

CHIRP FEEDBACK

Issue No: 12

3/2006

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Number of Reports since the Last Issue: - 45

Report Topics Have Included:

- Rosters & Fatigue
- Alcohol Use
- Near-collisions
- VHF Misuse
- Wake-wash incidents
- Electronic Chart Displays
- Familiarisation

BACK ISSUES

Back issues of CHIRP FEEDBACK are available from our website: www.chirp.co.uk

The MCA's 24hr Info No. is 0870 6006505.
 (Hazardous incidents may be reported to your local Coastguard Station.)

REPORTS

REPORTS ARE PUBLISHED ONLY WITH THE AGREEMENT OF THE REPORTER AND ARE, AS FAR AS POSSIBLE, IN THEIR OWN WORDS, EDITED ONLY TO REMOVE IDENTIFYING TEXT. THE SAFETY CONCERN(S) RAISED ARE BASED ON THE INFORMATION PROVIDED BY THE REPORTER AND THEREFORE REPRESENT THE REPORTER'S PERSPECTIVE.

MERCHANT SHIPPING

SITUATIONAL AWARENESS & SEAMANSHIP (1)

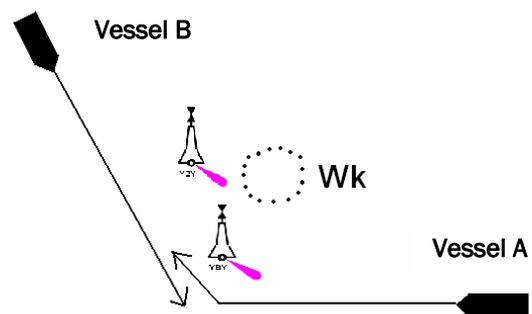


Illustration only. Not to scale.

Report Text:

0645 Pilot disembarked.

0650 "Vessel B" called on VHF requesting our intention.

I advised him that I would come to stbd. when my vessel was clear of the buoys. He said he would maintain his course and speed. At the time I did not have him plotted on my radar and did not appreciate how close he would pass the buoys.

In the event, he passed only about 1/2 a mile from the buoy, so I ended passing about 2 cables from the "Vessel B" and the buoy.

Afterwards VTS called "Vessel B" advising him that he exercised very poor seamanship; he should have passed the buoy at a greater distance to give my vessel more room.

I would class this as a near-miss.

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

A Maritime Safety Newsletter

from **CHIRP** the Confidential Hazardous Incident Reporting Programme

CHIRP Comment: This report was forwarded to the operator of Vessel B, who disagreed with the analysis of Vessel A and the VTS; believing Vessel A was most at fault as the give way vessel for not appreciating the risk of collision earlier and acting accordingly.

Looking only at Rule 15, Vessel B is correct, however Rule 2 does state:

(a) Nothing in these Rules shall exonerate any vessel, or the owner, master or crew thereof, from the consequences of any neglect to comply with these rules or of the neglect of any precaution which may be required by the ordinary practice of seamen, or by the special circumstances of the case.

(b) In construing and complying with these Rules due regard shall be had to all dangers of navigation and to any special circumstances, including the limitations of the vessels involved, which may make a departure from these Rules necessary to avoid immediate danger.

The bridge team on Vessel A should have been monitoring the movement of other vessels irrespective of any other activities being undertaken. The VHF communication from Vessel B indicates the bridge team had been monitoring and were aware of the developing situation, but both bridge teams should also have been aware that the planned manoeuvre would occur close to the buoys.

Slowing down could have resolved this situation, but as with many other incidents reported in these pages, it does not appear to have been considered.

The Maritime Advisory Board considered that in this situation it would have been appropriate and seamanlike in these special circumstances for Vessel B to have altered to starboard to allow more room for Vessel A's intended manoeuvre.

A good bridge team will make an assessment of planned manoeuvres and their impact, and may facilitate application of the Rules or even deviate from accepted practice if the situation warrants it and a proper assessment of the situation has been made.

