

MARITIME FEEDBACK

Issue No: 17

New Year 2008

EDITORIAL

COMPLIANCE

Having been acting as Director (Maritime) for three months, I am struck by the number of reports of vessels which appear to have contravened the International Regulations for Preventing Collisions at Sea (ColRegs), and/or in which the watch-keeper on the give-way vessel appears to have believed that it is acceptable to pass very close to the stand-on vessel, even in open waters. Whilst the theme of "compliance with regulations and best practice" may not produce an exciting headline, it is one that is fundamental to improving safety at sea. This applies particularly to compliance with the ColRegs.

What can the individual seafarer do to help improve this situation? Perhaps consider the following:

- Read the ColRegs again.
- Test yourself using a computer based training aid, if available.
- Think of the perception that the watch-keeper of the other vessel may have of your action. For example, the officer of a large vessel may believe it is safe to pass close to a small craft. However, this may cause much anxiety to the people on that craft.
- Think back to a previous occasion when you were the stand-on vessel and another vessel had failed to take proper action to keep clear. If hypothetically a collision had occurred, would you have been found to have complied fully with the regulations and best practice? For example:
 - The Master had been called?
 - Bridge team working cohesively together?
 - You applied Rule 17 (Action by stand-on vessel)?
 - And of course you gave at least five short and rapid blasts on the whistle, supplemented by a light signal, as per Rule 34?

Fortunately most close encounters do not result in a collision and we are not put to the test on these

questions. But what can you do about the other vessel that caused the situation? Filling the airwaves with invective probably doesn't achieve anything and may even confuse the situation. You may not be too surprised at our recommendation:

- Report the incident as soon as possible to the Coast Guard. (If you are in contact with the other vessel, advise him that you will be doing this.)
- Send a report to **CHIRP**.

If you are involved in managing ships, you may wish to review the procedures within your recruitment and verification processes by which you obtain assurance that deck officers have proper knowledge of the ColRegs and apply them correctly.

When **CHIRP** receives a report of a close encounter, we normally send a copy of it to the manager or owner of the other vessel for their comment and follow-up. As confidentiality is fundamental to the **CHIRP** Programme, we do not disclose the identity of the reporter or his/her vessel. We believe that by spreading the message that non-compliance with the ColRegs is observed and reported, we can all play a part in reducing the risk of collision.

If you have any comments - supportive or critical - about these Editorials or any safety issue, we are always pleased to hear from you. And please, do send in a report if you observe a hazardous incident.

Chris Rowsell

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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

CLOSE ENCOUNTER WITH COASTER

Report Text: We were on passage in a motorsailer from Troon to holy isle, (Arran) on a course of 270. Aaaa was seen to be approaching on our port quarter on a collision course (verified on our radar). Sounded 5 toots on the horn and called on vhf (at this time, did not know the name of the ship "coaster on my port side do you see me) no reply/response. She got closer so I turned to starboard to make her the overtaking vessel and called again - this time in panic and very able to read the name of the ship as it was so close "aaaa put a man on the bridge, I should not be put in this position"

We were left wallowing in the wake as she passed very close. A man did appear on the bridge wing but there was at no time any response from the ship on vhf or by way of course change. No damage was done but I believe the unprofessional way the ship was being operated could be an accident waiting to happen.

CHIRP Comment: With the agreement of the reporter, we sent a disidentified copy of the report to the manager of the coaster. He subsequently advised that he had discussed this with the Master and Chief Officer. Neither acknowledged having received a VHF call or having put another vessel in danger. Although this may appear inconclusive, we believe that the action of the manager in personally following this up will have sent an appropriate message to the seagoing staff.

NON-COMPLIANT COASTER

Report Text: This was the third week of a summer cruise from the UK with a crew of four aboard a 3 year old Bermudan rigged 35 ft Yacht The owner is an RYA Coastal Skipper with over 5,000 miles logged as skipper over the past 6 years. The navigator is an RYA Offshore Yachtmaster with many years of experience.

