

MARITIME FEEDBACK

Issue No: 22

Spring 2009

EDITORIAL

"READ ALL ABOUT IT !!! ???"

"Read All About It !!!" was the traditional call of newspaper vendors on street corners. So can you read about all types of hazardous incidents in MARITIME FEEDBACK? The answer is that you can read about some incidents but not all of them, for the following reasons.

Many ship managers have in-house near-miss reporting programmes, as described in their Safety Management System. Quite properly, mariners serving with these companies report near-misses via such programmes. If such company reports are of interest to the wider maritime community, CHIRP is pleased to receive them for publication in the section on "Reports from Ship Managers".

If however for any reason a mariner feels reluctant to use the in-house reporting programme, there is the option of reporting the concern to CHIRP. Indeed, the *raison d'être* for **CHIRP** is to provide a way for mariners to report safety concerns on a completely confidential basis. For example, a person may be concerned that fatigue is compromising safety, but may possibly be reluctant to discuss this with his/her manager. The person can report such concern to **CHIRP**. We will discuss it with him/her and agree the best way forward. This is developed on a case-by case-basis and may include:

- Suggesting that the individual contact the company's Designated Person, who must by law have direct access to the top management in the organisation.
- Suggesting that the individual raise the matter through a safety forum or through his/her professional association or union.
- **CHIRP** contacting the Designated Person and advising of the concern, without disclosing the identity of the reporter.
- **CHIRP** alerting the regulatory authority, again without disclosing the identity of the reporter. This would typically lead to a visit by the authority to the ship or company.

Such reports would make interesting reading, but often the circumstances are so specific that to publish even a disidentified summary may inadvertently lead to the reporter's identity being inferred. Confidentiality is key to the success of **CHIRP**. Therefore we do not publish

reports if there would be a possibility of confidentiality being prejudiced.

Another reason why you may not "read all about it" in MARITIME FEEDBACK is that no-one has sent us a report on the subject. One of our readers has commented that we do not have many reports about marine engineering issues. They are right. Although we do have some, these are generally ones received from companies rather than from individual marine engineers. We would welcome receiving more.

As another example, there is continuing concern in the industry on the number of fatalities related to entry into confined spaces. The UK Marine Accident Investigation Branch (MAIB) issued a Safety Bulletin on this in 2008, highlighting that they had carried out three investigations within a year in which six seafarers had died in enclosed/confined spaces. With such a fatality rate, one would expect there to be a significant number of related near-misses. However, whilst there can be little doubt that such incidents are happening, they are not being reported to **CHIRP**.

So we repeat our request:

Report hazardous incidents to improve maritime safety and save lives.

Chris Rowsell

REPORTS

CHIRP receives reports on a range of hazardous incidents that have occurred within the commercial, fishing and leisure sectors of the maritime community. Here are a number of reports which will be of wider interest, together with the "lessons learned" as described by the reporter. The **CHIRP** comments have been reviewed by the **CHIRP** Maritime Advisory Board which has members from a wide range of maritime organisations, full details of the membership can be found on our website - www.chirp.co.uk.

DOVER STRAIT CONTRAVENTION

Report Text: My vessel was in the Dover Strait NE lane approaching Gris Nez. Whilst this incident did not involve or affect me directly, I still feel it is worthy of a report.

I previously heard a large vessel reporting to Gris Nez Traffic that he was intending to cross the NE Lane coming from the SW lane bound for Dunkerque, so was

A Maritime Safety Newsletter

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

keeping a watch for him in case he crossed whilst I was in the vicinity.

I subsequently observed this vessel in the NE lane close to the Sandtette SW buoy, well clear of me, steering a course of 180T (gyro output from AIS) i.e. at an acute angle to the traffic lane. This appeared to be his set course, rather than one adopted to avoid any NE bound vessels. After observing him maintaining this course for some time I called Gris Nez Traffic to enquire if they were watching his progress and that I considered the vessel was in contravention of Rule 10. Gris Nez Traffic informed me that there was no contravention of the rules, "as he was bound for Dunkerque". The vessel continued on this course the whole way across the NE lane from Sandtette SW buoy to Ruytingen SW buoy.