SITUATIONAL AWARENESS & SEAMANSHIP (2)

Report Text: A tanker loaded with gas oil (diesel) was on passage from Rotterdam. It was approaching the South Falls Buoy about 4.5 cables from the eastern edge of the SW lane with a small vessel about 1 mile ahead on its stbd bow. A faster vessel was coming up astern and I expected him to overtake on the stbd side. However I noticed he altered course to port. The tanker called him up on the VHF suggesting he overtake on the stbd side as there was much more room, but he insisted on passing to port. He passed less than 1/2 mile off and probably entered the separation zone. The tanker actually altered course

to stbd to give him more room and advised the overtaking vessel of what he was doing. The overtaking vessel did not give any real reason for overtaking on the port side and I was very surprised at his actions, needlessly passing so close to a loaded tanker. The weather was fine; wind force 4 SW. Clear vis.

CHIRP Comment: This report was sent to the overtaking vessel's operator for assessment. The Maritime Advisory Board are grateful to the operator and the officers onboard for looking into the incident and providing the following response:

"Having reviewed the reports from our vessel and the tanker there does not appear to be a conflict in the facts of the manoeuvre. Our vessel's plan was to avoid the separation lane to the North, pass 0.5 miles off the tankers and be back on track for the Dover transit. The main issue appears to be that the tanker believes 0.5 miles was too close, yet clearly the Master and OOW both believed it was an acceptable passing distance. This view is supported by the company in the light of the second vessel ahead, the speed and manoeuvrability of own ship, the sea area they were operating in, where close passing is a fact of life, and that a plan had been prepared, explained and executed correctly."

The Maritime Advisory Board agreed with the Company's assessment of this incident, which provides a good example of the situational assessment recommended in the previous report resulting in a variation of accepted practice; in this case the practice of overtaking on the starboard side, under controlled conditions.

WORK PREPARATION & PLANNING

Report Text: It was after finishing a coffee break, where I was told by my 2/E to take out the connecting pipe of a condenser S.W. side in order to clean up inside the tube. The we together closed the inlet & outlet of S.W. line of the condenser and he (2/E) bypass the condensate stem that goes to the condenser, but he forget to closed the supply steam from the boiler; so as I was told to take out the pipe that has no more bolts and nuts and ready to taken out and the water has been drain already, the 2/E order me to lift up the pipe, as I lift up it, hot water poured into my neck and I covered it with my left arm and, because I was using a ladder, I tumbled down the floor. Luckily I did not hurt my head, only burn arms & neck down and then at a few minutes it was still ok.

I did not yet feel pain but my arm and body is hot, so I rushed to the ship's hospital together with my 3/E and 2/E. In there they call the Capt. And the 2/O who is acting as a doctor in the ship, but the 2/O only looking at me and did not do anything. Maybe he did not know what he would do! Only the

3/E give me cold ice water for first aid and at that time already the burn is now painful and the Capt. said if I can manage to dress up in order to get into a hospital and I said "Yes", but the burn getting really painful. After dressing up the C/O told me to go with the agent to take me to a doctor and I did.

The engineer officer must have a checklist of the job or a major job for the future, in order to be sure that all necessary v/v's, pumps, etc.....is been done before the taken up or ordering the crew to take out something and must be checked by the C/E.

And with regards to the 2/O on board he ok they must know what to do in time of emergency to apply first aid not just looking at the patient or person's hurt! The IMO must evaluate this kind of officers and take up some necessary steps to improve them.

CHIRP Comment: Unfortunately this is an all too common accident. On the facts reported there are serious failings in the work planning and risk assessment processes, as the reporter has correctly observed. A good deal of useful guidance in this area is contained in the UK's Code of Safe Working Practices for Merchant Seaman, which is recommended reading (Download from www.mcga.gov.uk/c4mca/coswp.pdf).

In section 1.3 Principles of risk assessment, the Code states:

“1.3.1 A “risk assessment” is intended to be a careful examination of what, in the nature of operations, could cause harm, so that decisions can be made as to whether enough precautions have been taken or whether more should be done to prevent harm. The aim is to minimise accidents and ill health onboard ship.

1.3.2 The assessment should first establish the hazards that are present at the place of work and then identify the significant risks arising out of the work activity. The assessment should include consideration of the existing precautions to control the risk, such as permits to work, restricted access, use of warning signs or personal protective equipment.”

There is little evidence in this report to suggest any such assessment took place and a permit to work system with appropriate double checking does not appear to have been used. In such circumstances the risks of an accident are much higher.

Even without risk assessment, applying the general guidance contained in 22.4 Maintenance of machinery, may have prevented this accident from happening:

22.4.2 Where valves or filter covers have to be removed or similar operations have to be performed on pressurised systems, that part of the system should be isolated by closing the appropriate valves. Drain cocks should be opened to ensure pressure is off the system.

