MARITIME

CHIRP FEEDBACK

Issue No: 13 4/2006

What's in this Issue?

Number of Reports since the Last Issue: - 35

Report Topics Have Included:

Near-collisions
Rough weather procedures
Engine room system design
Forged Certificates
Wake-wash incidents
Electronic Chart Displays
Familiarisation

BACK ISSUES

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

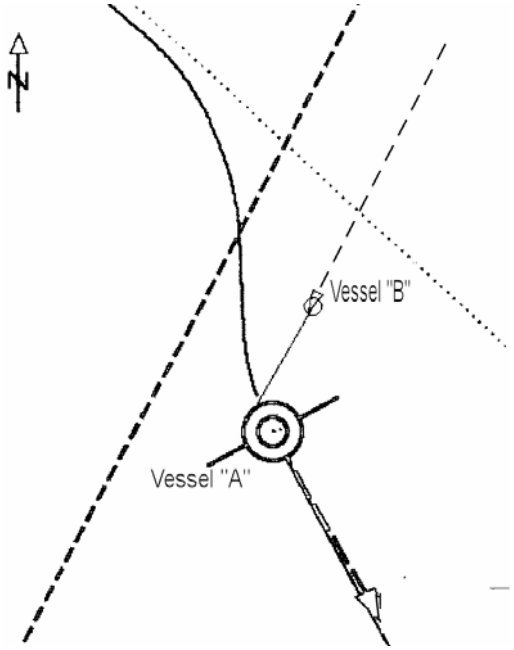
The MCA's 24hr Info No. is 0870 6006505. (Hazardous incidents may be reported to your local Coastguard Station.)

REPORTS

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

MERCHANT SHIPPING

COLLISION AVOIDANCE - CROSSING



Report Text: Vessel "A" on passage in the North Sea in position 52 34N 002 55E, approaching the DW Route a big vessel ("B") to port on a collision course.

The vessel did NOT show three vertical red lights!!

First contact on Channel 16 abt. at a distance of appr 3.5 miles. An immediate reply followed and went to working channel 6.

CHIRP, FREEPOST (GI3439), Building Y20E, Room G15, Cody Technology Park, Ively Road, Farnborough GU14 0BR **Free***fone*:(24 hrs) 0808 100 3237 Fax 01252 394290

confidential@chirp.co.uk

I asked him his intentions and that it was his duty to keep clear of me. He answered something like "Why should I..., and I cannot reduce speed"!!

Because of our relatively high speed I could easily cross him by going to starboard.

All the time he kept his course and speed. All the time we had a sufficient CPA, so we have never been in real danger!!

This was a typical example of careless and poor navigation.

CHIRP Comment: **This report was forwarded to the operator of Vessel "B", who investigated the incident and provided the following comments:**

1. **Vessel "B" was proceeding, in laden condition at a mean draught of 13.82 m when the incident occurred.**
2. **Vessel "B" was in the DW *(Deep Water)* channel with a course of 207 sailing at a speed of 13.2 kts, and was the give-way vessel, whilst Vessel "A" was on a course of 140 sailing at a speed of abt 21.5 kts.**
3. **The available Bridge Team comprises the Master, the Chief Officer and two (2) 2nd Officers, experienced and properly certified. The 2nd Officer that was OOW has been with the Company for many years. Rest periods were as per ILO and STCW. All navigational equipment was in order and in use.**
4. **As per data submitted by both vessels at 02:50 GMT the 2 vessels were abt 2 nm apart. Had the 2 vessels maintained their course and speed Vessel "A" would have passed from the bow of the Vessel "B" at a CPA (*Closest point of Approach)* of 0.3 nm.**
5. **Our company's QMS *(Quality Management System)* requires a CPA of 2 nm. As per company's QMS and Master's standing orders the OOW should have notified the master at least 15 mins before a CPA of 1 nm occurred. Consequently a non-conformity was raised. All above will also be discussed at next Safety Committee Meeting.**
6. **Clearly the root cause was Lack of Compliance with Company procedures.**
7. **As per company's QMS, and as a result of the near miss in caption, the OOW in question should have undergone additional training upon signing-off. However, in this case the OOW, has retired after his scheduled signing-off at next port.**
8. **As means of preventive action to avoid reoccurrence across the fleet and, according to company's QMS, an information circular will be distributed to the fleet. Same as per QMS procedures, will be discussed during each vessel's Safety Committee Meeting.**

The Maritime Advisory Board (MAB) are grateful to the operator for sharing the results of their investigation in circumstances where Vessel "B" was clearly at fault for not giving way and for their safety management system response.

It is possible the use of routeing by Vessel "B" caused some confusion in the mind of the OOW as to his status or he may have been overly focussed on maintaining track. It is unlikely, given the size of the vessel, that a reduction in engine speed would have had a significant impact on the vessel's speed over the ground in the time available.