On passage from St Peter Port to Carteret . Brief stop at Sark awaiting tide before north about passage. Weather was good. Wind forecast NE - F4. Visibility was 10 to 15 miles, bright sunlight with little or no cloud cover. Tide flowing from NE to SW - close to top of springs at a rate of 3.5 to 1.5 knots over the passage. Sea state moderate.

With the wind and initial tide set from the NE our passage plan calculations identified a need to hold a tight close hauled course enabling us to arrive just up tide at our destination.

We were keen to maintain our planned course and as the stand on vessel on a potential close encounter course with a small and manoeuvrable vessel we fully expected an approaching coaster, as the give way vessel, to alter course. When it became apparent that they had either not seen or heard us or were ignoring our presence (this was before we eventually established VHF communication) we took

a decision to alter our course to make sure that we avoided them. However our decision to bear away, increase speed and pass well ahead was not as successful as initially calculated as the tidal set and rate was greater than we had estimated from our tidal atlas (based on Cherbourg tides) - setting us down towards the oncoming coaster. It also cost us time as we later had to claw our way back up tide and up wind.

Both the skipper and navigator use traditional methods using paper charts first and then use electronics to back this up. We subsequently learned that the Raymarine C80 plotter has a facility to display the actual rate and direction of tide and current not just COG & SOG. The learning for us was to make sure we have a better understanding of the capabilities and make better use of modern chart plotters - particularly to assist and speed up decision taking on passage and alterations to plan.

The yacht has a mast mounted radar reflector plus a Sea-Me active radar target enhancer (switched on). The sails are white and highly visible. Navigation equipment includes a Raymarine C80 radar and plotter (no AIS receiver link) located at the chart table. We must have been visible to the coaster from at least six miles or more and one can only presume they had decided to ignore both our presence and our initial VHF transmissions or they were not monitoring channel 16 at the time. We knew that our VHF set was performing well as only a few days previously we had been sailing in company with three other sailing yachts and maintained contact on Channel 77 over longer distances than those encountered during this incident.

Hopefully you will be able to contact the owners/operators regarding this occurrence and they in turn will confirm they have taken the necessary action to ensure both their employees and crews are reminded of the need to observe their obligations under COLREGS and not just ignore small craft - and expect them to automatically stay out of their way.

The coaster we encountered carried the name of ### - registered port of AAA .

CHIRP Comment: In the open waters in which the incident took place, the coaster should have complied with Rule 18 and kept out of the way of the sailing vessel. We sent a disidentified copy of the report to the manager of the coaster in the Netherlands but as yet have not received acknowledgment.

As a general comment, yachtsmen should not assume that white sails are highly visible. They can be difficult to see from the bridge of a large vessel, especially if being viewed against a background of breaking waves. Also, active radar target enhancers generally operate only on X-band. Large vessels may be equipped with S-band and X-band radars and it is possible that the officer on an approaching vessel may be monitoring the former.

FOULED BY FISHING NET

Report Text: Passage between Breskens and Burnham on Crouch just before TSS.

@ 51°-36'.00N 02°-29'E:- Loud bang - stbd engine dropped to 1700rpm from 2300 (thorough check of engine and transmission outputs) concluded FOULED PROP - stbd engine would attain only 1700rpm - matched port engine to 1700rpm, 8kn was possible - proceeded to B.O.C.

Boat removed from water next day - a 1.5m "ball" of fishing net removed from stbd prop - SNAPPED the fixed part of the rope cutter - lucky we could use stbd propulsion at all.

CHIRP Comment: The disablement of small craft by fishing gear, in this case discarded net but often by buoys and lines that are difficult to see, appears to be an on-going problem. We make no pretence that there is an easy solution but we do encourage continued reporting of incidents so that, if appropriate, we can build the case for actions to improve the situation.