22.4.3 When joints of pipes, fittings, etc, are being broken, the fastenings should not be completely removed until the joint has been broken and it has been established that no pressure remains within.

Much of the Code (Reproduced under the terms of Crown Copyright Guidance issued by HMSO) is based upon the learning points from accidents, so others do not always have to learn the hard way.

The report was also forwarded to the Chief medical Adviser to the UK Maritime and Coastguard Agency, who provided the following comments with respect to the first aid aspects of this report:

“Reading the report indicates that the vessel was in port and as such first aid onboard rather than definitive treatment would be expected. Also I am writing as if it was a UK flag ship but for others the International Medical Guide for Ships or another national equivalent would give the relevant information. All responsible officers on any but the smallest coastal vessel should have received medical first aid training as this is an international requirement.

It would appear that the appropriate first aid measures were not taken, however without further clinical information it is not possible to form a view on the severity of any scalds and hence the need for action. The responsible officer should have received training in medical first aid and this would have included the use of both the ship's medical stores and the Ship Captain's Medical Guide (22 Edn.) The first aid treatment is, where possible, to immediately cool the area with cold water and then to cover with a dry, non-fluffy dressing (SCMG p 17). It seems that medical care was close at hand, but had this not been so then longer term treatment recommendations should have been followed (SCMG p 82-83)”

What is the work planning like on your ship? Are you confident this could not happen to you and, if it did, that you would receive the appropriate treatment?

RADARS AND PARALLEL INDEX LINES.

Report Text: Some radars, although type tested have a severe navigational limitation that I have observed, which I wish to bring to your attention.

I encounter a wide range of radars with very little opportunity to familiarise myself with their operation before I am using them in earnest. I receive regular radar updating training and know what I want a radar to do, but increasingly, I am unable to do so due the complexity of different knobs and menus that are used by all the various radar manufacturers.

The perception amongst ‘armchair critics’ is that parallel indexing techniques (PI) are employed at all times irrespective of the visibility. I find that on a

large number of radar installations that I come across it is increasingly difficult, if not near impossible, to simply set up a PI. I note that when I refer the problem to the Navigating Officer or Master, they more often than not, also struggle as well.

There is clearly a mismatch between the perception of what navigators are required to do and what is actually achievable. Current type testing has not kept pace with the technical innovations that are being applied by software engineers and embraced by the marketing department.

I have been using marine radars professionally for many years and whilst there have been some considerable overall improvements, there is now too much complexity presented by all the numerous radar manufacturers and little uniformity that would help mariners use the equipment easily and safely. Conversely, airline pilots who are type tested to fly certain aircraft will find that each cockpit they encounter is the same as the last, which gives an 'intuitive' feel to the use of all the equipment – something that due to poor design is alien to the mariner!

CHIRP Comment: Parallel Indexing (PI) is a simple and highly effective navigational technique for monitoring a vessel's track and all navigating officers should be able to use it as a fundamental skill. If difficulties are experienced in setting a PI up on particular radar types this should be reported through your Safety Management System, so manufacturers may be informed.

There have been a number of accidents in the past; such as the "Exxon Valdez", where the use of PI may have provided early warning of danger. It is a matter of concern to the Maritime Advisory Board that some radar equipment may not facilitate the use of this technique.

This report was accompanied by a detailed study of several radar types detailing the steps required to set up a PI and outlining the difficulties experienced. The report and attachments have been sent to the Nautical Institute for discussion with the International Electrotechnical Commission (IEC) and also to the Maritime Ergonomics Special Interest Group (MarESIG). MarESIG have published the issue on www.maresig.org.

The recently published CHIRP report on Marine Operating & Maintenance Manuals addresses the complexity of navigational systems in part and suggests standard document formats have a role to play in promoting efficient familiarisation and operation of equipment, however there is also an argument for specifying and prioritising basic functionality such as PI.

Design and operational issues such as these are important and CHIRP is well placed to bring these issues to the attention of those in a position to do something about them. Many manufacturers are

keen to learn from end users, so if you want your voice to be heard, CHIRP!

FATHOMS, FEET OR METERS?

Report Text: Whilst navigating up a river estuary, I was being followed some miles back by a coaster. All commercial shipping is under pilotage.

