

CHIRP FEEDBACK

Issue No: 14

1/2007

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Number of Reports since the Last Issue: - 41

Report Topics Have Included:

- Collisions
- Groundings
- Near-collisions
- Fire risks
- Overloading
- Risk assessment and work planning
- Wake-wash incidents
- Navigation lights

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.)

MAIB reports and incident report forms are available on their website www.maib.gov.uk and their 24 hr tel. no. is 02380 232527.

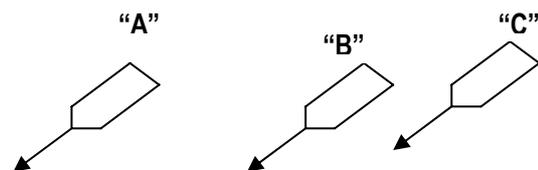
REPORTS

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.

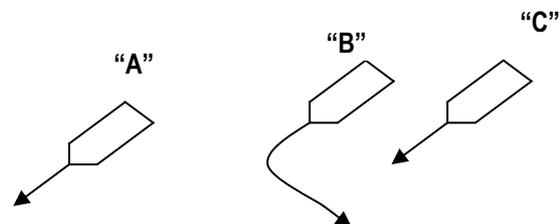
MERCHANT SHIPPING

NEAR- COLLISION – “SISTER” SHIPS

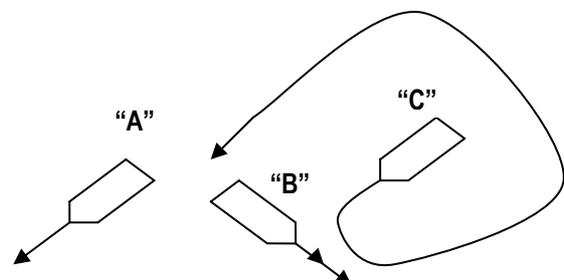
Report Text:



First “B” cuts across bows of “C”.



“C” has to alter 360° to avoid collision with “B” cutting across bows. No warning given. Near-collision. Appalling seamanship.



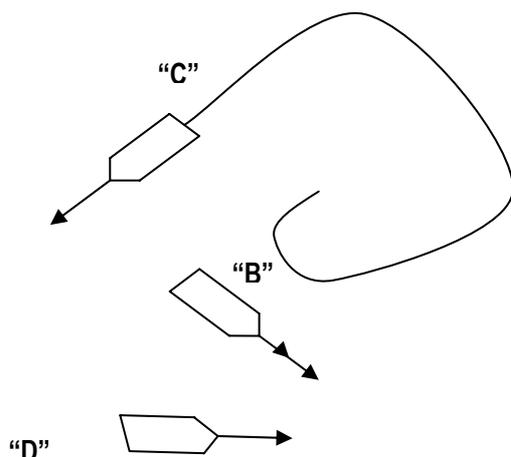
“B” now on collision course with Vessel D, who calls her up and she has to stay on course for three miles

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

A Maritime Safety Newsletter

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

before altering to port. Very open water, no traffic to worry about!



"B" has absolutely no idea or conception of traffic rules or seamanship and is an accident waiting to happen.

Eventually "B" is persuaded to alter course to port towards her destination and away from Vessel "D". The "Navigating" officer has obviously been instructed to blindly follow the red line on the radar without deviation.

CHIRP Comment: Initial investigation indicated vessels "B" and "C" were operated by the same company and CHIRP approached them to ensure they were aware of the incident. Subsequently it was discovered the two vessels were time-chartered and technically managed by separate companies, who provided the following edited accounts at the Charterer's request, first from Vessel "B":

With reference to the Near Miss Navigation Incident between the Vessel "B" and Vessel "C", we have carried out an investigation and would like to report the following:

Both the vessels were navigating in the Southwest Safety Fairway (in a high traffic density area) on a south westerly course with Vessel "B" doing about 14 knots with Vessel "C" overtaking.