EXTREME UNPREDICTABILITY

Report Text: During vessel's transit in open waters following close quarter situation took place.

Visibility in area was good, sky partly clouded, gentle breeze and slight sea. All happened during hours of darkness.

I was the officer on watch while situation took place. My vessel "A" was proceeding on course 110 deg at speed approx 13.6 knots in the Western Approaches to the English Channel. Other engaged vessel "B" was proceeding parallel on the same course and speed, about 6 nm ahead, approximately twenty-five degrees on my port bow. General traffic situation was clear without any potential collision risks for both mentioned vessels in original situation.

Suddenly vessel "B" started altering fast her course to starboard side. The green navigational light of vessel "B" was visible - it became apparent that vessel "B" intended to cross my course ahead of me at about 1.2nm and with an unstable CPA of about 0.8nm. I was "stand on" vessel and as it was noted above, both vessels at this moment were not limited with manoeuvring by any others vessels, crafts or obstacles - so it was obvious that crossing ahead of me and with this CPA was simply unnecessary. I made VHF call identifying myself and my relative position to the vessel "B". I brought attention of vessel's "B" officer on watch to resulted situation and requested him to take preventive action and manoeuvre according to COLREG R.15. At first vessel's "B" officer on watch had problems with assessment of situation resulted, but finally agreed to give way according to CDLREG R.15. At this moment the Captain arrived on bridge.

Vessel B hadn't executed any actions distance decreased to 3 nm. i made another VHF call, and

once again vessel's B officer on watch assured me that he intends to alter his course to starboard and pass safely port to port and then astern of me. Finally vessel "B" passed ahead of me at about 0.8 nm without carrying out any coordinated actions to follow COLREG R. 15 and normal or good practice.

From this moment everything happened very quickly. When situation appeared to be safe - vessel "B" had crossed ahead of my bow and had a CPA of about 0.5nm when she was approximately ten degrees on my starboard side, green to green but still at close passing-by distance, suddenly she started altering course to starboard showing red nav light. Sent doubt signal (5 short flashes). Captain ordered rudder to starboard, so she crossed my bow second time at distance of approximately less than 0.5 nm ahead and finally both vessels passed port to port at full speed and excessive close distance of 0.25 nm (CPA). After clearing my port side the other vessel altered course more to starboard and set her course towards Falmouth.

If the course of my vessel wouldn't be altered in critical moment - collision will be probable. Reduction of speed would have no effect due to drastically close distance. Alteration by my vessel to port was thought dangerous as the other vessel had already agreed to alter to starboard. An alteration of course to starboard would have resulted in an even closer quarters situation had the other vessel continued to stand on.

Thirty minutes later I received a VHF call from that vessel - asking if I am "cool down" already...

CHIRP Comment: The OOW on ship A appears to have acted prudently in calling the Captain for what turned out to be a highly unpredictable situation. Although the report does not explicitly state this, we assume that the Captain advised the OOW that he was taking over the con. Ship A appears to have taken proper action under Rule 17 to avoid a collision. We would however add that sound signals should be made in accordance with Rule 34.

We sent a disidentified copy of the report to the manager of ship B. He has acknowledged it and advised that he is following it up. However, at the time of going to press, we have not been advised of the outcome.

MISLEADING LIGHTS

Report Text: A yacht was making a night passage motor sailing from the Needles to Cherbourg.

Just after 2300 the watch-keeper called the skipper to help him classify a vessel approaching from the starboard side. The watch-keeper reported a red light above a white light above the bridge with a red navigation light lower on the bridge. He reached the conclusion that it was a fishing vessel in the act of fishing, and we were on his port side. What later turned out to be the area in front of the bridge was a

mass of white floodlights, thus confirming our view that it was indeed a fishing boat working nets.

It soon became obvious that the vessel was actually travelling at a speed nearer to 15 knots, - it is not uncommon to find fishing vessels showing these lights when passage making - and after taking a series of bearings it appeared to be on a collision course. We were the give-way vessel and we prepared to take avoiding action to allow the vessel to pass clear ahead.