I overheard a radio conversation with the port to the effect that the pilot was calling for 5.6m draught in the lock to which he received the reply that there was now 19ft which he accepted. I see this as an accident waiting to happen when there is perhaps some confusion, poor radio transmission or similar.

I have noticed this mix up of units going on in the past and have taken it up with the port management. Using these waters again recently; there is certainly no change.

CHIRP Comment: Different units of measurement are still in use in different parts of the world and mariners transiting between these areas need to be aware of the change.

As this report illustrates, in some countries, such as the UK, it is quite possible to encounter different units of measurement in the same sentence.

The difference between 6 meters under the keel and 6 fathoms may be the difference between a good and a bad day at the office!

LEISURE

READY TO GO TO SEA? (1)

Report Text: I recently took delivery of a new power boat, picking it up on a Friday. I did not have time to check it out completely, but the dealer had used the boat for a couple of demos with my permission up the river.

When I took delivery of it, I filled it to the top at a petrol station and, because I was standing on tip toes, I overfilled it slightly. When I put the boat in the water I noticed some petrol in the bilge and, assuming it was from the earlier spill, cleaned it out. I could still smell petrol and also discovered that one of the trim legs was not working and reported this to the dealer.

In the morning the boat stank of fuel I evacuated my family and I checked where the smell was coming from and it seemed to be the heads, it was so strong it was hard to breath, I opened all the windows to let air in, I then checked the bilge and found gallons of fuel in it and the surrounding area I realised the vapour had been going down the waste pipe channel into the heads, I cleaned out the whole bilge. Later in the day the bilge looked great and clean, the dealer called me to try and assist with the problem with the leg, I explained about the fuel leak and it confused us both.

I was guided on my mobile phone through the cables from the throttle to the engine and then to the servo tank where there were solenoids, I was asked to remove a screw on a plastic plate to get to them, it was getting dark, this was at the rear of the bilge and I had to use a torch. I read out a warning above the screw about the screw being attached to the positive feed and asked whether I should turn off the blowers and ignition to which I was told yes, I did this and then put the screwdriver on the screw, as I did so it touched the metal pipework to the fluid container and went BANG!! I was thrown across the bilge with the big spark/explosion, the screwdriver had weld marks where it had touched the pipework I was in bare feet standing in the remains of the water in the bilge after cleaning it I then told the dealer I WAS NOT touching another thing and left the boat. The next day I checked it and found that loads of more fuel had filled the bilge, it was a FLOATING BOMB, and it was removed from the marina by crane.

Subsequent investigation discovered the fuel was coming out of the top of the tank leaking from a faulty part of the sender unit. I and my family slept the night on that boat not knowing we were surrounded by pure petrol. I had made cup of tea the night before on the stove, it is dual fuel and the electric part was not working for some reason, I used the meths option to boil the water!

The leak was not detected before because during the demos the dealer only had a small amount of fuel in. I must be the luckiest person alive, why I was not blown to SMITHERINES I do not know, all I do know is that this has scared the crap out of my family, what if we had not fully filled the tank and it had gradually leaked for months until one day we are moored up having a cup of tea and BANG!! We are dead, who would ever have found the fault? Am I lucky or what?

What lessons can we learn here to share with others? I am still in shock really, the more I think about it the more I don't understand why I am not DEAD.

CHIRP Comment: There are a number of important safety points in this report which the Maritime Advisory Board wish to emphasise:

- Purchasers should check what pre-delivery testing has been undertaken by vendor.
- On taking delivery of a new or second-hand craft owners should ensure it is thoroughly checked out.
- Any identified problems should be traced until the source has been identified.
- Maintenance/repair should only be undertaken by competent persons in all but exceptional circumstances.

The reporter was indeed lucky and CHIRP is grateful for this report which we hope will encourage others to check thoroughly and not take the risk of being less fortunate.

READY TO GO TO SEA? (2)

Report Text: We were on passage when we saw a RIB stationery in the fairway with someone jumping up and down waving hands in the air. We assumed they were in distress and went over to investigate. There were two persons onboard and a small dog. (The dog was the only one with a lifejacket). The owner explained that he had bought the boat that day and was trying it out. He had no radio, flares, oars, anchor or much else and had suffered engine failure. We offered to pass a tow line, which was accepted and we towed him in to a marina where we dropped the tow. We passed him a paddle so he could get ashore. The owner of the RIB thanked us for our assistance later and returned our paddle. With hindsight I should have contacted the Coastguard (just to keep them advised).