I was not in agreement with Gris Nez Traffic and their interpretation of Rule 10 but did not consider it appropriate to discuss the matter on the VHF.

CHIRP Comment: Rule 10 (c) of the ColRegs says: "A vessel shall, so far as practicable, avoid crossing traffic lanes, but if obliged to do so shall cross on a heading as nearly as practicable at right angles to the general direction of traffic flow."

We advised the manager of the Channel Navigation Information Service at Dover of this report. He was able to verify from Vessel Traffic System data recording that the track of the large vessel was as described in the report. This was in contravention of Rule 10. There is no exemption for vessels bound for a particular port. He has drawn the attention of his counterpart in Gris Nez to the incident.

FOG SIGNALS - AN OPTIONAL EXTRA???

Report Text: My yacht was off the South coast of England during daylight but in reduced visibility, estimated 25 yards. Signal horn (manual) being sounded. Large engine noise astern heard. Within 20 minutes the windows of a ferry could just be made out abeam. No sound signals were heard. No VHF contact. Yacht carried radar reflector from lower spreaders.

CHIRP Comment: Here are some unjustifiable excuses for not sounding fog signals:

1. As we have radar, sound signals are superfluous.
2. Some of the ColRegs are mandatory, others are optional extras.
3. The noise disturbs the passengers and/or crew.
4. The signals won't be heard in the enclosed wheelhouses of other ships.

None of the foregoing will stand you in good stead at an inquiry!

Sound signals are mandatory, as per Rule 35 of the ColRegs. They do serve a practical purpose, for example in alerting small craft to approaching vessels. The whistle is a useful tool and its use is prescribed in the ColRegs – so use it!

The report also mentions that the yacht was carrying a radar reflector. On this subject, whilst the loss of the yacht "Ouzo" and her crew in August 2006 did not occur in fog, it nevertheless highlighted the potentially fatal consequences of poor radar visibility of small vessels.

Detailed guidance is given by the MCA in MGN349 - Carriage and Use of Radar Reflectors on Small Vessels. (Marine Guidance Notes can be accessed on the MCA website www.mcga.gov.uk by clicking onto "Legislation and Guidance".)

In general:

- There is a wide variation in the performance of different types of radar reflectors. Some do not meet ISO standard. For information on the comparative performance, consult the report by QinetiQ comparing various types of reflectors. This can be found on the MAIB website www.maib.gov.uk/publications/investigation_reports/2007/ouzo/cfm
- Care must be taken to mount the reflector as directed by the manufacturer. This sounds obvious but we have seen reflectors designed for mounting vertically but installed horizontally.
- The higher the reflector is mounted, the more effective it will be.
- Be aware that, notwithstanding the type of radar reflector fitted, in certain circumstances their craft may not be readily visible on ships' radars.

INAPPROPRIATE PILOTAGE

Report Text: I am Master of a vessel that was on a coastal passage. We had a coastal pilot. Due to the length of the passage, I left the bridge to get some rest. The following is a summary of events told to me by the watch-keeping officer.

The pilot was using his laptop on the bridge at night. He had set this up by the bridge front windows. This laptop was not equipped with an electronic chart programme. It was simply a new machine that the pilot wanted to get familiar with. He was using it to surf the internet, for music and on-line shopping. While doing that he was also calling somebody on his mobile phone. This was a personal call as he was asking about activating a feature on his new laptop.

The light from the screen lit up the inside of the wheelhouse. At some stage the pilot went out on the bridge wing so the OOW closed the lid of the laptop in order to remove the impairment to his night vision. The pilot was upset about this when he came back inside. The pilot subsequently made other personal calls on his mobile phone.

