



Anchor dragging: Master's authority and responsibility

Two recent pool claims and a single claim upon the Club, all caused by anchor dragging during Typhoon Hato, bring the subject of anchoring in poor weather to the fore.

The well-known case of the *Pasha Bulker*, and the Club's own experience of a large pool claim generated by shoreline bunker pollution clean-up, led to the Club reviewing its Ship Inspection Questionnaire a number of years ago. The questionnaire was amended to include the subject of the Master's authority to potentially depart an anchorage in the face of inclement weather. The Club can point to pool claims where entered ships have remained at anchor in the face of well-forecasted heavy weather when other ships have made clear decisions to weigh anchor and depart.

Under the ISM Code, the Master has an overriding authority to make command decisions of this nature and in many other situations. The Club asks all Owners to consider their own procedures and whether these fully support the Master when the decision is made to vacate the anchorage.



The Club has experienced a case where a solitary ship, left in an anchorage one nautical mile off the coast in an onshore gale, dragged her anchor and was unable to start her engines in time and found herself grounded with ruptured bunker tanks.

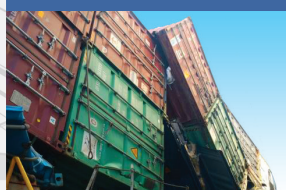
The Master can only make such a decision to depart an anchorage if the weather information provided to the ship by various means is properly assimilated and acted upon. It is not uncommon for ships to drag their anchor and ground, with published weather information warning of impending bad weather properly filed but never read.

The provision of the 'storm anchorage' remains an issue, where a false sense of security can result. An entered ship recently grounded during Typhoon Hato after anchoring in a designated 'storm anchorage'. Ultimately, the 'storm anchorage' did not offer sufficient protection to prevent the ship from dragging her anchor and being exposed to the subsequent high severity claim.

The Master's responsibility to monitor the weather conditions by all forecasting means available remains paramount, so that good decisions can be made over the conduct of the ship.