CHIRP Comment: This is a common incident and again illustrates the need to be prepared to go to sea by ensuring adequate safety equipment is available (not just for the dog!) and adequate checks have been undertaken before setting out.

For a related incident with a tragic outcome download the report on the investigation of the loss of one man overboard from the sailing yacht "Pastime" from the MAIB website.

We always hope for the best from our trips to sea and are often not disappointed, but we should always be prepared for the worst.

READY TO GO TO SEA? (3)

Report Text: We anchored in the early evening in squally weather. The wind variable in direction but generally NNE and unstable with gusts to 25 knots and heavy rain showers. Just over half way through the evening 8-12 watch an un-designated GMDSS distress alert was received from a sailing catamaran which was at anchor 0.2 miles inshore of our vessel. The substance of the message indicated that an unmanned yacht was adrift in the harbour and had come into collision with the catamaran, monitoring VHF traffic with local Marine Rescue Co-Ordination Centre, indicated no imminent danger to life and the alert was downgraded to PAN PAN (Urgency), almost immediately. The crew of the catamaran seemed to have little appreciation of the situation or how to resolve it and responded with an inappropriate GMDSS distress alert. In response I authorised the launch of our rescue boat to assist the crew of the catamaran who seemed unable to deal with the situation.

Our rescue boat launched with three crew and proceeded to the catamaran where they quickly assessed the situation. A yacht had dragged her anchor and set down towards a catamaran; the anchor of the yacht had fouled on the cable of the catamaran which had the effect of bringing the two boats together. The crew of the catamaran had

deployed some fenders to prevent damage but took no further action. Our rescue boat crew weighed the yacht's anchor and started the main engine. They then cleared the yacht from the catamaran and motored her to the stern of our vessel. Contact was established by heaving line and the yacht secured by two ship's lines. The rescue boat crew replaced the anchor and cable aboard the yacht and considered taking her to a new anchorage for the night. After discussion I recommended the yacht be left secured to our vessel so that she could be kept under observation and to avoid further labour at the end of a very long day.

Just after midnight the yacht's owner/skipper returned by inflatable tender with a lady (presumably his wife) wearing no life jackets and no shoes on a dark and squally night and, after we had explained that their yacht had been adrift and in collision with a catamaran, the couple decided to slip and proceed ashore. The yacht slipped our lines and motored away soon after.

CHIRP Comment: The Maritime Advisory Board believes the yachts involved in this incident were fortunate to have benefited from professional assistance close at hand, however, it is not safe to assume such assistance will always be readily available and there are a number of learning points the Board would like to highlight:

- In deciding whether it is safe to leave a yacht unattended the weather forecast and quality of mooring should be among the factors taken into account.
- Be prepared for the prevailing conditions; wear a lifejacket, this should be as natural as taking a coat or umbrella because it might rain!
- Learn how to use radio communications equipment properly. This is important in all circumstances, but particularly so in the event of an urgency or distress situation; getting it right can save time and lives and reduces the number of "false" alerts watch keepers have to deal with.

EDITORIAL

Edition 12; Maritime CHIRP is three years old. What has been achieved? Can CHIRP show you an accident it has prevented? Obviously this last question can't be answered, but what we can say is that 62% of the 309 reports received have been taken sufficiently seriously for third parties to take action. Even this figure is somewhat misleading because of the remaining reports some did not require third party actions, so the "strike rate" is even higher.

Ninety-five reports have been published in CHIRP FEEDBACK which continues to have a hard copy circulation of 140,000 and is now read in at least 70

countries, so there is little doubt this UK programme has an international impact.

The two thematic reports CHIRP has issued on promoting the reliability of the engine/ship fuel system interface and marine operating & maintenance manuals have prompted encouraging responses from some parts of the industry; an IACS Machinery Panel task holds out some promise of progress in the former and the UK's MCA is sponsoring the latter at IMO.

Encouraging as all this is, shipping is a very large industry and CHIRP is a small part of it; if more is to be achieved in this important proactive area, then more resources will ultimately be required. Concerns remain where there are parts of the industry that give the appearance of not being bothered by failing to even acknowledge receipt of the reports (individual or thematic), let alone showing interest in the issues they are attempting to highlight. Fortunately these occasions are relatively rare and CHIRP is very persistent and has not had to "name and shame" to date.

