

CHIRP FEEDBACK

Issue No: 6

What's in this Issue?

	Page
MERCHANT SHIPPING	
Fatigue	1
VTS Language.....	2
VTS Assisted Near Miss	2
No Safety Culture?.....	3
Dover Strait Deep Water Route.....	3
Dealing With Defect Reports	4
FISHING	
Ballast, Bilge Alarms and Bad Luck.....	4
LEISURE	
A Very Close Call.....	5
Unmarked Fishing Gear	5
EDITORIAL	
5	
REPORT UPDATE	
Manning Agents	6
Engine Integration Issues	6
Operating & Maintenance Manuals.....	6
Current MAIB Investigations.....	6
Contact us	7

Number of Reports Since the Last Issue:- 31

Report Topics Have Included:

Near Grounding at a Pilot Station
 Near Collision in English Channel
 ISPS Code v Emergency Escape
 Wake Wash Incident
 Near Miss Fire Involving "Tube" Lighting
 Lifeboat/Rescue Boat Testing
 VTS Authority
 Drills Required v Time Available

BACK ISSUES

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

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

FATIGUE

Report Text: During one long stand-by (about 10 hours), the duty engineer was so tired he mistakenly made an operational error of shutting down the second cooler (which was already open) in the central cooling system thinking that he was opening the cooler to the system, creating a bit of a panic when the main engine jacket cooling water temperature started rising rapidly. The situation was brought under control without any disastrous consequences. Had it not been detected and corrected sooner the consequences would have been that we would have lost engine power when it was required the most to overcome counter flow and drift. Due to very short sea passages between ports, fast turnaround / short port stay, combined with long stand-by duties and broken rest periods, fatigue and tiredness was setting in very fast.

We were only three engineers, including the Chief Engineer in the engine room, plus one Electrician with no watch keeping experience or watch keeping certificate.

The engine room is un-manned during the night, with 2nd or the 3rd engineer responsible for 24 hour duty cover from 0800 to 0800 next day. The duty engineer for the day is also responsible for preparation of the main engine for arrivals and departures and all stand-by duties that will fall within his 24 hour duty period. With only three engineers on board, the Chief Engineer covers all the stand-by duties, arrivals, departures, river and canal passages 24/7 as back-up to the duty engineer. This is to satisfy two of the company safety policies, i.e. every stand-by must be

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A Maritime Safety Newsletter

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

attended by two engineers in the engine room and Chief Engineer must be present in the engine room during all stand-by's (the duration of stand-by duties are from the time engine is rung Stand-by to Beginning of Sea Passage for departures and End of Sea Passage to Finish With Engine for arrivals). The Electrician also attends all stand-by duties but his physical presence in the engine room is required only during the crucial phases of the stand-by, e.g. docking and un-docking and during bow thruster operation. On this particular run, it is a matter of time before tiredness and fatigue will contribute to a major accident / incident, in the Engine Room, on Deck or on the Bridge.

You may well ask how the above is possible when every seafarer has to abide by STCW rest periods. This is the biggest "Con Game" ever introduced by the IMO especially for vessels on short haul and coastal trade voyages. The recording of these hours is carried out without any checks on actual hours worked by the seafarer, all assume the seafarer is recording these hours truthfully. If you do record them truthfully and your rest hours are outside the minimum, you will be soon asked to amend them to keep in within the regulatory rest hours by the Master before they are being filed away and a copy sent to the Office. On many occasions, I have been told by Masters that they have no power to delay sailing after the cargo work has been completed.

CHIRP Comment: This report was forwarded to the vessel operator, who provided the following edited comments:

"As a company we try to keep in touch with the workloads our ships are facing and have taken action where we think necessary. For example on the introduction of the ISPS Code we put Administration Officers on ships calling at more than 10 ports/month and on an ad-hoc basis ships that we see are in demanding trades will have engineers, cadets or ratings added to the complement to help with both maintenance and day-to-day operations.

However, before we can make decisions on increasing the complement of a ship we must have an open dialogue with the senior officers onboard. Without good information coming from the "sharp end" we here in the office cannot make good decisions about how we should operate our ships.