We were now about 2 - 3 cables away and keeping our attention on the bridge, still thinking that we were dealing with a fishing vessel. As the bridge superstructure approached the skipper looked to port to see the bow of a container ship pass ahead of us. It was connected to the vessel we had been monitoring! The front section of the ship was dark in colour, completely unlit and carried no forward mast head light. It was certainly well over 50metres in length. The red light at the mast head proved to be an "all round red light". We were not in danger of being run down as we were monitoring the situation closely and able to take the necessary avoiding action in good time, but the inappropriate lights of this vessel could have caused a catastrophic accident! Had she been correctly lit, we would have recognised the situation earlier and altered course earlier. We were not able to establish the name of the vessel.

CHIRP Comment: As the Reporter was not able to identify the container vessel, CHIRP has not been able to follow this up with her manager. If the foremast light was inoperative, there should have been a warning on the control panel on the bridge and action should have been taken to correct the fault. It is difficult to envisage why the vessel was showing an all-round red light at her mast-head. (It may possibly have been a local requirement for a dangerous cargo at a previous port, but, if so, it should not have been shown at sea.) Deck lights should not be on if they impede the keeping of a proper lookout or if they are likely to confuse other vessels.

Clearly this close quarters situation of 2-3 cables was much too close. This would have been so even if the other vessel had been a fishing vessel, as initially supposed, as it might have made an unexpected manoeuvre whilst shooting or hauling nets. As the give-way vessel, the yacht, which was under power at the time, would have been well advised to make a bold alteration to starboard as soon as the risk of collision had been identified.

CLARITY OF COMMAND

Report Text: This report, which CHIRP has summarised, was from the owner of a yacht on a passage for which he had engaged a professional skipper. During the voyage the yacht ran low on fuel making it uncertain whether there would be enough

for entering the next port. The owner became concerned that the skipper's plan for completing the voyage and entering the port whilst low on fuel had considerable risks without a contingency plan, so he intervened and insisted on a different plan to complete the voyage.

CHIRP Comment: As described in the full report, the owner was justified in his concerns about the risks in the plan intended by the skipper.

Without going into the specifics of this case, we would make the general point that, for the safety of any vessel, all on board must be absolutely clear as to who is in charge. In the unusual event that there is a transfer of responsibilities during a voyage, it is important that this is done formally, all the crew are advised and it is recorded in the logbook.

Also, the fact that the yacht was running low on fuel highlights the importance of thorough passage-planning from berth to berth.

SLUDGE SPILL

Report text: A large commercial vessel had arrived at a port. A representative from a sludge removal company presented himself to the Master and asked if the ship had sludge to discharge. It was the normal practice of the company for such arrangements to be made via the agent with an approved contractor but on this occasion the master contracted the service directly. The discharge was to be into a truck.

Prior to the discharge, it was noted that the connections between the hose sections were wrapped with plastic tape. The contractor advised that this was the hose normally used. The discharge was commenced. After about one hour, a hose connection failed and a small quantity of sludge was spilled onto the jetty and into the sea.

The company investigated the incident. The immediate cause of the pollution was the failure of the coupling. The root cause was the inappropriate contracting of the sludge removal company without the knowledge of the agent and without prior approval of a relevant authority.

There were "red and amber warning signs" prior to the operation that it was not safe to proceed. These were not heeded.

The company's report highlighted that the reason for arranging slop removal via the agent with an approved contractor is to ensure safe disposal. If sludge and slops are not taken to a proper facility but instead are dumped, there could be serious risk to the environment, possible poisoning of water supplies and harm to the local population.

CHIRP Comment We welcome receiving reports such as this so that the learning can be shared. This case highlights that what may initially appear to be a minor non-conformance with procedures can lead to serious risk to people and the environment beyond the boundaries of the ship and port.