I subsequently reported the matter to the pilotage authority. They thanked me for the report, agreed that the behaviour was unacceptable and advised that they had admonished the pilot.

CHIRP Comment: We were pleased to note that the Master had reported the matter to the pilotage authority. Intervention to correct an unsafe situation is a key to improving safety. In this case the Master intervened by advising the authority. Had he not done so, the authorities would not have known of the problem and the pilot may well have repeated the behaviour on other vessels, perhaps leading to a major accident.

No doubt the Master would have preferred to have been alerted by the OOW as soon as he/she had a concern. It is important to mentor junior officers that they must

intervene if they are concerned about any safety issue. In this case, the appropriate intervention could have been to call the Master.

There may be a natural reticence of some individual officers to challenge the actions of a senior person such as a pilot. However it is important that officers feel empowered to do so, and that the senior person responds constructively to such challenge.

(As an illustration, we recall a casualty in which the junior officer carefully plotted the track of the ship towards a sand-bank but did not feel able to express his concern to the Master who had the con. The ship went aground!).

This report is a good example of the need for Bridge Resource Management training, for ships' staff and pilots.

IN RIVER IN WINTER

Report Text: At dusk on a mid-winter day with poor visibility, shouts for help were heard by staff in the harbour office. They went out onto the jetty to look. It was seen that there was an upturned tender near the other side of the main channel with someone clinging to it. A patrol boat was immediately manned and went to assist. A man was pulled from the water. Although conscious and talking he was asked to remain in a lying position and covered with a blanket. Two younger men were seen to be on their moored fishing boat to which they had swum back, and were being attended by a RIB that had launched from a nearby boatyard.

The office was called and asked to phone for an ambulance. The casualties were taken ashore to the harbour office. There they were provided with dry clothing and a warm drink, and examined by a paramedic. There was concern regarding hypothermia and possible delayed shock. Fortunately however, they soon recovered.

The three men were commercial fishermen who had been crossing the river in their small tender when it capsized. They had no lights and were not wearing lifejackets.

Lessons Learned: Wear a life jacket. Don't overload. Have lights.



The photo shows the small tender after it was recovered.

CHIRP Comment: This report brings to mind a recent accident involving the loss of a small open boat, resulting in the death of its four occupants. It highlights

the reason for the RNLI's campaign, endorsed by the MCA and RYA - "A lifejacket buys you vital time - but only if you are wearing it".

As a reader of MARITIME FEEDBACK and interested in promoting maritime safety, you would never embark in a small tender without wearing a lifejacket would you?

DIVING BOAT MISIDENTIFIED

Report Text: I was skipper of a yacht sailing downwind at about 5 knots on passage along the south coast of England. We became aware of a small open boat ahead of us. We watched it carefully for signs of movement; was he drifting or anchored? There were no obvious signals and we saw no fishing rods over the sides. We assumed that they had lines over the stern or were hauling pots.

I took a course to avoid a collision but not deviate too far off course. As we got near there was some frantic waving from the moored boat, so we deviated a little more but not too far as I thought that they may have been requiring assistance. As we passed, the shouting became abusive and they pointed to their code flag A. I tried to call them on the radio to point out that, according to ColRegs, they should have been displaying a solid shape capable of being seen from all directions. Their flag was streamed out downwind and not visible to us.

This emphasises the need for care when making assumptions both about your own actions being obvious to others and what you assume that others are doing. In retrospect, we realised that I should have given them more sea room although as a yacht at 5 knots we were making little wash. I should have given more thought to what they might have been doing rather than what I assumed they were doing. On the other hand, they should have given some thought to what we as a vessel approaching from upwind could see of their signal.

CHIRP Comment: Although many diving boats indicate that they have divers down by flying flag "A", this may not be obvious to other vessels approaching from upwind or downwind. Rule 27 provides for a rigid replica of Code flag A and that measures shall be taken to ensure all-round visibility. The signal should only be shown when the vessel is engaged in diving operations. Exhibiting it when the vessel is not so engaged may lead to disrespect for the signal.