Thanks are due to all the Members of the Maritime Advisory Board, past and present and their nominating organisations for providing the technical resources which permit CHIRP to function and achieve the results it has. Thanks are also due to all the companies and organisations that have responded so positively to the reports, but most of all, thanks are due to the individuals and companies who take the time and often the risk of sharing their concerns and experiences with CHIRP and without whom, none of the above would be possible.

Safe sailing!

REPORT UPDATE

MARINE OPERATING & MAINTENANCE MANUALS – ARE THEY GOOD ENOUGH?

This report was published at the beginning of July and may be downloaded free from our website. Reaction to the highlighted issues has been very positive and there are encouraging steps being taken to advance the concerns raised.

FEEDBACK 11 – NEAR-COLLISION (OVERTAKING 1)

In the CHIRP comments on this report some confusion arose as to whether the Maritime Advisory Board were recommending shining searchlights into wheelhouses to gain attention in close quarters situations where the give-way vessel did not appear to be giving way or endorsing Rule 34 (d). CHIRP regrets any confusion and has to disappoint any who were looking forward to "laser beaming" offenders; the Board endorses the Rules.

CURRENT MAIB INVESTIGATIONS

The following accidents/incidents are being investigated by the MAIB as at 06.10.06:

Vessel's name	Accident/incident type	Date of Incident
Arctic Ocean/ Maritime Lady	Collision between Arctic Ocean (container vessel) and Maritime Lady (general cargo vessel) in the Elbe, Germany resulting in the sinking of the Maritime Lady.	5/12/05
fv Noordster (Z122)	Capsize of Belgian registered fishing vessel, 11 miles off Beachy Head, resulting in two fatalities, one survivor in hospital and one crewmember missing	14/12/05
Spruce	Accident to person onboard specialised Barge carrier.	06/03/06
Red Falcon	Heavy contact with link-span by ro-ro ferry in Southampton. Four injuries reported.	10/03/06
Star Princess	Fire aboard 109,000GT Bermuda-flagged cruise ship in Caribbean.	23/03/06
mv Neermoor	Crewmember died when hatchway fell on him	27/04/06
The Calypso	Fire in engine room of Cyprus-registered cruise ship in English Channel	06/05/06
Roaring Meg	Serious head injury to a female crew member and broken ankle to a male crew member which occurred onboard a charter yacht	20/05/06
fv Brothers	Loss of fishing vessel and two crewmen	01/06/06
Skagern/ Samskip Courier	Collision between vessels on the River Humber	07/06/06
fv Danielle	Injury sustained to crew member whilst on board fishing vessel	05/06/06
fv Pamela S (IH 308)	Capsize of 8m fishing vessel near Tenby, South Wales with one fatality and one injury.	17/06/06
Marie Claire	Flooding of fishing vessel whilst in Coastal waters	13/07/06
Dartmouth Speedboat	A speedboat collided with a moored motorboat, resulting in a serious injury to one person on board the speedboat	24/07/06
Midland 2	Grounding of cargo vessel off Plymouth	10/08/06
Thunder	Grounding of cargo vessel whilst at anchor in the approaches to River Dee.	10/08/06
Natalie/ Bay Protector	Collision between fv Natalie and Tug Bay Protector, causing damage to the fishing vessel.	12/08/06

Mollie Louise	Three people fell overboard the yacht, 40 miles east of Spurn Head, resulting in one fatality.	12/08/06
Ouzo	Sailing yacht missing with three persons onboard. Three bodies have been recovered off the coast of the Isle of Wight.	22/08/06
Hilli	Fatal accident onboard the LNG Tanker Hilli. The accident was reported to the MAIB on 10/7/2006.	13/10/03
fv Sian Elizabeth	Injury to crewmember aboard cockle dredger	14/09/06
Thomson Celebration	Crewmember was fatally injured while the vessel was alongside in Guernsey.	26/09/06
MAIB reports and incident report forms are available on their website www.maib.gov.uk and their 24 hr tel. no. is 02380 232527.		

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CHIRP

MARITIME REPORT FORM

CHIRP is entirely independent of any other organisation involved in the maritime sector, whether regulatory, operational, manufacturer or supplier.