RELEASE OF CO2

Report Text: This report is about incorrect use of safety locking pins on a fixed carbon dioxide fire fighting system and an accidental release of carbon dioxide.

CO2 bottles in a fixed installation are provided with safety locking pins to prevent accidental discharge of CO2 whilst the system is being maintained and/or whilst the vessel is in refit. The Planned Maintenance procedures require that other times the locking pins are not used. The incumbent ship's team decided that it would be better to have the pins in place at all times to prevent accidental release. They amended the on-board procedures to reflect this and to state that, in an emergency, the pins should be removed to allow activation of the system.

Whilst inserting one of the pins, one bottle was accidentally released into the main discharge pipe between the cylinder and the valve. The bridge was immediately informed. As a precaution, personnel were evacuated from the machinery spaces. The CO2 was subsequently safely discharged through a connection into the CO2 room and ventilated to atmosphere.

The ship's superintendent was advised. He instructed the ship to revert to the original, and correct, procedure which is that the locking pins are only intended for use during maintenance and/or during refit.

During subsequent removal of the cylinder for recharging ashore, the cylinder fell over and the valve head assembly sheared off. Cylinders are provided with a safety cap to prevent such damage during transportation. The cap had not been fitted.

The immediate lessons are that locking pins on CO2 bottles must only be used during maintenance and/or refit, and that safety caps must be put on for transportation.

In general, the incident highlights the need for proper understanding of the procedures for onboard systems. It must be ascertained at the work planning stage that the work being discussed is fully understood and if not the ship's superintendent should be consulted for further information.

CHIRP Comment: Again we welcome the sharing of such reports. This one highlights the importance of proper change management processes whereby the potential consequences of a change to operational or maintenance procedures are carefully considered. In particular, advice should be sought before deciding to alter the instructions provided by manufacturers.

This report also brings to mind two casualties examined by the Marine Accident Investigation Branch. In one, there was an intense fire in the engine room of a cruise ship in the English Channel. The subsequent fire-fighting response highlighted

flaws in the knowledge, experience and training of some of the officers, particularly in the use of the fixed CO2 system. (MAIB report 8/2007). More recently, accidental release of CO2 may have contributed to the disablement of a large car carrier in a storm in the Western Approaches. This accident is currently under investigation.

This report reinforces the theme of the Editorial of this Bulletin - COMPLIANCE.

FISHING VESSEL SAFETY

CHIRP Narrative: The safety of fishing vessels and the people working on them is an on-going concern. However the concept of near-miss reporting is not yet well established across the fishing industry. The value of near-miss reports is that lessons can be learned from situations in which there has been no harm to people. We are of course also able to learn from more tragic incidents. The reports published by the Marine Accident Investigation Branch (MAIB) are an excellent source of information. We summarise below some that have been published in recent months.

Loss of a fishing vessel with the loss of four crew 160nm due east of Aberdeen on 26 October 2006. (Report 20/2007 published September 2007)

The vessel was being used as a guard ship for oil pipeline construction activities. The weather deteriorated. The only signal of the vessel's distress and loss came from her EPIRB. Despite an extensive search of the seabed lasting some months, the wreck was not found. The MAIB therefore had to use its best judgment in assessing the most probable cause of the sinking.

The report concluded that the catastrophic chain of events which led to the loss of the vessel included a large amount of sea water being trapped momentarily on deck between the vessel's half shelter and her bulwarks. In her intact condition, the vessel was almost unsinkable. For her to have foundered she must have suffered down-flooding through an open door or hatchway, or because of the failure of parts of her structure.

The MAIB is publishing a two-page flyer highlighting the lessons to be learned from this tragic accident.

As well as publishing comprehensive reports on individual accidents, the MAIB also publishes a quarterly Safety Digest of lessons learned from marine accident reports. Digest 3/2007 includes six reports of accidents on fishing vessels, summarised below.