CHIRP received an additional report on this incident from another vessel in the area suggesting that the situation could have been avoided entirely if Vessel "A" had identified and selected a better opportunity to cross the routeing earlier.

The MAB has previously endorsed the importance of developing an appreciation of the overall situation and the advantages of "defensive navigation" in avoiding situations where the Rules have to be relied on. This approach may not always be possible, but clearly, given the reports appearing regularly in these pages, there remains much to recommend it.

COLLISION AVOIDANCE - RESTRICTED VISIBILITY

Report Text: At 6 miles range in fog a tanker on a reciprocal course, on a steady bearing slightly to port of head-on, requested to pass green/green. Both vessels in 40-50 metres water 7 miles from 30m contour. The request was denied and I advised vessel to keep his course and speed and that I would keep out of his way. It took a lot of persuasion to get the other vessel to keep his track. The tanker eventually passed safely astern, but I expressed my concern to the local Coastguard by telephone.

Rule 19 (Conduct of vessels in restricted visibility) states that so far as possible the following should be avoided:

"(i) an alteration of course to port for a vessel forward of the beam, other than a vessel being overtaken".

The standards of navigation and training need to be addressed.

CHIRP Comment: **This report was sent to the tanker's operator for assessment. The MAB Board are grateful to the operator for looking into the incident and providing the following response:**

"It is of course our firm view that the conduct of vessels in restricted visibility is not a matter of VHF discussions, but to act according to the rules. Apart from the conduct required by Colregs, the subject is further emphasized in our existing instructions.

The expression "so far as possible" in Rule 19(d) must interpreted in such a way that an alteration

to port is prohibited as long as it is possible to either alter the course to starboard or to stop the ship in time (taking 19 (b) into account).

The alleged incident has been addressed a in a fleet letter, and our Masters have been instructed to have the subject on the agenda at their next Navigational Safety Meeting and ensure the navigation officers full understanding of the issue. We have also instructed the navigation officers to complete the CBT refresher on Colregs, which is available on board all our vessels."

The MAB considers this to be a good example of an appropriate safety management system response.

COLLISION AVOIDANCE - OVERTAKING

Report Text: Own vessel course 317 (T) smg 8 kts. Other vessel co 317 (T) speed 22 Kts; good visibility, plenty of open water for collision avoidance.

Lookout reports other vessel 5NM directly astern of own vessel. ARPA plot is acquired & visual bearings maintained (There is no other conflicting traffic). It is obvious from both these methods and visually looking at the ferry's aspect that we are a classic, well defined stand-on vessel and the ferry is give way vessel (Rule 13 applies).

Over an unspecified period of time the range between the two vessels reduces with no apparent change in course by the ferry (0.0 CPA) with the aid of AIS & double checking other vessel's posn in relation to ourselves. The other vessel is contacted at 1 NM range via VHF and is asked of intentions & requested to give more sea room to own v/l. Other vessel OOW obliges and alters 3 deg to stbd. CPA is now 0.1 NM. Realising this guy is taking a huge risk, own v/l alters course 10 deg to port increasing CPA to 0.3NM/0.4Nm. No further contact with other vessel is made. Master advised.

I have never witnessed such risk taking! If either of us had experienced main engine or rudder failure this could have been a MAIB report & no doubt TV headlines. Why are operators prepared to take such risks?

CHIRP Comment: This report was sent to the overtaking vessel's operator for assessment.

"... on behalf of my Company, I thank you for bringing this to my attention. It is obvious that I prefer not to have received this report, but we will use it as a valuable learning event, which we take very seriously.

...The Master of the vessel has been immediately informed of this report and he has been requested to give his comments and to address this with all Navigational Officers onboard his vessel.

After considering the report, we have concluded that the rules of the Anti-collision regulations have not been met, which should obviously not be allowed.

This is of course a concern for me as our Fleet Regulations (navigational section) is very clear and takes care to avoid any potentially hazardous situation. These regulations are taking care for enough safe passing distances to allow for a technical failure or human error on either vessel. Fleet Regulations requires a minimum of 0.5 mile beam passing in all situations when safe to do so and require greater safe passing distances where possible.

Reviewing this incident within our Safety Management System did reveal that no improvements to the Fleet Regulations are required, but we do however agree that this report identifies a need for improvement of the human element in carrying out navigational watchkeeping duties.

All Company vessels will be informed of this report and will be distributed by Fleet Circular as a Learning Event to ensure all Officers in charge of the navigational watch do comply with Company and Anti-collision regulations at any time...."

The MAB is grateful to the operator for investigating the incident and for providing another example of an appropriate safety management system response. Information provided by CHIRP subsequently has identified an individual training need in addition to a fleet wide learning event.

This incident also emphasises the importance of keeping a good lookout astern as well as ahead. The frequency of high speed transits is increasing in many areas and the time to assess and respond to situations may be limited. In this incident the vessels were potentially just over 4 minutes from impact. When would you have reacted?

