CHIRP

MARITIME FEEDBACK

Issue No: 18 Spring 2008

EDITORIAL

PLEASE RESPECT MY SAFETY MARGIN!!!

It is apparent from a number of reports received by CHIRP that some watch-keepers are "cutting it too fine" in passing other vessels.

There is an old English saying that "a miss is as good as a mile". This is not a philosophy to which we subscribe. If someone were to fire a gun towards you and the bullet just missed, you would probably not feel sanguine about the situation. Similarly the watch-keeper of a stand-on vessel should not be caused anxiety by a give-way vessel that takes no action or minimal action resulting in an unnecessarily close passing distance.

Typically, in such cases, it is apparent that the watch-keeper of the give-way vessel is failing to consider the risks inherent in passing unnecessarily close to another vessel.

The situation is exacerbated if the give way vessel is highly manoeuvrable and the stand-on vessel relatively less so as the latter is then put in an invidious position in determining when to apply Rule 17b. This may be due to the different perceptions of the risk.

Consider for example an encounter between a fast motor cruiser as the give-way vessel and a large bulk carrier as the stand-on vessel. The watch-keeper on the motor cruiser thinks "I will hold on for the time being to see what happens. If the bulk carrier is still on a collision course when I get to a couple of cables from her, I will nip round her stern." However on the bridge of the bulk carrier there will be consternation once the motor cruiser is at less than, say, two miles and still on a collision course. This consternation may subsequently result in the bulk carrier taking action under Rule 17b. What should have been a straight-forward situation has now become more complex, especially if there are other vessels in the vicinity.

In general, the give-way vessel should allow a reasonable margin of safety in its passing distance from the other ship. As Rule 16 states succinctly: "Every vessel which is directed to keep out of the way of another vessel shall, so far as possible, take early and substantial action to keep well clear."

Or, put in another way, "Please respect the safety margin of the other vessel".

So what can be done to improve matters? When *CHIRP* receives a report on an alleged violation of the Collision Regulations by a commercial vessel, the Director (Maritime) generally writes to the manager of that vessel, without disclosing the identity of the reporter. This helps spread the message that breaches of the Collision Regulations are observed and may be fed back to managers.

There are various computer-based training tools for providing training, refresher training and individual testing of watch-keepers on the application of the International Regulations for Preventing Collisions at Sea. Use of such tools can be considered as good industry practice.

On another subject, since MARITIME FEEDBACK normally comprises reports of near-misses and hazardous incidents, it is pleasing to be able to pass on a favourable comment from a passenger on a small Antarctic cruise vessel regarding the comprehensive safety briefings to passengers.

And on a personal note, acting as Director (Maritime) since September has reinforced my belief in the value of the Confidential Hazardous Incident Reporting Programme. I am therefore pleased that the Trustees of *CHIRP* have confirmed that I will continue in the role. But I do need you to continue sending in reports!!! **Chris Rowsell**

WHAT'S IN THIS ISSUE?

MARITIME FEEDBACK is also available on the *CHIRP* website - www.chirp.co.uk

A Maritime Safety Newsletter

from *CHIRP* the Confidential Hazardous Incident Reporting Programme

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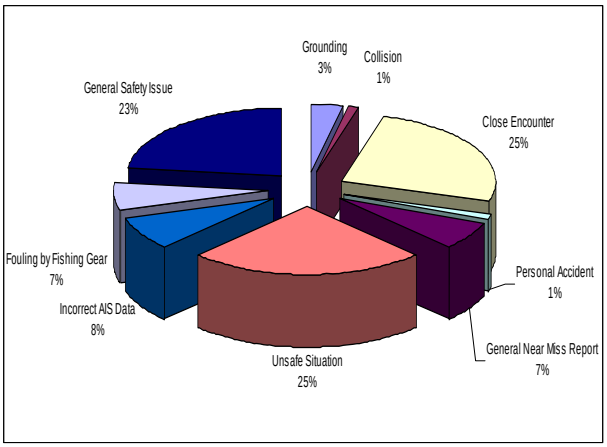

REPORTS RECEIVED IN 2007

The pie chart above shows the various categories of incidents and issues of the reports received by ***CHIRP*** in 2007. We have differentiated between "unsafe situation" and "near miss", taking into account how close the person or vessel was to risk of injury or damage. For example, in this categorisation we would classify a machinery breakdown in open waters as being an unsafe situation. If the vessel were to drift close to shore before being able to anchor, we would categorise that as a near-miss. If a yachtsman goes to sea without wearing a life-jacket, that is an unsafe situation (also referred to "at-risk behaviour"). If he falls overboard but is subsequently rescued, that would be recorded as a near-miss.