CORRESPONDENCE

CHIRP welcomes correspondence about the reports we publish. We reserve the right to summarise letters received. We apply the same rules as for reports, i.e. although you must provide your name, we do not disclose it.

ANGLING BOAT

Report Text: The second report in MARITIME FEEDBACK No. 21 describes an incident in which a small angling vessel at anchor was involved in a near miss with a tug and its tow. I would like to make the following comment on the CHIRP comment, based on my understanding of the Colregs.

Your comment on the report quotes Rule 26 prescribing the day signal for a vessel engaged in fishing. This is not appropriate in this case as although the occupants were fishing with rod and line that did not make the angling vessel a "vessel engaged in fishing" as defined in the rules.

(As per ColReg 3d: The term "vessel engaged in fishing" means any vessel fishing with nets, lines, trawls, or other fishing apparatus which restrict manoeuvrability, but does not include a vessel fishing with trolling lines or other fishing apparatus which do not restrict manoeuvrability.)

As it was at anchor the small craft should have exhibited where it could best be seen a single ball shape. Rule 18 would not apply in this case as the small craft was not underway, but at anchor. A signal ball would have been visible to the watch-keeper of the tug far enough away for him to take avoiding action. In addition, if, by the nature of its tow, the tug was a vessel restricted in its ability to manoeuvre as defined in the rules it would have indicated as much by exhibiting the appropriate shapes. The skipper of the small craft had no reason to conclude that the tug was a vessel restricted in her ability to manoeuvre on the strength of his observation of the fact that it was towing or exhibiting a diamond shape. However, I do agree that these observations should have put him on his guard.

It seems probable that the watch-keeper of the tug based his assessment of the developing situation on the assumption that the small craft was a powered vessel underway. The failure of the small craft to take action as the give way vessel would have led the tug to make the sound signals.

Whilst most charter angling boats exhibit a ball shape when at anchor the majority of private angling vessels do not, and I am sure that the situation described in the report is not an isolated case.

CHIRP Comment: We apologise that the **CHIRP** comments on the report "Tug, Tow and Fishing Boat" in the previous **MARITIME FEEDBACK** contained two errors.

Firstly, the provision for a small vessel engaged in fishing to carry a fishing basket as a signal was withdrawn from the International Regulations for Preventing Collisions at Sea (the "ColRegs") some years ago.

Secondly, and more pertinently, as our correspondent has correctly pointed out, a vessel fishing with trolling lines or other apparatus which do not restrict manoeuvrability is excluded from the definition of "a vessel engaged in fishing". An angling vessel at anchor should carry an anchor ball.

Other readers questioned whether a boat at anchor is obliged to keep a look-out. In response to this question:

Rule 1(a) says "These Rules shall apply to all vessels upon the high seas and in all waters connected therewith navigable by seagoing vessels."

Rule 5 says "Every vessel shall at all times maintain a proper look-out by sight and hearing as well as by all available means appropriate in the prevailing circumstances and conditions so as to make a full appraisal of the situation and of the risk of collision."

From our reading of this, vessels at anchor are not excluded from the requirement to keep a look-out. We are not arguing that a small boat at anchor close inshore or in a safe boat anchorage area is expected to keep a continuous look-out. However, in the context of the published report, the small boat was at anchor offshore from the Isle of Wight in an area in which passage by large vessels can be expected. In these circumstances, it is prudent to keep a proper look-out so that the skipper has an early indication of an approaching vessel which may be a hazard.

We thank all those who have written to us on this.



Whilst at Plymouth, the **CHIRP** Director (Maritime) rues his incorrect interpretation of the ColReg requirements for an angling boat.

REPORTS FROM SHIP MANAGERS

CHIRP Narrative: Ship managers with well established safety management systems typically have their own in-house reporting schemes. Often such reports would be of interest to the wider maritime community. **CHIRP** is pleased to receive and publish these. We respect the confidentiality of the reporters and do not disclose identities of ships or companies.