Nevertheless, we are not ignoring this matter and we will send a Marine Advisory to our fleet reminding them of the work / rest hours regulations, where information can be found in our Safety Management System and what to do if it is found impossible to abide by the regulations."

The Company has requested CHIRP to provide more details to allow it to take more specific measures and CHIRP is discussing what steps might be taken with the Reporter, but believes, once the Marine Advisory

has been produced, it should be easier to raise these concerns with the company directly.

During a recent series of CHIRP presentations many of the participants confirmed Hours of Rest records are often inaccurate and had similar experiences to this Reporter. CHIRP has even been informed verbally of a company time recording system which does not permit the entry of "true" hours if they do not comply with the regulations.

Any discussion on Minimum Manning is likely to consider the hours seafarers are recording; if those hours are incorrect to a significant extent, what are the chances of those discussions leading to valid conclusions? This is an issue of global importance.

If you have concerns about the hours you are resting/working and those you are recording or permitted to record, let CHIRP know. Remember, your report will not be released to anyone else without your consent.

VTS LANGUAGE

Report Text: During departure pilotage in restricted visibility the radar echoes of barges in mid-stream were concealed by overhead power cables. Barges were on extreme edge of fog bank. Three warnings of the presence of the barges from traffic management were missed by Pilot (Warnings were not in English and were not therefore picked up by the Bridge Team).

VTS ASSISTED NEAR MISS

Report Text: Embarked Pilot and vessel was proceeding towards the entrance. The Pilot reported his presence on the bridge, by VHF, to VTS and there was a short conversation not in English. Full ahead was ordered and the vessel proceeded on a heading to make the entrance channel east of an island.

As the vessel was approaching the island, the stern of a large vessel was observed on the far side of the island with the bulk of the vessel being out of sight. It was soon realised that this vessel was actually lying completely across the channel, about six cables distance, as it was manoeuvring astern to her berth. The Pilot ordered 'Stop Engine' and 'Full Astern', soon after the starboard anchor was let go, followed by the port anchor as the vessel swung towards the shore of the island. The vessel eventually stopped, without any contact, about 50 metres from the visible shoreline. Fortunately the shore of the island is steep to.

The pilot said that VTS had advised him that there was one small vessel proceeding to the shipyard but had failed to mention that a large vessel was in the channel, and in the process of swinging to make a stern approach to its berth.

CHIRP Comment: These reports share some common features in that the Bridge Team were not party to important communications with VTS. The second report was sent to the Harbour Master of the port concerned and both were sent to the International Maritime Pilots' Association (IMPA), who kindly provided CHIRP with a copy of IMO Resolution A960 – "Recommendations on Operational Procedures for Maritime Pilots Other Than Deep-Sea Pilots", which states at section 6.3:

"When a pilot is communicating to parties external to the ship, such as vessel traffic services, tugs or linesmen and the pilot is unable to communicate in the English language or a language that can be understood on the bridge, the pilot should, as soon as practicable, explain what was said to enable the bridge personnel to monitor any subsequent actions taken by those external parties."

IMPA added:

"All messages with navigational relevance should be translated and summarised for the Bridge Team, as necessary, in accordance with A960. Pilots should be familiar with the Standard Marine Communication Phrases approved by IMO and using those phrases will assist in avoiding situations such as these."

NO SAFETY CULTURE?

Report Text: On joining day, on my first trip on this vessel, the crew change took place, with the vessel sailing soon after. The crew had all the normal jobs to do; garbage, stores, bunkers, etc and on this day, the port liferaft was replaced. I was busy getting to know the vessel during this time.

The weather was reasonable during the trip, but bad enough to limit deck work. About three weeks in to the trip I was on deck near the port life raft when I noticed that it didn't look right. On further examination I noticed that the securing lashings were fitted to the hydrostatic release properly, but the painter was not; it was coiled up and taped to the side of the raft case. Three weeks at sea without a port life raft in an old ship in the North Sea.

When LSA comes aboard it should be checked that it's correct and stowed properly by an officer, but on this occasion it was left for someone else or another day due to pressure from the office for the vessel to sail and crew incompetence. I tried to bring it up at the "safety" meeting and the "Captain" said it wasn't relevant!

