, is the danger associated with fitting handrails to bulwark ladders.

In the case reported by the Nautical Institute detailed above, the ladder would not have been capable of tipping in the absence of handrails - which are not required by SOLAS - and the pilot should not have been presented with any handhold other than the appropriately secured stanchions, which are required by SOLAS.

## Malaria alert

The Club is concerned that there is evidence of a rising trend in the number of seafarers who contract malaria, and also that the seafarers involved in some of those cases may not have fully appreciated the risk of contraction or the need for prompt diagnosis and treatment.

Malaria has an incubation period of between seven days and three months. It is transmitted by mosquitoes in tropical and sub-tropical areas, and causes acute fever. There are several different strains of malaria, but some types can be fatal unless the infection is diagnosed and treated promptly. For any strain, there is no prophylactic medicine which is completely effective, and the problems facing seafarers are compounded by the fact that a vessel can trade between areas in which different anti-malarial medicines are recommended.

Members are reminded that there are four principles of malaria protection; be aware of the risk and main symptoms; take appropriate antimalarial treatment; if possible, avoid being bitten by mosquitoes, especially between dusk and dawn; and seek immediate diagnosis and treatment if a fever develops.

**(Medical Rescue International)**



## Lifeboat safety warning



**A** amendments to Regulation 19 of Chapter III of SOLAS will come into force on July 1, 2006, restricting the circumstances in which lifeboats will be manned during inspections and drills. The Club has continued to receive frequent reports of very serious accidents involving lifeboats, and it is hoped that these changes will lead to a reduction in the number of such cases.

In a recent case, one seaman was killed, and another two badly injured, while they were working as the launching crew of an open lifeboat which fell fourteen metres into the water as it was being lowered to the embarkation deck, during a drill. Subsequent investigations confirmed that all the lifeboat gear and equipment was in satisfactory condition. The accident is thought to have resulted from operator error, in that the falls were paid out too far,

such that the weight of the boat was largely transferred onto the tricing pennants. As the falls slackened, the blocks slipped from the hooks, just as the pennants released under the abnormal load.

In another recent case, two seamen died, and three others suffered serious injury - again during a drill - when the stern of their lifeboat detached from its hook arrangement. As a result, the boat plunged sixteen metres into the sea. On this occasion, the ensuing inquiry suggested that the cause of the accident involved a structural failure of a fixing plate in the hook arrangement. Members are reminded again of the need to conduct thorough examinations of lifeboats and associated equipment, and are referred to the IMO Guidelines in MSC Circular 1093. (For further details see [www.imo.org](http://www.imo.org))

## Beware enclosed spaces

The Club continues to receive reports of fatal accidents involving entry into enclosed spaces, which would have been avoided if the seafarers involved had been obliged to follow an appropriate entry permit system.

The IMO Recommendations for Entering Enclosed Spaces Aboard Ships note that the atmosphere in such an enclosed space could be unsafe because it "may be deficient in oxygen and/or contain flammable and/or toxic gases or vapours".

The IMO also recommends that "a competent person should always make a preliminary assessment of any potential hazards" and that "no person should open or enter an enclosed space unless authorised by the master or nominated responsible person and unless the appropriate safety procedures ... have been followed" and that "a permit has been issued authorising entry."

The entry permit system requires the responsible individuals to confirm that all necessary safety procedures have been completed, and the permit should be signed prior to entry by both the responsible individuals and those entering the space. Further details can be accessed at: [www.imo.org](http://www.imo.org)

### PUBLISHED

on behalf of The London Steam -Ship Owners' Mutual Insurance Association by A. Bilbrough & Co. Ltd.,  
50 Lemn Street, London E1 8HQ, UK.  
Tel: +44 (0) 20 7772 8000  
Fax: +44 (0) 20 7772 8200  
E-mail: [london@a-bilbrough.com](mailto:london@a-bilbrough.com)  
[www.lssso.com](http://www.lssso.com)

### EDITED BY

Chris Hewer,  
Merlin Corporate Communications,  
11 Kingsland Court,  
Three Bridges Road,  
Crawley RH10 1HL, UK  
Tel: +44 (0) 1293 55 00 44  
Fax: +44 (0) 1293 55 04 04  
E-mail: [wizard@merlinco.com](mailto:wizard@merlinco.com)

### PRINTED BY

Stuart Vaux Associates,  
Chiltern Lodge,  
38 Clifton Road, Amersham,  
Buckinghamshire  
HP6 5PP, UK.  
Tel: +44 (0) 1494 726593  
Fax: +44 (0) 1494 726593  
E-mail: [sales@svaux.com](mailto:sales@svaux.com)