Approximately two thirds of the reports were received from the commercial sector and one third from the leisure sector. None were received in 2007 from the fishing sector. We do wish to increase the number of reports received from all three sectors of the maritime community.

EASTERN ENCOUNTER

Report Text: My vessel, a large tanker, was making its approach towards the Traffic Separation Scheme for an entry to Singapore Straits from the east.

At the time of the incident we were steering a course of 245 degrees True with a speed of 12 knots. The engine was on stand-by and the telegraph set to manoeuvring on the telegraph.

As we were approaching the Eastern Banks the traffic was exiting the TSS and steering a northerly course for ports in the Taiwan/Japan range. As is common the crossing traffic was heavy. Two container vessels were crossing ahead with CPA's of 1 to 2 cables. Own ship a/c to starboard to exhibit a broader red and encourage vessels to a/c to starboard and transit my stern. When it became apparent that they were not going to give way and were in fact increasing speed to enable a bow crossing my speed was slackened in order to increase bow crossing range. My engine was eventually stopped and speed reduced down to 6 knots. Both container vessels crossed ahead in broad daylight 4 cables. Both were clearly in violation of Rules 15 and 16. No attempt was made for a safer passing distance. There was no apparent reason for not a/c to starboard and passing round my stern. Both vessels were very close together and crossed the bow at the same time.

Could this have been the result of bravado, racing each other or just plain bad seamanship?

This type of near miss is becoming increasingly more common.

CHIRP Comment: **We sent a disidentified copy of the report to the managers of both the container ships.**

The reply from the manager of the first ship, the faster of the two container vessels, included a full statement from the Officer of the Watch (the Captain having left the bridge when the ship had cleared the Singapore Strait). In summary, this statement was that the OOW had been closely monitoring the other container ship that he had passed and the tanker on his starboard bow. The OOW considered that he was passing safely ahead of the latter vessel. He added that the tanker gave no indication of concern by sound signal or light or VHF.

The reply from the manager of the second container vessel was that the master was emphatic that his vessel had not been in a close quarters situation with a tanker.

Whilst this may be inconclusive as regards to the actual events, we believe that the tanker acted correctly in reporting the incident to *CHIRP* and that the managers of both container ships acted responsibly in following it up.

It appears that the watch-keepers on the container ships may have had a different perception of the risk than that of the Master of the tanker. The report illustrates the situation described in the Editorial to this issue of MARITIME FEEDBACK where the stand-on vessel (in this case the tanker) is less manoeuvrable than the give-way vessel (s) (the container vessels).

We note that the tanker altered course to starboard to encourage the other vessels to transit her stern. Whilst we recognise the concern that was being felt on the bridge of the tanker at the developing close quarters situation, *CHIRP* does not endorse this action as described as it does not appear to be in compliance with Rule 17 (a) (i) *("Where one of two vessels is to keep out of the way the other shall keep her course and speed.).* It is of course a matter for judgement by the stand-on vessel as to when an alteration of course and/or reduction of speed may be appropriate under Rule 17 (a) (ii) *(The stand-on vessel may however take action to avoid collision by her manoeuvre alone, as soon as it becomes apparent that the vessel required to keep out of the way is not taking appropriate action in compliance with these Rules.)*

Whilst it is not possible to reconstruct the situation exactly, it remains questionable whether the watch-keeper(s) on one or both of the container ships had properly assessed the risk and considered their obligation to take early and substantial action to keep clear of the tanker as per Rule 16, as quoted in the Editorial to this issue.

Both container ships commented on the absence of VHF communication from the tanker. However *CHIRP* advises great caution in the use of VHF for collision avoidance.

We do draw attention to Rule 34(d):

"When vessels in sight of one another are approaching each other and from any cause either vessel fails to understand the intentions or actions of the other, or is in doubt whether sufficient action is being taken by the other to avoid collision, the vessel in doubt shall immediately indicate such doubt by giving at least five short and rapid blasts on the whistle. Such signal may be supplemented by a light signal of at least five short and rapid flashes."

So if you are the stand-on vessel are in doubt as to the intentions of the other vessel, put yourself in full compliance with the Rules by using the whistle and light.