At about 1205 hrs LT, Vessel "C" was noticed on the port quarter, overtaking on the port side. Vessel "B" was a bit concerned about this and raised Vessel "C", informing Vessel "C" of her destination and that she would be altering course to port shortly. This was acknowledged by the Vessel "C". The AIS on the Vessel "B" was also programmed to show her destination.

Since Vessel "C" was the overtaking vessel, it was her duty to keep clear of the Vessel "B" till finally past and clear. Also, general seamanship practices suggest that vessels be overtaken

from the stbd side. However, Vessel "C" continued on her course and speed.

At 1225 LT, Vessel "C" was reminded by Vessel "B" that they will be altering course shortly. This was acknowledged by the other vessel.

At 1445 LT, when Vessel "C" was about 1.3 miles on the port quarter, after assessing the situation, Vessel "B" informed Vessel "C" of her intentions, and altered course to port.

Shortly afterwards, Vessel "C" was noticed to alter course to port and taking a full turn to keep clear.

The above situation could have been easily avoided if the Vessel "C" had correctly assessed the situation and taken early action.

Next we hear from Vessel "C":

I clarify incident reported by CHIRP and report is correct.

According COLREG Rule 8 "Action to avoid collision" I decided that I have only one possibility to avoid close-quarters situation and risk of collision with actions:

Immediately rudder was made hard to port (very short distance, no idea which course she will have and her intention) to keep as far as possible from vessel which suddenly (without any notice) altered her course to port and cuts across our bow.

Master was informed immediately and he was present on bridge during the circulation.

From my side I did my best for prevention collision according regulation and good sea practice.

The reason for the sudden manoeuvre of Vessel "B" is unknown.

There was nothing in the course of the Vessel "B" which forced them to alter course that drastically- open water, clear way (as mentioned in report).

The closest distance during the manoeuvre of circulation between our vessels was approx 0.2-0.3miles.

Finally we hear from the Charterer:

We meet with our suppliers, in this case the Owners of the Time-Chartered Vessels, regularly and present them with our views, concerns and wishes in respect to various matters related to the business.

As pointed out, our company/brand, are vulnerable towards accidents, bad press etc thus we do all that we can think of to protect it. We will use this case in our next presentation to the various Owners we deal with and we have of course already shared it internally to all relevant parties.

CHIRP Comment: The Maritime Advisory Board is grateful to the Charterer and the Owners/Managers involved for their co-operation in looking into these incidents and sharing their investigations with CHIRP.

The Board notes the accounts provided by the owner/operators conflict and suggests the Charterer, on the information supplied, has not gained much, if any, reassurance that the risks to safety and their brand have been adequately identified or mitigated.

The Board recommends that incidents of this nature should be investigated as if they were accidents if the maximum benefit is to be gained from them.

The following report, submitted by a company to CHIRP for the benefit of the industry, provides a good example of how these incidents should be treated.

DRYDOCK - HOTWORK IN VICINITY OF OPERATING HYDRAULICS

Report Text: Contractor was discovered hot working in the vicinity of the vessel's steering compartment whilst aft mooring hydraulic system was in operation. Had there been a hydraulic leak there could have potentially been a fire and/or explosion. The conflicting work had been discussed at the daily work planning meeting, however it had been misunderstood by the contractor foreman.

What went well:

- Prior to the incident the daily planning meetings had been effective in ensuring all involved were aware of work planned for the day,
- The ship's safety officer suspended the hot work immediately and reported the near miss to the yard safety officer and master,
- A meeting was convened shortly after with all involved to discuss what went wrong and what could be improved. These were implemented immediately,
- A mass toolbox briefing was held the next day with all contractors attending the vessel to discuss the initial findings of the incident,
- Shipyard completed over 400,000 man hours during the refit without injury.

What went wrong (Critical Factors):

- The yard's permit to work system allows hot work permits to be suspended, but not cancelled nor removed from site, during activation of hydraulic systems. This is typically coordinated at the daily work planning meeting and the permits are not returned to the yard HSE Officer,
- Communication from the meeting to the sub-contractor foremen and subsequently the

workers was poor, resulting in lack of understanding. The venue of the daily work planning meeting was becoming congested and the contractor foreman was too far away from the discussion to clearly understand the instructions.

