STOPLOSS
BULLETIN

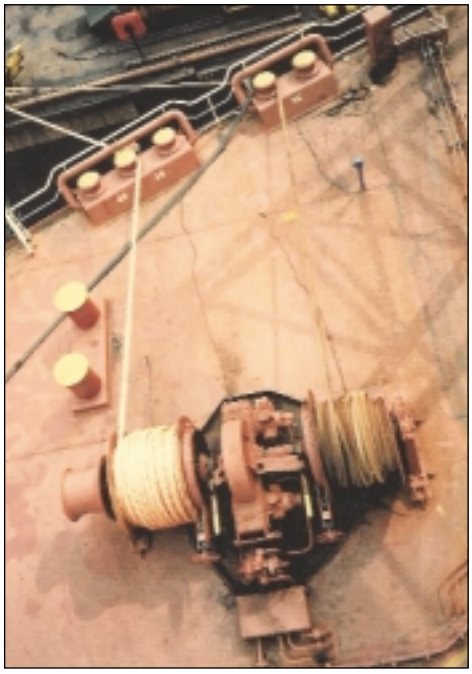
THE LONDON P&I CLUB

NOVEMBER 2005
ISSUE 40

Take care when mooring

The Club has recently seen a tragic case emphasising the very close care and attention required - on board and ashore – during the mooring and unmooring of ships.

The vessel concerned was preparing to leave a river berth and all of the mooring lines except one had been let go. As the current caught the ship the load on the last line, which was held fast on a winch brake, increased significantly. The officer in charge of the mooring station was uncertain whether he had missed an order to let go the last line. But as he sought clarification the line parted suddenly and struck a mooring man waiting on the quayside.



The subsequent death of the mooring man serves as a salutary reminder of the need for particular care in such operations. And important general principles are contained in the UK Maritime & Coast Guard Agency's Code of Safe Working Practice for Merchant Seamen, which makes the point that:

...Immediate action should be taken to reduce the load should any part of the system appear to be under excessive strain...

Communication breakdown

Recent editions of *StopLoss* have highlighted casualties both resulting from - and averted by - the quality and the extent of communication and cooperation between masters / officers and pilots. And another case recently reported to the Club again unfortunately illustrates the dangers that can arise, when such aspects of bridge team management fall short of proper standards.

In the case in question a laden containership ran aground just outside a buoyed channel in the US, after a near miss with a pleasure craft. The pleasure craft - which was under an obligation to give way - maintained a course and speed across the channel which to some degree impacted on the containership's ability to follow a bend in the channel. However, although the master and second officer were satisfied that their ship had sufficient room to allow the pleasure craft to pass ahead and still complete the necessary turn, the pilot advised the helmsman – without consultation - to go hard to starboard, just as the channel turned to port. Although the pilot was immediately challenged, the vessel was, crucially, already swinging to starboard, and then ran aground.

The pilot's subsequent explanation was that he had been left with no choice other than deliberately to ground the ship on what he knew to be a soft bottom because, in his opinion, there was otherwise a serious risk of collision with the pleasure craft.

The pilot's analysis was vigorously disputed by the rest of the containership's bridge team. And, indeed, following investigations into the casualty by port, flag and pilotage authorities, the pilot was ordered to retrain in modern bridge team management techniques. In the meantime, the case serves to further underline the importance of proper pilot participation in bridge team procedures.

IN THIS ISSUE

VDR impact on casualty investigation

Recent reports - including those accessible at: www.maib.dft.gov.uk - illustrate how Voyage Data Recorders (VDRs) can perform a similar role in the investigation of shipping casualties to that of so-called 'black boxes' in the context of accidents involving aircraft.

For example, in one collision case, the flag state investigators' understanding of the cause appears to have been significantly assisted and accelerated by downloading and analysis of information recorded on the VDR of one of the ships. The VDR recording included video output of the ship's primary radar, enabling the investigators to view what the officer of the watch could have seen on his radar screen. Further, the data contained audio recordings of discussions on the bridge as well as of VHF calls made from the other vessel, prior to the collision.

StopLoss 20 reported on SOLAS requirements for the fitting of VDRs on cargo ships of 3000gt and more built on or after July 1 2002. And a further amendment to SOLAS, to come into force on July 1 2006, will make mandatory the fitting of Simplified Data Recorders on existing cargo ships of 3000gt and upwards, by not later than July 1 2010. Further details on the regulations can be accessed at: www.imo.org

Rest reminder

The Club has recently reviewed reports (including a number of the Danish Maritime Authority, accessible at: www.dma.dk/sw164.asp) which serve as stark reminders of the vital importance of ensuring that bridge team members are properly rested, prior to standing a navigational watch.

The casualty reports include examples of groundings appearing to have resulted from the officer of the watch falling asleep and, consequently, missing key course alterations. Further, in another case, the grounding occurred following the helmsman's failure to correctly follow a helm order, as the bridge team attempted to execute a turn while navigating in restricted waters. Subsequent investigations suggested that the helmsman was inadequately rested before taking the wheel for a difficult port approach.