COASTER TOO CLOSE

Report Text: Own vessel, a coaster, was approaching N.E Cross Sand buoy which was 1m on port bow. Our speed 5 knots.

Another coaster was overtaking on my starboard side and closing. She overtook me on my starboard side at a distance of 0.07 cbls, then crossed my bow to the port side and altered course around the above buoy I kept my course and speed as per rules as he was overtaking V/L.

In the middle of the North Sea this would not seem to be good practice.

CHIRP Comment: We suspect that the reporter meant to say 0.07 miles rather than 0.07 cables. Even so, this close passing distance, followed by alteration of course by the overtaking vessel across the bow of the reporting vessel, appears to have caused unnecessary risk. It illustrates the point we have made in the editorial.

We have passed the report to the manager of the other vessel.

CONSTRUCTIVE FOLLOW-UP

CHIRP Narrative: In the previous edition of MARITIME FEEDBACK, we had summarised a report, entitled "Extreme Unpredictability", about two vessels proceeding on a parallel course up the English Channel. Vessel B suddenly altered course to starboard across the bow of vessel A and then re-crossed with a closest point of approach of only 0.25 mile.

CHIRP has subsequently received a comprehensive reply from the managing company of vessel B. We had previously sent them the original report (with the identity of vessel A not being disclosed.) They had sent a senior manager to vessel B to investigate.

The incident had occurred during the 2000 - 2400 watch, held by a junior officer. He had an experience of six months as an independent watch keeping officer, and was employed for the first time in the company. He had spent about a month and a half on board and was trained in the company's policies and safety management system. The Master was satisfied with his performance as a watch keeper on board the vessel. On the particular day, the vessel was adjusting its ETA to a port in the vicinity and the Master had instructed the OOW to execute a 180 deg turn manoeuvre at a certain time during his watch. It was promptly obeyed by the watch keeping officer.

The actions of the junior officer were not in line with the ColRegs. Furthermore, the VHF communications between the two vessels appear to have confused the situation.

The manager of vessel B was very concerned both with the incident itself and also that it had not been reported internally in their near-miss reporting system. The company has taken a number of actions. During the pre-joining induction of officers, it has been decided to emphasise company's No Blame Policy for reporting of Incidents and Near Misses on board. A Safety Alert Bulletin (Internal Company Document) is being circulated for circulation to all the fleet and offices, highlighting the lapses in the above incident especially with regards to use of VHF as a device for collision prevention. It has also been decided to incorporate during onboard training by company training officers, a module which highlights the negative aspects of VHF as a device for collision prevention. Masters are being briefed to appraise new personnel in respect of professional abilities and to reinforce belief in the company's internal reporting system.

CHIRP Comment This is a good example of the value of ***CHIRP***. Without the report from ship A, the manager of ship B would not have been aware of the issues. With the report, he was able to act responsibly in investigating the incident, following up with the individual officer and strengthening procedures across his whole fleet.

COLLISION IN PORT

Report Text: INCIDENT - Whilst manoeuvring from a lay-berth to the cargo wharf a 10,,000 dwt vessel made contact with a larger vessel, a tanker, moored on an adjacent berth. The smaller vessel sustained damage to her starboard side bulwark. The larger vessel sustained a minor indentation on her port bow.

IMMEDIATE CORRECTIVE ACTION - The smaller vessel safely berthed as planned starboard side to its intended berth. The duty superintendent, casualty coordinator, Flag State, P&I club, Classification society, owner and charterer were advised. P&I representative and a class surveyor attended the vessel and certified it as seaworthy.

INVESTIGATION BY THE OPERATOR - The vessel is fitted with a single medium speed diesel driving a controllable pitch propeller (CPP) and a shaft generator. The vessel is fitted with a 400kw bow thruster powered by either 3 generators or the shaft generator.

The engine is fixed speed (600 rpm) but has a low constant speed (400rpm) for clutching in the propeller and the shaft generator.

At the previous port, 2 mooring lines had fouled the propeller so upon arriving at the subsequent port the vessel had berthed at a lay by berth to allow divers to inspect the rudder and propeller and remove any rope remaining on the propeller. Prior to berthing the vessel had anchored and there had been some doubts over

the performance of the CPP, resulting in the propeller being clutched in and out a number of times during the anchoring operation. Following the rope fouling incident the managing office advised that the bow thruster must be powered by 3 generators in parallel rather then the shaft generator. This would then allow the thruster to be available independently of having the propeller clutched in.