Lessons learned & Recommendations:

- Changes should be made to the Safety Management Plan for vessel refits, or to the HSE elements of the contractual documents between owner and shipyards where they exist, to ensure that actuation of hydraulics, or transfer of other flammable fluids, forms part of the yard's permit to work system,
- Consideration should be given to the venue of daily work planning meetings, including but not limited to, general location, noise levels, seating arrangements, essential attendees, policy on disturbances, etc where these are able to be modified,
- It must be ensured that any key messages resulting from the daily work planning meeting are adequately passed to the yard workers and sub-contractors. The use of daily toolbox talks would seem to be the best method.

Conclusion

In conclusion the importance of adequate communication must be the significant root cause of this near miss – whether this is verbal or via posted information (including hot work permits). The challenge is to ensure that all those involved in the repair of vessels in a shipyard are fully aware of the work of others and the systems still in operation.

The efficiency of the permit to work system used by shipyards must also be vetted thoroughly, possibly as part of the HSE inspections already carried out to keep them on the approved list, and measures put in place to ensure that the recommendations are implemented.

COLLISION WITH FISHING VESSEL

CHIRP Comment: Here is another company investigation report of a high standard; whilst the format is slightly different, the results are similar in effect.

Report Text: At 04:59 a loaded merchant vessel collided with a wooden fishing vessel of less than 20m in international waters. The fishing vessel sustained extensive damage above the waterline but safely made port under her own power. The fishing vessel's crew suffered minor injuries and the merchant vessel sustained minor scuffing damage.

The 04-08 morning bridge watch consisted of an experienced Officer of the Watch (OOW) and a JOS (Junior Ordinary Seaman) lookout. At the time of the collision it was dark, the visibility was good (>8nm), the wind was light, the sea state was calm and the traffic density was light. The vessel was approaching

a waypoint to alter course from 295° G to 270° G. A red light was reported by the lookout fine to port at 04:41 and again reported to port at 04:56 but was assumed by the OOW to be a target further away (>9 nm).

The OOW was monitoring the 3cm radar and reports that no target was observed on this unit. The Simplified Voyage Data Recorder (SVDR) shows that the target was picked up quite clearly by the 10cm radar. As the vessel approached the new course of 270°G a single red light and corresponding silhouette was observed directly ahead before being lost from view beneath the bow. The collision occurred at 04:59 when a light bang was reported coming from forward. On moving to the starboard side of the bridge the OOW and the lookout observed a fishing vessel was passing down the starboard side. The Master was immediately informed.

The vessel reduced to manoeuvring revolutions and turned around to assist the fishing vessel. The vessel's rescue boat and lifesaving appliances were prepared. The nearest coast radio station and coastguard were informed. The vessel attempted to make radio contact with the fishing vessel but this was not successful, possibly due to the damage sustained during the collision. The Operator's 24hr duty phone was called and operator advised of the situation. Damage to the vessel was assessed and found to be minimal. The vessel stood by until a coastguard vessel rendezvoused with the fishing vessel to escort her into port. Upon instruction from the local authorities the vessel continued on her voyage. After the incident the OOW concerned was removed from watch keeping duties and was repatriated at the next opportunity.

Investigation by the Operator

An investigation team boarded the vessel at the earliest opportunity. Statements were taken and evidence removed from the vessel, included the SVDR data. The OOW concerned attended the operator's office for a further interview. Following a review of the investigation report, the VDR data and the interview with the OOW, the following conclusions were made:-

- The lights that were seen were not positively verified against a radar target,
- A visual lookout was maintained and all lights were observed, however the lights of the fishing vessel were incorrectly identified,
- Radar observation was undertaken only on the 3cm radar,
- It is probable that the 3 cm radar was not tuned to provide optimum performance. (There is no evidence to prove this other than the fact that the fishing vessel target was apparently not detected on this radar),

- The 3cm and 10cm radars were on different ranges but the 3cm was incorrectly set to the longer range (12nm) and the 10 cm was set to the shorter range (6nm),

NOTE: 10 cm (S band) radar provide better detection at longer range and 3cm (X band) radar provides better definition at smaller ranges.