During this trip there were chemicals used, hot work, men going aloft and other jobs that warrant a permit, but not one permit was issued during that trip. This is a major problem on ERRV's [Emergency Response and Rescue Vessels] who, compared to other offshore vessels, have a massive number of LTI's and other accidents. There is no safety culture; with some not seeing the point and injuring themselves

and allowing unsafe practices to occur, like non-secured liferafts.

CHIRP Comment: Information on the safety performance of the Offshore sector in the UK is relatively easy to obtain when compared with other sectors and the industry at large. Its cross-sector Marine Safety Forum contributes a great deal to the sharing of information and promotion of best practice.

Whilst there was evidence that some ERRV operating companies are not league leaders in safety performance the figures available do not support the reporter's contention that the standards are vastly different.

The report was forwarded to the vessel operator who responded positively and has taken a number of steps intended to address the issues raised within this report and others identified internally. These measures include shore based and shipboard training in areas such as company procedures, risk awareness, hazard identification, near miss reporting and permit to work systems.

DOVER STRAIT DEEP WATER ROUTE

Report Text: Own vessel was a fully loaded VLCC with a draft of 21.9 metres.

As vessel was approaching the Sandettie Deep Water Route in the Dover Strait, it was observed on radar another vessel 1 mile astern overtaking with a CPA of 2 cables.

This vessel was identified and bound for Amsterdam with a draft of 7.5 metres (this information supplied by Cap Gris-Nez Traffic Surveillance). I called the other vessel on VHF radio and informed him of my position and that it is not recommended to use the DW Route if your vessel's draft is not more than 16 metres or to overtake another vessel in the DW Route. The other vessel replied that if I could alter my course to starboard then he could pass safely down my port side. I replied that I would not alter course to starboard, but would continue to follow the DW track.

The other vessel continued to overtake on my port side and appeared to leave the F1 light buoy on his starboard side (so entering the South West lane of the TSS), and then passed clear of me.

As both Cap Gris-Nez and Dover Coast Guard Traffic Surveillance were broadcasting my position and progress through the Dover Strait I find it hard to understand why the other vessel chose to overtake me in the position he did.

I pass through the Dover Strait on a fairly frequent basis.

It is increasingly common to observe vessels with drafts of as little as 5 metres using the Sandettie DW Route. I have never heard the Traffic Surveillance agencies, which monitor shipping movements in this

area challenge a vessel as to why he is using the DW Route against the recommended guide lines.

I feel that if such a challenge were made over the VHF radio this would not only educate the vessel concerned, but all other vessels, which would hear the broadcast and so be similarly informed.

Certainly if a very large and deep draft vessel is in the process of transiting the DW Route, then any other vessel which can safely use the normal route should be informed by the Traffic Surveillance agencies to keep clear of this vessel.

CHIRP Comment: This report is representative of six reports received by CHIRP related to the use of the Deep Water Route (DWR) in the Dover Strait. The rules of the Dover Strait Traffic Separation Scheme (TSS) state:

“The main traffic lane for north-eastbound traffic lies to the south-east of the Sandettie Bank and shall be followed by all such ships as can safely navigate therein having regard to their draught.”

The DWR falls within the UK Search and Rescue Area, but the French VTS at Cap Gris Nez has responsibility for monitoring NE bound traffic, including the DWR. Traffic advisory broadcasts are made by both Gris Nez and the Dover based Channel Navigation Information Service (CNIS), operated by the UK's Maritime and Coastguard Agency (MCA).

A number of reports were sent to the MCA and a visit to CNIS was arranged to discuss the issues raised and to explore how they might be assessed and, if necessary, advanced.

Initially, a survey was conducted to ascertain the number of DWR transits made by shallow draft vessels and the reasons why the DWR was used in preference to the eastern branch of the NE lane. The information gathered from this survey was presented at the UK Safety of Navigation Meeting in November 2004 and resulted in a recommendation to strengthen the rules of the TSS which will be presented to the IMO during 2005.

DEALING WITH DEFECT REPORTS

Report Text: I was a passenger on an EU registered cruise ship. As an East Coast yachtsman with 30 years experience I was concerned to note that the propeller on No 1 starboard lifeboat was so badly bent that in my view it would render the lifeboat engine inoperable.