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CONTAINER LOSSES

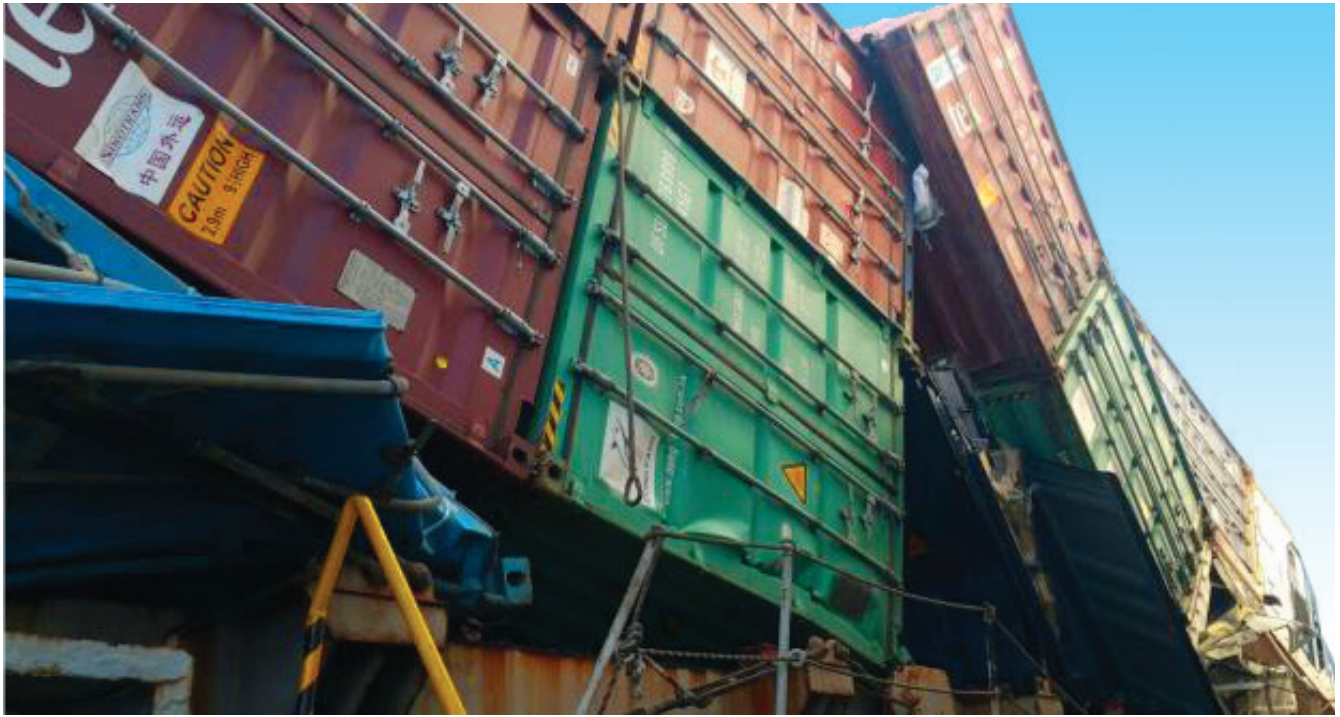


EMERALD STAR/ LIQUEFACTION



CORRECTING SYSTEMIC ISSUES





Container loss claims

A recent run of container loss claims has highlighted some of the common contributory factors which have emerged from the investigation process.

The subject of mis-declared container weights continues to be a problem. However, in this particular run of claims it was the attending surveyor's observations regarding cargo securing equipment that catch the eye.

In these cases, it became clear that several manual twist locks were not correctly locked at the time of the incident. The causes for this were considered to be two-fold – some twist locks were damaged (specifically with locking levers either bent or missing), or the units in service were a mixture of right and left-hand locking units, leading to confusion over the observed status of the twist lock.

On investigation, a number of container corner castings and container foundations showed no signs of having a locked twist lock forcibly removed during the collapse, the natural conclusion being that the twist locks were in those cases in the unlocked position.

It was also evident that in some cases the degree of wastage of deck/hatch container foundations was such that they were no longer serviceable. As a result, even the best maintained twist lock cannot properly contribute to the planned securing arrangement.

Owners are reminded of the need to ensure that container lashing and securing equipment (including fixed fittings) are included in the ship's planned maintenance system. It is further recommended that at the same time, the ship's equipment is all checked for consistency against the provisions of the ship's prescribed cargo securing equipment inventory within the cargo securing manual.

The Club's *LP Focus* publication entitled "The causes and prevention of container losses", produced with TMC Marine Consultants, discusses the general subject of container losses.

[Click here to view or download](#)



Clear evidence of the forced removal of a 'locked' twist lock



A container foundation's very poor condition makes it unserviceable



Loss of the *Emerald Star*

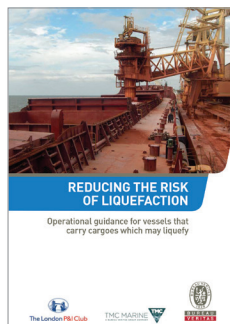
The loss of the bulk carrier *Emerald Star* on 13 October 2017 off the coast of the Philippines has again focused attention on cargo liquefaction. While the cause of the loss is not conclusive, various sources have suggested it is associated with liquefaction of her nickel ore cargo.

The cargo was loaded in Indonesia, and raises further concerns over the safety of cargoes of this nature which are loaded in Southeast Asia. Click [here](#) to view Club Circular 5:428 on Nickel Ore Cargoes loaded in Indonesia and the Philippines.

Members are encouraged to review with the Managers steps that might be considered to reduce the risk presented by this cargo before loading. Members are also reminded that Club cover may be affected if they do not comply with the requirements of the IMSBC Code.

In response to the continued losses internationally in connection with liquefied cargoes, the Club collaborated with Bureau Veritas and TMC Marine Consultants to produce the booklet "Reducing the risk of liquefaction – Operational guidance for vessels that carry cargoes which may liquefy".

Please click [here](#) to view or download a copy from the Club's website. To request A5-size hard copies which are free of charge to Members, please email publications@londonpandi.com



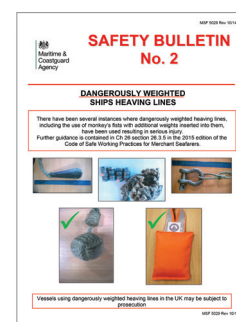
Heaving lines

The industry became aware of the dangers of weighted heaving lines some time ago. The use of heavy items such as steel bolts and even shackles have been seen in the past.