- The alteration of course at the waypoint was made using the autopilot in small increments that would not be readily apparent to another vessel (The fishing vessel) observing visually or by radar,
- The OOW did not advise the lookout of the alteration of course.

With respect to the conduct of the OOW, the investigation team concluded that:

- There had been no knowingly breached procedure. While the performance of lookout could have been better by using more of the tools available to him, the OOW and the lookout had observed the fishing vessel lights and had been performing lookout duties,
- The incident occurred due to an error in judgment by the OOW rather than a reckless violation of procedure or by negligence.

Lessons Learnt /Key Messages

- Observed targets and lights should be positively identified and compared with radar targets to avoid making assumptions on the basis of scanty information.
- All available means shall be used to observe and identify hazards to navigation including sight, hearing, visual bearings, AIS and radar (including auto acquisition tools such as guard rings when appropriate).
- Radar range scale and tuning (gain, sea clutter, rain clutter) should be regularly adjusted throughout the watch in order to increase the probability of detection of weak radar targets.
- Emphasis should be placed upon creating a strong relationship between OOW and lookout that includes good communications (discussions of the traffic & navigational situation) and positive reporting (confirmation of receipt of report).
- The lookout should be encouraged to make use of navigational aids such as radar to increase their situational awareness.

Close Out Action Taken by the Operator / Preventative Action

- The OOW will be issued with a written formal warning.
- The OOW will be targeted for additional training at a Bridge Team Management (CRM) course prior to his next appointment.

- The OOW will undertake a management course at the next convenient opportunity to improve his leadership skills and integrated team working.
- Details of the incident will be promulgated to the fleet, highlighting the mistakes made and the best practices that should be adhered to.
- Identified failures in best practice will be raised with the institutions that conduct the company bridge team management (CRM) courses.
- Details of the incident will be forwarded to the Confidential Hazardous Incident Reporting Programme (CHIRP) and to the Nautical Institute's Marine Accident Reporting Scheme (MARS) to promulgate the learning throughout the industry.

CHIRP Comment: The Maritime Advisory Board wishes to draw attention to and commend two aspects of this report in addition to its general high standard; firstly the fact the merchant ship stood by ready to render assistance after the collision, an action reportedly often not taken, and secondly, the company's commitment to sharing the information as widely as possible. CHIRP is more than pleased to play its part in this.

LEISURE

NEAR-COLLISION – SINGLE-HANDED YACHTSMAN

Report Text: I was sailing single-handed in my yacht which had been substantially refitted during the course of this summer for the purpose of the cruise, of which this was the first stage. I have been sailing, mostly but not exclusively single-handed, for over 40 years. I have held the Yachtmaster Offshore certificate since the early eighties and I also have considerable racing experience in my home waters. I believe I understand the risks of single-handed sailing well and, on voyages such as this one, restrict my sleep breaks to 20 minutes and often wake earlier than this.

As an aid to keeping a lookout, I have fitted two forward-facing windows in the coach roof - there are the standard three each side as well. Otherwise the yacht is fitted out conventionally for this type of sailing, with Hydrovane self-steering and roller-reefing genoa. The fully-battened main rolls round the boom for both reefing and stowage. To aid daytime visibility a top section of the mast is covered with fluorescent orange vinyl and, most importantly, for this trip I have invested in an active radar target enhancer in place of my previous 18-inch conventional square reflector. It is mounted on a separate spar at the stern and stands about 3m above water level. The control box flashes a red LED every time it replies to a radar interrogation, does

not use much current even when doing so, and the makers assure me that the effect on the receiving radar's screen is similar to the echo from a super tanker.