On the morning of the incident, the vessel was to be shifted from the lay-by berth to the cargo berth, a distance was around 1.0nm. Upon boarding, the Pilot advised the master that a single tug would be made fast aft and would tow the vessel to the loading berth. It was advised that the vessels engine would probably not be used. This information was passed on to the Engine Control Room. The duty engineer after clutching in the propeller at low constant speed did not increase to high constant speed because 1) the bridge had advised the engine would probably not be needed, 2) there was a recent history of having to clutch the propeller in and out at short notice and 3) the shaft generator was no longer required to power the thruster. The fact that the M/E was not at high constant speed and therefore not in full standby condition was not passed on to the C/E or the bridge team.

Upon letting go the vessel was towed astern by a large tug with a 70mt bollard pull. The speed of the tow steadily increased to 7.5 kts at which point steps were taken to slow the vessel down by reducing the tug pull and using slow ahead on the main engine. The speed of the vessel did not slow fast enough and the main engine was put to full ahead pitch as she approached the cargo wharf. In order to avoid a collision with the larger vessel moored on an adjacent berth, the pilot requested the tug tow the stern to port. The bow-thruster was also put 100% to port but the resultant shear caused the bow to make contact with the moored tanker.

It was later proved that the operation of the CPP had not been affected by the fouled mooring ropes.

Root Causes of the incident

1. The Master and pilot did not take action soon enough to slow down the movement of the vessel astern, possibly due to lack of experience handling a vessel of that size.
2. The Tug involved was large and powerful relative to the tanker involved. The towing power used by the tug was excessive and resulted in excessive tow speed (7.5 kts).
3. The vessels main engine was not in its full standby condition (high constant rpm) and was therefore unable to respond as required to arrest the vessel sternway.
4. The Bridge team were unaware of any limitation imposed on the M/E performance.
5. Towing a vessel astern with a single tug is not considered 'best practice'. The tug should be in a position to stop a vessel should propulsion be lost. In this case the vessel should have been manoeuvred ahead under her own power, turning around as necessary and the tug should be in a position to stop her movement if necessary. Towing astern also reduces the effectiveness of the rudder.

CLOSE OUT ACTION TAKEN BY THE OPERATOR

PREVENTATIVE ACTION

1. Masters who are proposed for appointment to small ships to be assessed on their experience of small ship handling
2. A notice will be placed on the main engine (M/E) tachometer on the bridge of the vessel and sister vessels to warn that M/E is not in standby until the M/E is at high constant speed (600 rpm)
3. Duty engineer to be advised that failure to follow documented and familiar safety procedures is not acceptable
4. Revised procedure to be instigated on the vessel and her sister vessel such that bow-thruster is always powered by 3 x generators rather than shaft generator
5. The guidance within the Safety Management System relating to the use of tugs shall be reviewed and updated.

CHIRP Comment: **This report has been kindly provided to *CHIRP* by the manager of the vessel so that the learning can be shared more widely in the industry. It is a useful case study that highlights a number of generic issues that frequently arise:**

- **It is vital that the plan for the passage to and from the berth is fully discussed with the pilot – a "one team" approach. In this case, the plan should have included the expected speed of towing.**
- **The Bridge Team must closely monitor that passage is being executed in accordance with the plan. If it is not, the Master should express concern to the pilot and intervene if necessary.**
- **Key points of the plan must be communicated to all involved, including the engine room and the tugs.**

CHIRP **fully endorses the learning point that during manoeuvring the thrusters should be powered by the independent generators rather than the shaft generator. (If this is not the practice on your ship, do raise the issue on board, or with your DPA or let *CHIRP* know.)**

The decision on whether to tow a ship astern has to take into account the physical constraints of the port. At some ports this is a standard practice and can be exercised safely provided of course that the operation is properly planned and the pilot has the appropriate training and expertise.

Although the damage was minor, the consequences could potentially have been more serious. A thorough investigation was carried out, the root causes were identified and preventative action was implemented on the specific ship and sister vessels and generally across the whole fleet.

PROPELLER FOULED, LIFEBOAT CALLED

Report Text: Vessel: A yacht under power. Event: Motoring close to wind, engine suddenly stopped.

Tackle seen around transom. Onshore wind, force 4 to 5.