I formally reported my findings in writing to the Cruise/Tour Operator using the Company's own Customer Complaint Form as I was anxious to see the fault properly registered and promptly followed up.

After approximately one month there was no formal feedback and, as an ex Trade Union Safety Officer, I was concerned that there may have been no follow-

up to my report. I therefore contacted the Cruise/Tour Operator again by telephone and was informed that I should contact a company who were responsible for maintenance of the vessel concerned. I then had a discussion about the Corporate responsibility of the Cruise/Tour Operator Company and in particular about section 3 of the Health and Safety at Work act 1974. It was then agreed that they would refer the matter to the Ship Operator.

After another month of no feedback I again contacted Cruise/Tour Operator; the company again noted the details for forwarding to the Cruise Company.

My concern is that the Cruise/Tour Operator having given out customer complaint forms, have not responded or perhaps even followed up my formal complaint that a major piece of lifesaving equipment requires urgent attention. I have written the account for your Maritime Feedback because it illustrates the important interface and responsibilities between the Ship Operator, the Cruise/Tour Operator and the passenger who notes the actual safety breach.

CHIRP Comment: This report was forwarded to the Managing Director of the ship operating company. The lifeboat defect was known to the company and repair had been affected and approved by a Classification Society. The Company was disturbed that a safety related passenger report had not been forwarded to them by the Tour Operator and have modified the report handling process to ensure this incident is not repeated.

FISHING

BALLAST, BILGE ALARMS AND BAD LUCK

Report Text: A trawler recently changed hands and a high level alarm conforming to the attached schematic was ordered to be fitted before the vessel sailed.

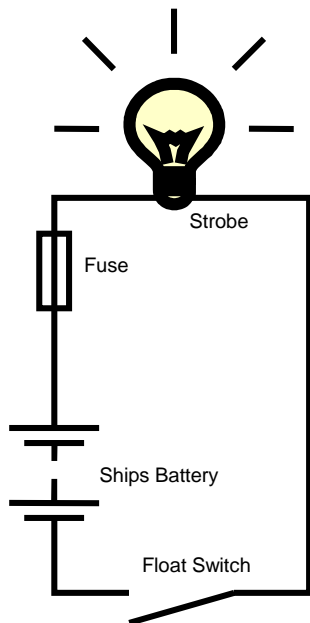
The new owner agreed and put the job in hand, but unfortunately the vessel sprang a leak whilst alongside the quay and flooded the engine room causing considerable damage before the installation was completed. The leak was caused by localised corrosion where pig iron ballast was in contact with the hull.

The strobe would have been noticed by harbour security that night had the yard electrician completed his job a little faster!

CHIRP Comment: Flooding that goes undetected regularly leads to loss of the vessel with serious risk to life. The schematic below is referred to in the report and intended as a secondary alarm, directly wiring the ship's batteries to a strobe on the wheelhouse deck-head via a float switch.

Simple and cheap for any size of vessel; below shaft level, high enough to test easily and less likely to generate annoying false alarms, but allowing adequate time to sort out most problems and always on; even in port.

It is a common sense solution, but also the law; the 15-24m Code states that ships must have either an independent secondary alarm or a "fail safe" primary system.



LEISURE

A VERY CLOSE CALL

Report Text: I was heading towards the harbour entrance (in my 25ft yacht) doing approx. 1.5 knots, when I noticed a speed boat heading straight towards us. It became obvious he had not seen us and was going to hit the boat. My son and I ducked down in the cockpit; the speedboat hit us on the port side causing extensive damage to the hull. The speedboat then travelled over the top of the yacht (the prop causing more damage) destroying the rigging and bringing down the mast which snapped in two.

We were extremely lucky to come away from the accident uninjured.

CHIRP Comment: This was a serious incident which could easily have resulted in injury or death and could just as easily have been avoided if Rule 5 (Lookout) and Rule 6 (Safe Speed) had been observed. These two rules form a key part of the RYA's Sea Sense campaign:

- Cut your speed
- Look around & be aware

The reporter was unaware that this incident could have been reported to the MAIB and unfortunately when they were informed too much time had passed for them to conduct a meaningful investigation. In circumstances such as these, people should not hesitate to contact the Coastguard and/or the Police, where a criminal act may have been committed.