The incident took place at about 49d 52' N 003d 24' W. We were heading for Ushant and right on the rhumbline of 220 degrees, close reaching on port tack under Hydrovane, with the tiller lashed. Both genoa and main were part-reefed as the wind had earlier risen to the lower end of Force 5, and I had left them like that, although it had dropped back to F3, because there was quite a spectacular thunderstorm in the direction of the Channel Islands and also because that raised the foot of the genoa and thus improved visibility from inside. I was thus making about 4 knots and exhibiting only the masthead tricolour light. I had just had "20 winks", taken a look round from inside, without seeing anything, and checked the course and track. The radar enhancer showed that there must be a few radars around. I was sitting on the port saloon berth considering what best to do next when a very loud horn blast precipitated me into the cockpit.

One look round the genoa showed a large vessel behind it coming up Channel. By the time I had reached the tiller, I had rejected the possibility of tacking - it takes too long with the self-steering (and meant turning to port and sailing along with the threat). Whatever I did with the helm, after I had unfastened it, would be immediately counteracted by the self-steering anyway, so I went straight past it and turned the vane, which I never clamp solid, through 90 degrees. Fortunately the Hydrovane's own rudder was up to this challenge and we immediately started to bear away to starboard. Meanwhile the ship's bow had appeared round my forestay (still hooting) and I became concerned as to how wide her beam was... I returned to the tiller, freed it and used the main rudder to finish off the turn, finding that we had less than a boat length clearance when we came to the parallel hull. We continued thus down her side, and I waved at the bridge but couldn't make anyone out. When we got to her stern I was unable to read her name (other than that it seemed very long, possibly three words) against the deck lights. There was no lettering down the side; she was not heavily laden. I would estimate her size as approximately 90 000 tons. At the time she seemed to go on for ever.

I was very grateful for the warning that was given me, late though it was. Had it been any later, or had I been unable for some reason to get to the controls as quickly as I did, or indeed done the wrong thing in the initial surprise, I would not be writing to you now. I think I have drawn all the useful lessons that apply to me from this experience and now look around the genoa at least thrice, but I still wonder how the ship came to be in such a potentially disastrous situation in view of my use of the ARTE.

CHIRP Comment: This incident; so nearly a tragedy, took place close to the Traffic Separation

Scheme (TSS) off the Casquets in the English Channel; one of the busiest commercial waterways in the world. Unfortunately the reporter was unable to see the name of the vessel involved and CHIRP has not been able to trace it.

Merchant vessels navigating in this area will often be lined up for the TSS well before they enter the lanes and therefore traffic is concentrated along the course lines associated with the TSS for a considerable distance before and after the Scheme itself.

Eastbound traffic will generally be following a course of around 075°(T) and westbound around 255°(T); the 220°(T) track reported therefore crosses the lines of traffic obliquely and may cause uncertainty as to whether the yacht is crossing or following the direction of traffic flow. In addition the course selected increases the period of time the yacht is exposed to encounters with merchant vessels.

The “20 winks” reported would appear to have been taken whilst crossing the westbound lane.

The particular radar enhancer in use should have been effective provided the merchant vessel was operating its 10cm radar and this was the radar being used by the Officer of the Watch (OOW). It is entirely possible the OOW may have been observing the 3cm radar on which the radar enhancer would have been ineffective and the yacht more difficult to detect. (See “Collision with Fishing Vessel” earlier).

The Board makes the following comments:

- It is not possible to comply with Rule 5 of the International Regulations for Preventing Collisions at Sea if you are asleep!
- If necessary at all, single handed transits must be approached and planned with particular caution considering factors such as length of transit, avoiding known areas of dense traffic and/or crossing them as quickly as possible.
- At night shining a light on the sail is often of assistance.
- Radar enhancers may be useful, but their limitations should be borne in mind; the handbook for this particular equipment states it: “...does not obviate you from your responsibility under the International Regulations for the Prevention of Collisions at Sea to both keep a good lookout and to take whatever action is required to avoid a collision.”
- Boats under 12m LOA are only required to carry side lights with a visible range of 1nm, which when sailing close hauled and heeled > 5° may be reduced to 0.5nm. 0.5nm will be covered by a ship making 20 knots in 90 seconds i.e. giving just enough time to lean on the whistle if you’re spotted instantly!