RESCUE BOAT ACCIDENT

Report Text: A large cargo vessel was at anchor. The opportunity was taken to carry out a drill of launching the vessel's rescue boat. The boat is an open dory, made of glass reinforced plastic. For lifting, it has three eye-plates, one forward, and one each side at the after end. Each eye-plate is bolted to the hull with four bolts. The heads of the bolts are visible but not the shanks or nuts. The boat is lifted by a single arm davit, with a three-part wire bridle, with one part to each of the eye-plates.

The boat's crew of four were wearing boiler suit, safety boots, helmet and life jacket. The boat was swung out with the four crew members on board. As lowering commenced, the eye-plate on the port side aft suddenly detached from the hull. The boat was left hanging starboard side up. Three of the boat's crew plummeted into the sea, a distance of approximately 12 metres. The officer in charge of the boat was left hanging on. Having ascertained that this officer was able to remain secure, the boat was lowered to the water and the three crew members were recovered, fortunately without long-term injury.

Subsequent examination showed that all four stainless steel bolts had failed.



Photo1: The rescue boat after it had been recovered back on board. The large webbing strap had been rigged whilst the boat was in the water to replace the third part of the bridle which is hanging loose.



Photo 2: The detached eye-plate.



Photo 3. Two of the failed bolts. The other two had similarly failed.

The ship's manager arranged an urgent survey with the boat manufacturer on two vessels with the same rescue-boats of similar age. The bolts and eye-plates were found to be in satisfactory condition. At the time of publication of this newsletter, the manufacturer is analysing the broken bolts to determine the cause of the failure. Possibilities include a production error with these bolts or galvanic action.

CHIRP Comment: We are very grateful to the ship manager for sharing this information at an early stage after the incident. If any other mariners or managers have experienced similar failures, we would like to hear from you.

LED LIGHTS

Report Text: I wish to call your attention to a new type of navigation light bulb which has appeared on the market. These are multiple L.E.D. (light-emitting diode) bulbs which replace the 10W and 25W single vertical filament bulbs in various navigation lamps on small vessels. The bulb fitment is for a direct plug in replacement with the "advantage" of reducing current and battery load at night. HOWEVER, these bulbs DO NOT have a definite cut-off point when fitted into a standard housing. The cut-off points for a masthead tricolour are approximately PLUS / MINUS TWENTY DEGREES !!! Thus: Dual light segments can be seen up to a 40 degree horizontal range!! With the similar 20 degree visual overlap on Bi-colour bow lights and single colour sights. THE ONLY lights for which these LED bulbs are safe to use are for all round white anchor lights and other ALL ROUND lights. You will see that it is quite possible for a vessel to stand into danger attempting to avoid an ambiguous light with expanded sectors. This is clearly a serious accident situation waiting to happen.

CHIRP Comment: **CHIRP** is fortunate in being able to access expertise from across the maritime sector through its Maritime Advisory Board, one of the members of which is the Cruising Manager of the Royal Yachting Association. He advises that there is concern in a number of respects:

- Some manufacturers are producing LED lights that emit light that is at the blue end of the spectrum and not clearly red or green.
- If an LED bulb is fitted as a replacement in a lantern designed for an incandescent bulb, it may be visible over a much larger angular sector than that prescribed in the ColRegs.
- The electrical circuitry of these lights typically has an inverter but no filter. This may cause interference to electronic equipment.

The RYA has been in discussion with MCA on this issue. The MCA has recently issued Marine Guidance Note 393 on the subject.

AVIATION & MARITIME SYNERGY

UK **CHIRP** was introduced for the aviation sector in 1982 and was expanded to cover the maritime sector in 2003. There are synergies between the two sectors as illustrated in the following report that is published in the **CHIRP's** Spring 2009 edition of GENERAL AVIATION FEEDBACK.