UNMARKED FISHING GEAR

Report Text: Vessel ran over unseen lobster pot marker, which was marked with a half submerged plastic container. Rope wrapped around propeller and shaft, bringing vessel to a halt. Engine was not running at the time. Rope was removed when engine was started, but there was no drive in forward or reverse and rudder did not have free movement. Prop shaft was found on examination by engineers to have been pulled from gearbox. There are many such lobster pot markers in eastern Solent and off NE side of Isle of Wight; some almost invisible.

CHIRP Comment: Regular readers will know CHIRP has been assisting in the capture of data on encounters with unmarked fishing gear. The above report is an example of the type of incidents reported.

In 2004 CHIRP received a total of ten reports from around the UK, detailing various encounters with fishing gear and other flotsam and jetsam. Some of these encounters resulted in serious consequences, but fortunately no loss of life.

It is hoped that the information submitted to the MCA, MAIB, NFFO and RYA will assist them in developing an accurate assessment of the risks to life associated with these encounters and in identifying appropriate solutions, where required.

The data collection exercise will continue through 2005, so please continue to report your encounters to the RYA or, if necessary, CHIRP.

EDITORIAL

In this first issue for 2005 the format of MARITIME FEEDBACK has been revised in response to your comments and we hope you like it. Comments are always welcome.

CHIRP wishes to thank The Honourable Company of Master Mariners, who have again agreed to host the 2005 CHIRP Maritime Advisory Board (MAB) meetings onboard HQS Wellington.

In the period since our last edition the MAB has changed; Stephen Johnson has left and CHIRP thanks him for his contribution to the Programme. His replacement on the Board is the new Cruising Manager for the RYA, Stuart Carruthers.

There is plenty of evidence of positive dialogue and action in this issue of FEEDBACK, which is very

encouraging. CHIRP is intended to support the industry's safety efforts; particularly company safety management systems and it is vital this purpose is understood.

Confidential reporting processes are not "comfortable", but if the purpose, process and potential benefits are understood, then the temptation to try and "shoot the messenger" may be more easily resisted!

CHIRP has received occasional correspondence from lawyers and challenges based on UK information laws, so you may appreciate why the Editor is particularly keen to emphasise this point.

REPORT UPDATE

MANNING AGENTS

On 9 December 2005 CHIRP attended a meeting hosted by the British Chamber of Shipping to discuss the safety role of manning agents and specifically the requirements of the UK Conduct of Employment Agencies and Employment Business Regulations 2003. The meeting was attended by representatives from a number of manning agencies and the author of the regulations, the UK Department of Trade and Industry (DTI).

For a lawyer's view of the Regulations CHIRP is grateful to Peter Handley, Solicitor and Master Mariner with City law firm Stephenson Harwood:

"UK based seafarer recruitment agencies, and manning agents involved in the direct supply of seafarers to client hirers under short term assignments or contracts, are likely to fall within the definition of "employment agent" and "employment business" respectively. Both types of organisation should be aware of the new regulations and ensure that their activities are compliant with them.

One of the most striking features of the new regulations is that they place an employment agency or business under a specific duty to obtain certain information from the hirer about the position to be filled, including any risks to health or safety known to the hirer and the steps taken by the hirer to prevent and control such risks (Regulation 18).

An employment agency or business must therefore ensure that the hirer has carried out a thorough risk assessment of the workplace (in practice, by requesting a copy of the risk assessment) so that it can provide the work seeker with sufficient information, before he begins work. This is in addition to the obligation to ascertain that the work seeker has the necessary experience, training and qualifications for the position that the hirer seeks to fill (Regulation 19).

The recruitment industry should note that Regulation 30 imposes civil liability on employment agencies and businesses for any damage resulting from contravention or for failure to comply with the Regulations. It is particularly worthy of mention that "damage" is defined in the Regulations as including the death of, or injury to, any person; i.e. not just work seekers. So if, for example, a co-worker or a member of the public were injured by the act of an incompetent work-seeker provided to fill a position, Regulation 30 would appear to give that injured person a statutory right of action against the employment agency or business who supplied the work seeker."

These are important Regulations intended to promote best practice and contribute to the safety of work seekers. Seafarers should ensure the employment agent/business they are using provides the information required by the Regulations.