Action: Hastily anchored as we getting perilously close to concrete blocks on the lee shore. Listening on channel 72 (a club cruise channel). Notified that Coastguard was trying to reach us. Called CG who had already received a number of calls (origin unknown to me) and Inshore Life Boat was on its way. I had not called CG as once the anchor held we were not in immediate danger and I wanted to resolve the problem if possible. Not possible. Towed to port by ILB.

Damage: Prop jammed by rope and damage to the cutlass bearing.

Cause: The only surface evidence of the tackle was a buoy about 20cm in diameter which was 80% covered in weed, as were the odd bits of rope. This appeared to be redundant tackle. In the sea then running it was invisible.

It has been suggested that the more evidence of similar events that you have the more likely is something to be done. One suggestion is that all fishing tackle should have the owners or the boats name on it. There is a vast amount of tackle in this area , some of which is badly marked, and it is on the inshore route taken by small vessels.

CHIRP Comment: In respect of the actual incident, an earlier call to the Coastguard would have been prudent. This would have provided them with more comprehensive information in determining what action was appropriate, for example whether to ask another vessel to stand-by or to call out the life-boat. The yachtsman may have been confident in the ability of his anchor and warp to prevent him grounding but, in the absence of information from the yacht, the Coastguard would not necessarily assume that. In calling out the ILB, the Coast Guard no doubt had in mind that with the yacht's close proximity to the shore, the situation might have deteriorated rapidly.

The report also highlights the importance of maintaining a listening watch on Channel 16 as well as any working channel. This would have allowed the Coastguard to contact the yacht.

In respect of the general problem of fouling of propellers by fishing gear, please do continue to send us reports. We are pleased to advise that, following consultation with the various interested parties, the Maritime and Coastguard Agency will soon be issuing a new leaflet giving guidance on the marking of fishing gear.

AUTOMATIC IDENTIFICATION SYSTEMS

Report Text: I am a yachtsman who sails in the Solent, cross channel and around Brittany and have radar and AIS fitted on my vessel.

I am very concerned about the vessels I have observed travelling in shipping lanes and cross Solent ferries which are not transmitting ANY AIS signals.

CHIRP Comment: ***CHIRP*** has received reports from time to time about vessels which are transmitting incorrect information, typically large errors in the Heading. However we have not received previous reports about ships that are not transmitting an AIS signal. ***CHIRP*** is therefore keen to learn whether non-transmission is a frequent occurrence. If you do observe such an occurrence, please send us a report.

As this report mentioned the Solent ferries, we have checked the publicly accessible AIS website on a number of occasions and ascertained that the Solent ferries have been showing their AIS signals.

In further communication with the reporter, we were given further specific details of an occasion last year when a specific vessel was not giving a signal because, reportedly, the equipment was undergoing servicing. With the passage of time since then, we have not determined the particular circumstances. It is however appropriate to make some general comments regarding AIS.

Subject to further reports we may receive, we are currently inclined to think that the commercial vessels are generally transmitting an AIS signal, but recognise the possibility that there might sometimes be isolated failures. There may also be the possibility that there may be a technical problem with individual AIS receivers on small craft, but ***CHIRP*** has not received previous reports to indicate that this is a general issue.

We suggest the following as the way forward:

1. If you can identify a vessel that is not transmitting an AIS signal, call her on the VHF and advise them. Such intervention gives the vessel the opportunity to rectify it immediately.
2. If there is no response from the vessel, or if you cannot identify her, advise the Coastguard immediately by VHF. This gives the Coastguard the opportunity to check and contact the vessel.
3. In any event, ***CHIRP*** would be pleased to receive a report of the incident. If the identity of the vessel is known, we would follow-up with the manager. We generally find that shipping companies, including the Solent ferry companies, appreciate receiving reports on safety issues so that they can take corrective action.

As further information, the regulatory requirements for fitting of AIS are subject to a phase-in timetable. The full details are available on the MCA website under SOLAS V regulations, Chapter 19 (Shipborne Navigation Systems) and Annex 17.

TRAGEDY IN A DORY

CHIRP Narrative: The Marine Accident Investigation Branch (MAIB) has published a comprehensive report on the capsize of a rigid raiding craft being used by Army Cadet Force. This craft, 7.35 metres in length, is similar in appearance to a large dory and powered by a 200 HP outboard engine. The craft, with two others, was on exercise in the Scottish Isles. The weather worsened. One of the boats, which had accumulated a large amount of water on board, capsized.