Report Text: I was positioning my private aircraft with a friend from my base airfield to a nearby airfield to get fuel. I was allowing my passenger to fly the aircraft to gain experience.

I was very comfortable with this short 20 mile trip having completed it many times (my airfield does not have aviation gasoline). It was a beautiful late spring day, the air was calm and, at the end of a busy work day, this trip was great therapy.

Approximately 8 miles from our destination, we commenced descent from 2,500 feet toward a left base for the easterly runway. I was coaching my passenger whilst trying to point out the airfield to her, which looked

different from the last time we had flown together due to the abundant rapeseed crop in full bloom. I was not executing a proper lookout scan and my passenger pointed out a Cessna at our 11 o'clock position heading north. Having seen one aircraft, I believe I thought that no other could be so close. Still trying to point out our destination as we continued heading south, descending at around 300 feet per minute, I glimpsed an aircraft on a reciprocal heading on a steady bearing and slightly below. I immediately took control and climbed the aircraft while applying full power, commencing a shallow left turn to improve my chances of seeing the other aircraft.

It passed directly below and approximately 200 feet separated at crossing. Had I not seen it and not initiated the climb from the shallow descent, I believe the separation at crossing would have been 50 feet or less. There was a high risk of collision. The other plane did not appear to have seen me either in time or at all as it maintained its course without any attempt to manoeuvre.

Lessons Learned:

1. I treated this frequent trip to get fuel too lightly and allowed complacency to reduce my basic airmanship skills. 20nm or 200nm trips need equally as much concentration to avoid incidents or accidents.
2. I paid too much attention to my passenger and allowed my lookout scan to break down.
3. I was too focussed on showing the location of the airfield to my passenger in a position where most traffic would fly to avoid the ATZ of the destination airfield.
4. I believed (subconsciously) that the first aircraft was the only one in the area as the chances of two in the same area/height/direction was very low.

CHIRP Aviation Comment: A common misconception among General Aviation pilots is that the risk of a collision in the Open FIR (Flight Information Region) is extremely low; in many cases, the funnelling of traffic between and around Controlled Airspace and the use of IFR (Instrument Flight Rules) Reporting Points/VORs (VHF Omnidirectional Range beacons) can significantly increase the risk of a collision. As the reporter notes, this 'near hit' highlights the dangers that can arise from adopting a complacent attitude to flying.

It is also worth noting that mentoring a passenger is a form of instruction. Instructor training includes tuition on how to maintain a high standard of airmanship whilst instructing. It is very easy to become distracted and allow your normal vigilance to drop.

CHIRP Maritime Comment: The underlying causes of this "near-hit" are similar to those of a number of the maritime incidents reported to us. There must be a nautical equivalent of the saying "familiarity breeds contempt". If you can think of one, please drop us a line!

The **GENERAL AVIATION FEEDBACK** newsletter, with **MARITIME FEEDBACK**, are available on our website www.chirp.co.uk.



The **CHIRP** office is located next to Farnborough Airport. Here, an Airbus A380 flies over during the Farnborough International Air Show in 2008.

Maritime & Coastguard Agency 24hr Info No:

0870 6006505

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

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

www.maib.gov.uk

MAIB 24 hr Telephone No:

02380 232527

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Registered in England No: 3253764 Registered Charity: 1058262

CHIRP

MARITIME REPORT FORM

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

Name:	▲
Address:	▲
Post Code:	Tel:
e-mail:	▲ Indicates Mandatory Fields

- 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.
- On closing, this Report Form will be returned to you.
NO RECORD OF YOUR NAME AND ADDRESS WILL BE KEPT
- CHIRP** is a reporting programme for safety-related issues. We regret we are unable to accept reports that relate to industrial relations issues.

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

No. I do not require a response from **CHIRP**

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

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

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

No. Please do not publish in **MARITIME FEEDBACK**.

PLEASE COMPLETE RELEVANT INFORMATION ABOUT THE EVENT/SITUATION

YOURSELF - CREW POSITION		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"/>	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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