The meeting ended positively with the Chamber of Shipping agreeing to assist in the formulation of industry guidance in co-operation with its members, manning agencies and in consultation with the DTI.

ENGINE INTEGRATION ISSUES

A draft CHIRP report on this subject has been prepared and will be available soon. Visit the CHIRP website www.chirp.co.uk for news.

OPERATING AND MAINTENANCE MANUALS

There has been a considerable amount of interest in this topic and CHIRP is grateful for all the contributions received. Work on the CHIRP report will commence as soon as the report on engine integration issues is finalised.

CURRENT MAIB INVESTIGATIONS

The following accidents/incidents are being investigated by the MAIB as at 03 March 05:

Vessel's name	Accident/incident type	Date of incident
Hyundai Dominion/Sky Hope	Collision between two container ships off S.Korea.	21/06/04
Daggri	Shetland inter island ferry made contact with breakwater at entrance Ulsta on Island of Yell, Shetland.	30/07/04
Kathryn Jane	Loss of fishing vessel off Talisker, Isle of Skye. One death confirmed-possibility of one further fatality.	07/08/04
Albatross	Fatal injury to UK passenger; fell	22/08/04

	from rigging onboard Dutch sail training vessel off Southend.	
Coral Acropora	Cargo leak on liquefied gas carrier alongside berth at Runcorn allowed escape of approx. 1 ton of VCM to atmosphere. Two people were taken to hospital for precautionary check-ups.	10/08/04
Jackie Moon	Grounding of Antigua and Barbuda flag cargo vessel in the river Clyde.	01/09/04
RFA Fort Victoria	Accident that occurred on RFA <i>Fort Victoria</i> during a routine test of lifeboat on-load release gear in Falmouth. At least two persons were injured when the lifeboat was released about 1.75m from the surface.	10/09/04
Noordstrand	Collapse of portable bulkhead in cargo hold when vessel alongside at Seville, Spain. Two ship's staff crushed with one fatality and one serious injury.	20/09/04
Swan	Capsized below Bath Weir.	14/10/04
Balmoral	Contact with unknown object off the Welsh coast.	18/10/04
Border Heather	An explosion onboard BP tanker whilst loading petrol/kerosene, Grangemouth	31/10/04
Dorthe Dalsoe/Scot Explorer	Collision between Danish FV and UK registered cargo Scot Explorer.	02/11/04
Emerald Dawn	Loss of Fishing vessel whilst on passage to fishing grounds off Kilkeel.	10/11/04
Cepheus J/Ileska	Collision between Maltese registered mv Ileska and UK registered German owned MV Cepheus J	22/11/04
Stolt Tern	Grounding of tanker, off Holyhead Harbour.	06/12/04
British Enterprise	Grounding just off Istanbul.	11/12/04
Jann Denise II	Foundering of 9.79m fishing vessel in North Sea off the River Tyne	18/11/04
Beatrice/Brenda Prior	Collision on the River Thames between coaster and amphibious passenger vessel	17/12/04
Audacious	Loss of fishing vessel and one crew member in the mouth of Stornoway Harbour	19/12/04
Yves Marie Amil	Fire involving Jersey registered fishing vessel in UK waters - three crew rescued	21/12/04
Isle of Mull/Lord of the Isles	Contact with berth and collision at Oban	29/12/04
Sea Fox	Shift of timber deck cargo.	03/01/05

European Highlander	Ro-Ro passenger vessel grounded on approach to Cairnryan in very strong winds	08/01/05
Sardinia Vera	Ro-Ro passenger vessel grounded in Newhaven Harbour	12/01/05
Alfa Germania /Aquarius	Collision between 56,000 Bahamian-registered tanker and 13m UK-registered fishing vessel in North Sea	16/01/05
Amenity/Tor Dania	Collision in the River Humber. UK registered tanker and Norwegian freight ro-ro.	23/1/05
Freedom 90/ Hampshire	Hazardous incident in Solent between hovercraft and pilot vessel	8/2/05
Higher Dartmouth Ferry	Chain ferry broke free from moorings - River Dart	13/2/05
MAIB reports are available on their website www.maib.gov.uk		

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

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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