Four of the 12 persons on board initially surfaced under the upturned hull, but only three managed to swim clear. The fourth, a 14 year old female cadet remained under the hull. Although a headcount was conducted, it failed to identify that the girl was missing. She was later

found under the boat on the rocky shore. She was taken to hospital by helicopter but was pronounced dead on arrival.

The MAIB investigation identified a number of factors which contributed to the capsize and the death of the cadet, including:

- The weight distribution within the boat reduced the freeboard forward and increased the likelihood of water being shipped.
- Water accumulated on the deck because the boat's self-bailers had not been lowered.
- The actions taken by the boat's coxswain did not take account of the free surface effect of the accumulated water.
- The lifejacket worn by the female cadet was not suitable for use by children and would have prevented her escape from the upturned hull once inflated.
- The delay in identifying that she was missing undoubtedly reduced the chance of her survival.

CHIRP Comment: If you are involved in the operation of dories or RIB's and/or in organising group activities afloat, we strongly recommend that you read the full report of this tragic accident. It can be found on www.maib.gov.uk

COMMENTS ON PREVIOUS REPORTS

(1) - NON-COMPLIANT COASTER

CHIRP Narrative: In the previous issue of MARITIME FEEDBACK (17) we featured a report from a yachtsman about an encounter with a coaster. The report included the statement that "when it became apparent that the coaster had not seen us or were ignoring our presence, we took a decision to alter our course to make sure we avoided it. However our decision to bear away, increase speed and pass well ahead was not so successful as initially calculated as the tidal set and rate was greater than we had estimated from our tidal atlas - setting us down towards the oncoming coaster."

In the ***CHIRP*** comment, we had commented on the lack of action by the coaster and also on the yachtsman's incorrect presumption that white sails are highly visible. However we did not comment on the effect of current on a collision situation. Three readers have written to us on this.

The first pointed out that "...the report states that this incident took place in open waters. In that case tidal stream would have had little effect on the collision situation since both vessels would have been subject to the same or similar tidal stream. It is unlikely that the yacht was significantly set down towards the oncoming coaster."

The second reader made the same point and added that "... although there was little detail in the published report of the exact position of each vessel, he could think of no instance where bearing away to increase speed to pass across the bow of a boat underway would be a safe manoeuvre."

The third reader pointed out that " ... the yacht and the coaster would have been similarly affected by the wind, although the yacht may have been more affected by leeway from the wind."

CHIRP Comment: One of the reasons for publishing the reports is to promote discussion on the learnings from incidents. We therefore particularly appreciate receiving comments from readers. In this case, we endorse the comments received and thank the three correspondents for having written to us.

For completeness, we would add that the current may have an effect on the apparent wind on the yacht, thus having a further effect on her speed and course made good. This reinforces the need to leave an adequate margin of safety in determining an appropriate passing distance.

(2) MISLEADING LIGHTS

Report Text: In MARITIME FEEDBACK No17 in the report entitled "Misleading Lights", CHIRP commented that it is difficult to envisage why the vessel was showing an all round red light. Your assumption about dangerous cargo is perfectly sound and it used to be that occasionally forgetting to turn off the light when clear of the port was the cause.

On a Channel Passage it is not unusual to see at least 2 vessels per watch showing the red light or flashing red light. It seems to be used now as a warning 'that if you hit me there will be a big bang'. According to AIS some of these ships have come from America, or farther afield. It may be that in certain territorial waters this light is required and this causes confusion, but it also confuses us. A 250,000t fishing vessel is quite a sight!

CHIRP Comment: We thank the correspondent for the follow-up. ***CHIRP*** would welcome reports on such incidents. Please provide us with the identity, if known, of the ship exhibiting incorrect lights so we can follow up the report with the manager.

Maritime & Coastguard Agency 24hr Info No:

0870 6006505

(Hazardous incidents may be reported to your local Coastguard Station.)

Maritime Accident Investigation Branch (MAIB) reports and incident report forms are available on their website:

www.maib.gov.uk

MAIB 24 hr Telephone No:

02380 232527

CHIRP

MARITIME REPORT FORM

CHIRP is totally independent of the MCA and any organisation in the maritime sector

Name:

Address:

Post Code: Tel:

e-mail: ◣ Indicates Mandatory Fields

1. Your personal details are required only to enable us to contact you for further details about any part of your report. Please do not submit anonymous reports.
2. On closing, this Report Form will be returned to you.
   NO RECORD OF YOUR NAME AND ADDRESS WILL BE KEPT
3. CHIRP is a reporting programme for safety-related issues. We regret we are unable to accept reports that relate to industrial relations issues.