However, during ship inspections the Club occasionally notes this outdated practice today and reminds Owners that this is dangerous and could result in serious injury or fatality.

The Club suggests that Members consult the current edition of the Code of Safe Working Practices for Merchant Seamen (COSWP) for guidance, along with relevant Flag state guidance.

An example of such advice can be found by clicking [here](#).



SHIP INSPECTION PROGRAMME

Correcting systemic issues highlighted in ship inspections



The Club's ship inspection programme provides Owners with an independent assessment of operational risks which can result in third party liabilities covered by the Club.

Many findings can be of a physical nature, so can be corrected by the completion of remedial work. Examples such as hatch cover gasket maintenance and cosmetic repairs to deck coatings can sometimes be dealt with, and a possible internal 'close out' achieved in a short period of time.

There are, however, circumstances where it is not possible to correct matters for several months. These cases usually relate to safety cultural and/or procedural issues. Inspectors often find that systemic problems are in evidence despite clear guidance and procedures being prescribed in the company Safety Management System.

Such shortcomings are often a result of habitual behaviours that are difficult to remove and liable to be passed on to junior seafarers, particularly where officer cadets are under training.

It is therefore important for Owners to consider whether having a one-off discussion or potential reprimand is sufficient for a matter to be internally 'closed out'. The Club believes that when, for example, a ship has a poorly maintained record of hours of rest, it may be necessary for the efficacy of the system to be verified over several months to ensure that the Owner's corrective action has indeed been successful.

An inspection conducted on an entered ship is only a sampling process and cannot detect all possible risks. But when an inspection highlights systemic/procedural issues, and where Owners run a further fleet of ships, similar issues may be apparent elsewhere within the fleet, particularly if ship's officers commonly move around the fleet for tours of duty.

We therefore recommend that Owners take steps to ensure that when reporting back to the Club after an inspection, the act of correcting a finding may extend many months beyond that report – and beyond the inspected ship.

ACCIDENT INVESTIGATION WORLD ROUND-UP

In this regular column, we round up some of the eye-catching accident investigation reports from around the globe:

Nortrader MAIB – United Kingdom

Nortrader, anchored off Plymouth with a cargo of unprocessed incinerator bottom ash (U-IBA), suffered two explosions in quick succession. The first explosion was in the forecandle store and the second in the cargo hold. The chief engineer, in the forecandle store at the time, suffered second degree burns requiring four months to recover. The ship suffered extensive damage putting it out of service for over three months.

Safety lessons highlighted:

- Sea transportation of a cargo that was not included in the schedule of authorised cargoes of the International Maritime Solid Bulk Cargoes (IMSBC) Code
- Not conducting appropriate tests that could have identified the propensity of the cargo, U-IBA, to release hydrogen when wet
- The inadequacy and the inappropriateness of United Nations Test N.5 for the detection of flammable gases from non-homogeneous material

[Click here to view report](#)

Swiftnes/Fuji Maru MLIT – Japan

During its service to help the cargo ship *Swiftnes* dock at Tomakomai Port, Tomakomai city, Hokkaido, work boat *Fuji Maru*, with a coxswain and a workman on board, was handling mooring ropes from the aft deck of *Swiftnes*. During the operation, the mooring ropes entangled the ship's turning propeller. *Fuji Maru* was drawn towards the propeller of *Swiftnes* and she subsequently capsized resulting in a fatality.

Among the factors discussed as probable causes were communication of information between Master and Pilot.

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Tug Ken Mackenzie TSBC – Canada

The tug *Ken Mackenzie*, with two people on board, reported a fire in the engine room while transiting the Fraser River, British Columbia. The two crew members abandoned the tug and were picked up by the assist tug *Harken No. 5*. The fire was extinguished with the assistance of other ships in the area.

Among factors discussed are components for emergency equipment and machinery being installed or replaced by personnel without adequate guidance or knowledge of industry standards, and such equipment being subsequently put into service without being inspected by a competent person, there being a potential risk that the installation will be unsafe.

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The London P&I Club



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