1) "Too Much Up Top"

A 10m GRP trawler was heaving in her trawl wires when an abnormal load came on the gear, possibly due to boulders in the cod end of the net. During the efforts to recover the net, it was suspended from the high gantry. This resulted in a loss of stability and capsizing of the vessel. The crew were able to escape to a liferaft. Vessels of this size are not required to have a liferaft or EPIRB. Fortunately the vessel was equipped with both and the two crewmen were saved.

2) "Not Dressed For The Job"

An injured fisherman was being airlifted by helicopter in gale force conditions. He was wearing a survival suit but not a lifejacket. It became necessary for the helicopter crew to guillotine the winch wire because the crew man was being dragged violently towards the boat's rail. He went overboard. Fortunately, as he was conscious, he was able to float face up. He was skilfully recovered by the fishing boat and was subsequently transferred to a lifeboat.

The report notes that this vessel carried mandatory type approved lifejackets which, although ideal for abandonment, are impossible to wear on a regular basis and would have been extremely cumbersome during this rescue. The report recommends that self-inflating lifejackets should also be provided for daily wear.

3) "Shrimp Boiler Lights Up Engine Room"

A diesel-fuelled shrimp boiler caught fire. The fire spread to the whole engine room. The skipper attempted to stop the engine using the remote fuel pump stop in the wheelhouse. This was unsuccessful because the linkage had broken. The crew were taken off by lifeboat and the fishing boat was towed back to harbour still on fire.

4) "Spot the Difference"

This report is about two similar incidents in which a crew member's foot became caught in pot ropes as they were paid out over the stern. In one case, the man was airlifted to safety and made a full recovery. In the other a man tragically lost his life. Neither was wearing a lifejacket.

5) "Trim For Safety, Not For Catching Fish"

A 20m GRP trawler was returning to port after poor fishing. She had used all the fuel in her forward tank and the fresh water from her fore-peak. There was little weight in the forward fish room. Seawater entered an obsolete fuel tank at the stern. The stern trim increased and a list developed. The crew were airlifted to safety before the vessel sank.

6) "Both Sides of the Same Coin"

This report describes the circumstances on a fishing vessel and on a tanker before they collided. The crewman on watch on the fishing vessel had received 5 hours sleep the previous morning and had not slept for the 24 hours before that. The crewman described the watch alarm as snooze alarm, and used it as such to check the course before returning to his slumbers. On the tanker the OOW was concentrating on handing over the watch to his relief rather than on the approaching fishing vessel.

THE FULL REPORTS ARE AVAILABLE ON THE INTERNET: www.maib.gov.uk

For each of the type of incidents described in the MAIB reports, there were undoubtedly many near misses in the industry beforehand from which lessons could have been learned. **CHIRP** would welcome more near-miss reports, with the lessons learned being applied to reduce the number of accidents such as those described above.

CONTACT US

Peter Tait	Chief Executive
Chris Rowsell	Acting Director (Maritime)
Kirsty Arnold	Administration Manager

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CHIRP
FREEPOST (G13439) [no stamp required]
Building Y20E, Room G15
Cody Technology Park
Ively Road
Farnborough GU14 0BR, UK

Freefone (UK only): 0808 100 3237 or
Telephone: +44 (0) 1252 393348
Fax: +44 (0) 1252 394290 (secure)
E-mail: confidential@chirp.co.uk

REPRODUCTION OF FEEDBACK

CHIRP® reports are published as a contribution to safety in maritime matters. Extracts may be published without specific permission, providing that the source is duly acknowledged.

MARITIME FEEDBACK is published quarterly and is circulated widely in the maritime commercial industry, the leisure sector and the fishing industry.

Registered in England No: 3253764 Registered Charity: 1058262

Maritime & Coastguard Agency 24hr Info No:
0870 6006505
(Hazardous incidents may be reported to your local Coastguard Station.)