It is CHIRP policy to acknowledge a report on receipt and then to provide a comprehensive closing response, if required. If you do not require a closing response please tick the box:

No. I do not require a response from CHIRP ☐

If your report relates to non-compliance by another vessel with regulations, for example the International Regulations for Preventing Collisions at Sea, CHIRP generally endeavours, when appropriate, to follow this up with the owner or manager of that vessel, unless you advise otherwise. The identity of the reporter is never disclosed.

No. You do not have my permission to contact a third party ☐

If your report relates to safety issues that may apply generally to seafarers, it may be considered for publication in MARITIME FEEDBACK unless you advise otherwise. Reports may be summarised. The name of the reporter, the names of vessels and/or other identifying information are not disclosed.

No. Please do not publish in MARITIME FEEDBACK. ☐

PLEASE COMPLETE RELEVANT INFORMATION ABOUT THE EVENT/SITUATION

YOURSELF - CREW POSITION

MASTER	☐	NAVIGATING OFFICER	☐
CHIEF ENGINEER	☐	ENGINEER OFFICER	☐
DECK RATING	☐	ENGINE RATING	☐
CATERING	☐	OTHER (HOTEL, ETC)	

THE VESSEL:

TYPE (TANKER, BULK CARRIER, PASSENGER, ETC)		
YEAR OF BUILD / GT		
FLAG / CLASS		
NAME OF VESSEL:		

EXPERIENCE / QUALIFICATION

TOTAL YEARS		YRS
YEARS ON TYPE		YRS
CERTIFICATE GRADE		
PEC ☐	YES ☐	NO ☐ NA
OTHER QUALIFICATIONS:		

THE INCIDENT

DATE OF INCIDENT		AT SEA ☐	IN PORT ☐
TIME	LOCAL/GMT	DAY ☐	NIGHT ☐
VESSEL LOCATION		HOURS ON DUTY BEFORE INCIDENT (IN PREVIOUS 24 HRS):	

TYPE OF VOYAGE

OCEAN PASSAGE	☐	COASTAL	☐
INLAND WATERWAY	☐	OTHER	☐

TYPE OF OPERATION

COMMERCIAL TRANSPORT	☐	OFFSHORE	☐
FISHING	☐	LEISURE	☐

WEATHER

WIND FORCE		DIRECTION	
SEA HEIGHT		DIRECTION	
SWELL HEIGHT		DIRECTION	
VISIBILITY		RAIN	☐
FOG	☐	SNOW	☐

VOYAGE PHASE

PRE-DEPARTURE	☐	ARRIVAL / PILOTAGE	☐
UNMOORING	☐	MOORING	☐
DEPARTURE / PILOTAGE	☐	LOADING	☐
TRANSIT	☐	DISCHARGING	☐
PRE-ARRIVAL	☐	OTHER (SPECIFY IN TEXT)	☐

THE COMPANY

NAME OF COMPANY:	TEL:
DESIGNATED PERSON ASHORE (OR CONTACT PERSON):	FAX:

DESCRIPTION OF EVENT - PHOTOGRAPHS, DIAGRAMS AND/OR ELECTRONIC PLOTS ON A CD ARE WELCOME:

Your narrative will be reviewed by a member of the CHIRP staff who will remove all information such as dates/locations/names that might identify you. Bear in mind the following topics when preparing your narrative:

Chain of events • Communication • Decision Making • Equipment • Situational Awareness • Weather • Task Allocation • Teamwork • Training • Sleep Patterns

continue on reverse

PLEASE PLACE THE COMPLETED REPORT FORM, WITH ADDITIONAL PAGES IF REQUIRED, IN A SEALED ENVELOPE (no stamp required) AND SEND TO:

CHIRP • FREEPOST (GI3439) • Building Y20E • Room G15 • Cody Technology Park • Ively Road • Farnborough • GU14 0BR • UK

Confidential Tel (24 hrs): +44 (0) 1252 393348 or **Free***fone* (UK only) 0808 100 3237 and Confidential Fax: +44 (0) 1252 394290

Report forms are also available on the CHIRP website: **www.chirp.co.uk**

For market research purposes, where did you obtain this report form:

LESSONS LEARNED

Describe the lessons learned as a result of the incident. Do you have any suggestions to prevent a similar event?

The UK Confidential Hazardous Incident Reporting Programme

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