- There appears to be an assumption the onus is on the larger vessel to detect the smaller; there is in fact a joint obligation so make sure your life is in your hands!

RACING AGAINST THE RULES

Report Text: I was sailing close hauled on starboard tack at about 3.5 knots, heading a little south of east when I saw two large, apparently identical sailing yachts several hundred metres away to port. They were close hauled on port tack and appeared to be racing. The leading yacht was to port of the second one, tracking about 100 yards from it. It was obvious that a close quarters situation was likely to develop so I considered whether I should move out of their way. As a sailing yacht, mine has many qualities, but speed and windward ability are not included, so, in view of our relative speeds, I decided that my best course of action as stand on vessel was to hold my course and speed. As the leading yacht approached, it bore away in good time to pass close astern of me. I fully expected the second vessel to do the same, but it held its course. Mine is a slow boat and I am used to racing yachts passing me by very close, so I stood on until it became clear that it had no intention of taking any avoiding action and that, without action on my part, a collision was inevitable.

At this point, my options were very limited. I was helming and the only other person on board was disabled and would not have been able to handle the genoa sheets and there was no time to transfer the helm, which is our usual practice when tacking. A turn to starboard would have therefore have left me in irons or hove to with no control and quite possibly still in the path of the other yacht. As a result, I turned more than 90° to port, as sharply as I could, and passed the other yacht starboard to starboard less than 20m away. I would estimate the other yacht's speed as in excess of 15 knots. There was no reaction from the helm or anyone else on board, but I heard loud boos from the first yacht that had already gone past. Had I not made the turn, I am certain that we would have collided and, given the relative speeds and sizes of our vessels, mine would have been sunk with almost certain injury to my passenger and myself and quite probably the loss of one or both of our lives.

Anyone who sails regularly has had to take take avoiding action or endure abuse from yachts who seem to believe that the fact that they are racing exempts them from the colregs or principles of good seamanship, and I would normally regard such incidents as no more than a story to tell over a pint, but this was such flagrant and dangerous behaviour from a yacht that must have a professional skipper that it calls into question his or her fitness to be in command.

CHIRP Comment: The Maritime Advisory Board is well aware racing is taken very seriously by many individuals and makes the following observations:

- An early appreciation of and reaction to the overall situation is important and may permit the avoidance of conflicts with racers. There is no suggestion this reporter did not appreciate or consider action in good time.
- Racing does not relieve boats from their obligation to comply with the International Regulations for Preventing Collisions at Sea or the ordinary practice of seamen.
- However the words of Rule 17 – Action by Stand-on Vessel, should be borne in mind:

(a)(i) Where one of two vessels is to keep out of the way the other shall keep her course and speed.

(ii) The latter vessel may however take action to avoid collision by her maneuver alone, as soon as it becomes apparent to her that the vessel required to keep out of the way is not taking appropriate action in compliance with these Rules.

(b) When, from any cause, the vessel required to keep her course and speed finds herself so close that collision cannot be avoided by the action of the give-way vessel alone, she shall take such action as will best aid to avoid collision.

Being the stand-on vessel does not confer an absolute right of way!

EDITORIAL

There are not as many reports as you're used to seeing in this edition, as the reports are substantial, but I hope you'll agree there is a great deal of useful content to discuss and learn from.

There are examples of the varying standards of near-miss incident investigation in this issue and it is hoped the examples of good practice provided will assist companies in developing robust processes.

CHIRP particularly welcomes an increase in contributions from companies wishing to share reports received through their Safety Management Systems. The more near-miss incident reports are shared and the more companies mitigate the risks identified within them, then the better will be the improvement in overall safety performance.

This must be an objective worth contributing to.

CHIRP also accepts reports:

- ✓ When you are concerned to protect your identity (please note that anonymous reports are **not** accepted)

- ✓ When you wish others to benefit from an important "Lesson Learned"
- ✓ When other reporting procedures are not appropriate or are not available
- ✓ When you have exhausted company/regulatory reporting procedures without the issue having been addressed.

CONTACT US

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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:

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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