Maritime Accident Investigation Branch reports and incident report forms are available on their website
www.maib.gov.uk

MAIB 24 hr telephone number: 02380 232527

BACK ISSUES

Back issues of MARITIME FEEDBACK are available on our website: www.chirp.co.uk

CHIRP

MARITIME REPORT FORM

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

Name: 	<p>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.</p> <p>2. On closing, this Report Form will be returned to you.</p> <p>NO RECORD OF YOUR NAME AND ADDRESS WILL BE KEPT</p> <p>3. CHIRP is a reporting programme for safety-related issues. We regret we are unable to accept reports that relate to industrial relations issues.</p>
Address: 	
Tel: _____ Post Code: 	
e-mail: _____  Indicates Mandatory Fields	

<p>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:</p>	No. I do not require a response from CHIRP	<input type="checkbox"/>
<p>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.</p>	No. You do not have my permission to contact a third party	<input type="checkbox"/>
<p>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.</p>	No. Please do not publish in MARITIME FEEDBACK .	<input type="checkbox"/>

PLEASE COMPLETE RELEVANT INFORMATION ABOUT THE EVENT/SITUATION

YOURSELF - CREW POSITION		THE INCIDENT					
MASTER <input type="checkbox"/>	NAVIGATING OFFICER <input type="checkbox"/>	DATE OF INCIDENT			AT SEA <input type="checkbox"/>	IN PORT <input type="checkbox"/>	
CHIEF ENGINEER <input type="checkbox"/>	ENGINEER OFFICER <input type="checkbox"/>	TIME	LOCAL/GMT		DAY <input type="checkbox"/>	NIGHT <input type="checkbox"/>	
DECK RATING <input type="checkbox"/>	ENGINE RATING <input type="checkbox"/>	VESSEL LOCATION			HOURS ON DUTY BEFORE INCIDENT (IN PREVIOUS 24 HRS):		
CATERING <input type="checkbox"/>	OTHER (HOTEL, ETC) <input type="checkbox"/>	TYPE OF VOYAGE			TYPE OF OPERATION		
THE VESSEL:		OCEAN PASSAGE <input type="checkbox"/>	COASTAL <input type="checkbox"/>	COMMERCIAL TRANSPORT <input type="checkbox"/>		OFFSHORE <input type="checkbox"/>	
TYPE (TANKER, BULK CARRIER, PASSENGER, ETC)		INLAND WATERWAY <input type="checkbox"/>	OTHER <input type="checkbox"/>	FISHING <input type="checkbox"/>		LEISURE <input type="checkbox"/>	
YEAR OF BUILD / GT		WEATHER			VOYAGE PHASE		
FLAG / CLASS		WIND FORCE	DIRECTION	PRE-DEPARTURE <input type="checkbox"/>		ARRIVAL / PILOTAGE <input type="checkbox"/>	
NAME OF VESSEL:		SEA HEIGHT	DIRECTION	UNMOORING <input type="checkbox"/>		MOORING <input type="checkbox"/>	
EXPERIENCE / QUALIFICATION		SWELL HEIGHT	DIRECTION	DEPARTURE / PILOTAGE <input type="checkbox"/>		LOADING <input type="checkbox"/>	
TOTAL YEARS	YRS	VISIBILITY	RAIN <input type="checkbox"/>	TRANSIT <input type="checkbox"/>		DISCHARGING <input type="checkbox"/>	
YEARS ON TYPE	YRS	FOG <input type="checkbox"/>	SNOW <input type="checkbox"/>	PRE-ARRIVAL <input type="checkbox"/>		OTHER (SPECIFY IN TEXT) <input type="checkbox"/>	
CERTIFICATE GRADE		THE COMPANY					
PEC <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> NA	NAME OF COMPANY:			TEL:		
OTHER QUALIFICATIONS:		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 (G13439) • Building Y20E • Room G15 • Cody Technology Park • Ively Road • Farnborough • 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

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

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