NAME: _____ ADDRESS: _____ POST CODE: _____ TEL: _____ DO YOU HAVE A PREFERRED DATE AND/OR METHOD FOR CHIRP TO CONTACT YOU?:-	1. THIS REPORT WILL ONLY BE SEEN BY CHIRP STAFF. 2. YOUR PERSONAL DETAILS ARE REQUIRED ONLY TO ENABLE US TO CONTACT YOU FOR FURTHER DETAILS ABOUT ANY PART OF YOUR REPORT. 3. YOU WILL RECEIVE AN ACKNOWLEDGEMENT AS SOON AS POSSIBLE. 4. THIS REPORT FORM WILL BE RETURNED TO YOU OR DESTROYED. <p style="text-align: center;">NO RECORD OF YOUR NAME AND ADDRESS WILL BE KEPT. THE REPORT WILL NOT BE USED WITHOUT YOUR APPROVAL.</p>
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PLEASE COMPLETE THE **RELEVANT** INFORMATION ABOUT THE EVENT/SITUATION

YOURSELF - CREW POSITION			THE INCIDENT			
MASTER <input type="checkbox"/>	NAVIGATING OFFICER <input type="checkbox"/>		DATE OF OCCURRENCE		TIME	(LOCAL/GMT)
CHIEF ENGINEER <input type="checkbox"/>	ENGINEER OFFICER <input type="checkbox"/>		LOCATION:			
DECK RATING <input type="checkbox"/>	ENGINE RATING <input type="checkbox"/>		AT SEA <input type="checkbox"/>		DAY <input type="checkbox"/>	NIGHT <input type="checkbox"/>
CATERING <input type="checkbox"/>	OTHER (HOTEL, ETC) <input type="checkbox"/>		IN PORT <input type="checkbox"/>		HOURS ON DUTY BEFORE INCIDENT (IN PREVIOUS 24 HRS)	
THE VESSEL			TYPE OF VOYAGE		TYPE OF OPERATION	
TYPE (TANKER, BULK CARRIER, PASSENGER, ETC)			OCEAN PASSAGE <input type="checkbox"/>	COASTAL <input type="checkbox"/>	COMMERCIAL TRANSPORT <input type="checkbox"/>	OFFSHORE <input type="checkbox"/>
YEAR OF BUILD / GT			INLAND WATERWAY <input type="checkbox"/>	OTHER <input type="checkbox"/>	FISHING <input type="checkbox"/>	LEISURE <input type="checkbox"/>
FLAG / CLASS						
EXPERIENCE / QUALIFICATION			WEATHER		VOYAGE PHASE	
TOTAL YEARS		YRS	WIND FORCE	DIRECTION	PRE-DEPARTURE <input type="checkbox"/>	ARRIVAL/PILOTAGE <input type="checkbox"/>
YEARS ON TYPE		YRS	SEA HEIGHT	DIRECTION	UNMOORING <input type="checkbox"/>	MOORING <input type="checkbox"/>
CERTIFICATE GRADE			SWELL HEIGHT	DIRECTION	DEPARTURE/PILOTAGE <input type="checkbox"/>	LOADING <input type="checkbox"/>
PEC <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA			VISIBILITY	RAIN <input type="checkbox"/>	TRANSIT <input type="checkbox"/>	DISCHARGING <input type="checkbox"/>
OTHER QUALIFICATIONS:			FOG <input type="checkbox"/>	SNOW <input type="checkbox"/>	PRE-ARRIVAL <input type="checkbox"/>	OTHER (SPECIFY IN TEXT) <input type="checkbox"/>
THE COMPANY						
NAME OF COMPANY:					TEL:	
DESIGNATED PERSON ASHORE (OR CONTACT PERSON)					FAX:	

ACCOUNT OF EVENT - (PLEASE DESCRIBE THE EVENT, WHY IT RESULTED OR COULD HAVE RESULTED IN AN INCIDENT AND WHAT MIGHT BE DONE TO PREVENT IT HAPPENING AGAIN. PLEASE CONTINUE ON ADDITIONAL SHEETS IF NECESSARY)



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

CHIRP • FREEPOST (G13439) • Building Y20E • Room G15 • Cody Technology Park • Ively Road • Farnborough • Hampshire • GU14 0BR • UK

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

For e-mail reports first apply for a security certificate to confidential@chirp.co.uk with "Certificate" in subject line only; submit no other information.

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