The International Convention on Standards of Training, Certification and Watchkeeping for Seafarers (STCW), as amended in 1995, sets out requirements for rest periods for officers and others forming part of a watch. And the cases highlighted above underscore the adverse impact that fatigue may have on the performance of ship's staff and, so, the importance of proper rest in accordance with the STCW provisions.

Protection from falls

A recent claim serves as a further reminder of the potential risks involved while working aloft - and the need for personnel involved in such activities to take careful measures to prevent falls.

The case concerned injuries sustained by a crewmember, who fell from a stage while painting the ship's funnel. Although the crewmember was wearing a suitable harness, it seems that he had unclipped this from the lifeline while painting. As a result, the harness provided no protection whatsoever when the crewmember fell. The case highlights the importance of proper safety practices and procedures - including supervision - while crew are working aloft.

Delay in China following collision

The Club has recently seen a difficult case involving a collision between a containership and a small locally owned coastal tanker, in Chinese territorial waters.

As a result of the casualty the coastal tanker was reported to have spilt fuel oil and was required by the authorities to provide security, for the alleged clean-up costs. However, the authorities demanded additional security for the clean-up from the containership - at levels which appeared very excessive - and it was only after some 30 days of intensive negotiations that acceptable security terms were agreed. The approach taken by the authorities may very well reflect concern at whether the level of liability insurance possessed by the coastal tanker was sufficient to meet the alleged cost of the clean-up operation - and highlights the risks faced by foreign flag ships unfortunate enough to be involved in such casualties.

Shortages of edible oil cargoes at Chittagong

Reports continue to be received of shortage claims involving bulk edible oil discharged at Chittagong. The claims arise from a number of causes, including the basis upon which cargo duties are calculated by the local authorities. The calculation of the 'bonded temperature quantity' involves an unnecessary double conversion from metric units to imperial units and back to metric units. In the process, "rounding errors" create an apparent shortage of about 2.20mts of cargo for every 1,000mt discharged.

Despite recent proposals to remove this anomaly, little progress has been made and scope for disputes remains. Difficulties faced by carriers are intensified by controversy over the admissibility of the 1% trade allowance previously accepted by the local Courts and the result is a large volume of protracted and potentially expensive litigation.

In the circumstances, the suggestion to Members is that efforts be made to clause bills of lading to the effect that the quantity of cargo discharged should be determined by an ullage survey performed onboard. Further, since agents will be liable for shortage claims in the first instance, and will usually be looking for security in respect of that exposure, the risk of delay in the event of a shortage claim arising can be reduced by consideration being given to the appointment of agents willing to accept such security in the form of a Club Undertaking.

(Interport, Chittagong).

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Welding risks warning

A recent accident resulting in the death of a shipyard welder, while working onboard a Member's ship, emphasises the importance of following proper safety procedures in performing such operations.

Investigations revealed that the welder was killed while using the yard's equipment and indicated - in particular - the welding cable to be in poor condition and that several breaks in the insulation had been covered with electrical tape. The death occurred during welding and when the welder's arm touched a damaged section of the cable. The level of danger was most likely increased by very humid atmospheric conditions which had dampened the welder's clothes.

Although there was no liability on the Member's part in this case, it nevertheless highlights generally the need for extremely strict inspections of cable condition prior to use. And it also underlines the importance of attention to other safety issues, including the use of proper clothing and footwear.

Working in hot conditions

Investigations into the cause of a claim involving an engine room wiper's temporary partial paralysis indicate that he was suffering from a severe form of salt deprivation. The engine room's temperature was reportedly in excess of 40C for a sustained period. And although supplies of chilled water and salt tablets were freely available, the wiper does not appear to have taken the salt supplements. It is thought that this led to his collapse, from an extreme form of heat cramp.

The wiper was hospitalised and then repatriated but, happily, made a full recovery. Nevertheless, this case serves as a reminder that ship's staff working in hot conditions should ensure that they adequately replace salt and water lost through sweat.

Watch needed for slips and trips

In a number of recent cases in the US, shore personnel have raised claims against Owners, alleging that they sustained significant injuries following seemingly innocuous incidents during the descent of accommodation ladders. In each case the claimants waited for several months before making any complaint.

Investigations have revealed that crewmembers (on station for security purposes) had witnessed the minor trips and stumbles which now form the basis of the claimants' legal actions. But since the crewmembers considered the incidents to be very insignificant, they made no contemporaneous record or report to the Master.

While the nature and extent of the claims are subject to vigorous defence by the P&I attorneys, the legal advice is that the Owners' position would have been even stronger if the crewmembers' evidence had been collated and collated at the time. Accordingly, the claims illustrate the importance of note being taken of what may well appear very minor mishaps involving US shore personnel, with prompt advice being passed to the Club, for an assessment of whether additional early investigations should be performed.

In-house events

- 'An introduction to the IMDG Code' - A talk by David Fletcher of Bilbroughs - Wednesday, November 23, 12.00 hours.
- 'ISM Code and Case Management' - A talk by Ian MacLean of Bentleys Stokes & Lowless - Wednesday, December 7, 12.00 hours.

PUBLISHED
on behalf of The London Steam -Ship Owners' Mutual Insurance Association by
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