COLLISION AVOIDANCE – LOOK OUT

Report Text: While own vessel was on passage we observed a target on our port side: radar plot was initiated. After initial monitoring it was apparent that close quarters was obvious. Warning signal was made not once, but 3 times, but still the vessel did not alter to stbd and go around our stern as per collision regulations. The local coastguard was contacted and after repeated calls on VHF 16 and they in turn tried to contact said vessel even after DSC call the CG and own vessel were unable to contact vessel. When own vessel altered crs to avoid collision several lookouts on bridge could not tell if there was anyone on the bridge of the vessel who continued on original course and speed.

CHIRP Comment: This report was presented to the operator of the give way vessel for assessment. As the incident occurred within UK waters the operator self-reported the incident to the Marine Accident

Investigation Branch (MAIB) (contact details on page 7).

Whilst hazardous incident reports are voluntary the MAIB are keen to receive them where they fall within their interest i.e. incidents involving any vessels in UK waters and UK vessels anywhere in the world.

ESSENTIAL SPARES

Report Text: This Company doesn't take issues related to the health and fire hazards seriously. It was found around 10th Oct. '06, that exhaust gas outlet expansion bellows of Main Engine No. 5 unit was cracked and leaking. I don't remember the exact date, but a requisition was made to that effect asking for the appropriate bellow after attempts to repair the crack by welding by ship's staff were futile. The above said crack was pumping a lot of exhaust gas and carbon "soot" in the engine room which were being inhaled by the engineers and the engine room crew of the vessel. There were sparks coming out at times from the crack leading to serious engine room fire hazard. But after the requisition, the said component was not supplied at our next European port on, 1st Nov. or the one after, 5th Nov. We had to sail out and the exhaust gas leakage increased to large extent, increasing the air pollution and risk of fire in the engine room. We experienced extremely rough weather and god forbid if this bellow crack had propagated to such an extent to remove the bellow completely out of place then during such rough weather conditions it would have been impossible to stop the vessel. But since the company was not serious enough and was trying to save on the money by delaying the supply (it should be noted that emergency supply of spares sometimes costs hell of a lot than the regular supply). It was not supplied by 20th of Nov. when I signed off. God knows the fate of the vessel if the vessel is still sailing in such a condition towards its next loading port in S America.

CHIRP Comment: The risk of the reporter being identified was too great for the Company to be approached directly, but CHIRP is working to establish an alternative method of ensuring this issue has been addressed and that steps have been taken to prevent recurrence.

The Owner or his Representative has a clear obligation to report this defect to the Class Society and possibly to the Flag Administration. The failure to make required reports or to rectify defects promptly, if detected, can have serious consequences for Owners and crewmembers.

In this case an attending surveyor would have appraised the extent of damage and the possibility of a fire hazard. The Surveyor would then most probably have required an immediate replacement of the defective bellows and, if the Owner had been able to demonstrate that the replacement part was not immediately available he/she may have listened to proposals for a temporary repair pending the fitting of the replacement.

It is unlikely a temporary weld repair by ships staff would have been acceptable (and clearly and not surprisingly, it did not work in this case). A temporary repair in port by specialist welders might have been accepted. It is a requirement of SOLAS and of Class that hot surfaces such as exhaust manifolds are suitably insulated/covered to prevent any inadvertent ignition - not to mention exposure of personnel to burning. Another matter which may have pressing urgency is if any of the insulation in the vicinity of the damaged bellows contains asbestos and the risk this poses if it is being distributed around the machinery space.

The situation described by the reporter indicates that at the time of writing such protection was either severely damaged or non-existent. Setting aside the obvious safety dangers arising from the conditions described, the situation is almost certain to invalidate the Class and hence the Safety Construction Certificate.

The ISM Code at 10.1 stipulates that the Company should:

> "... establish procedures to ensure that the ship is maintained in conformity with the provisions of the relevant rules and regulations and with any additional requirements which may be established by the Company."

This must involve making an assessment of the appropriate spares inventory taking factors such as criticality of equipment, availability, etc, into account.

WAKE-WASH INCIDENT

Report Text: I had left port single handed, under sail making about 3 knots through the water. I became aware of a sea-going tug heading towards me from astern. It had a large 'bone in its teeth' and a fan of breaking waves behind it. It was doing 10 to 15 knots.

I remained under autohelm to keep a straight course while observing the vessel, but with my hand over the controls in case it became necessary to alter course. Only when the tug was about 100m away was it apparent that it would pass me close on my starboard side. It would have been clear from the bridge that I was watching the tug closely. As it got closer it gave a distinct 'jink' TOWARDS me. It passed my quarter at a distance where I could have lobbed an apple aboard (perhaps even have touched its sides with an oar). The wash was serious and my boat was thrown about. With a lower freeboard the cockpit would have been swamped, and with an unprepared crew they could have been hurt or thrown overboard.

Two people (I think) were on the bridge and watched me throughout the incident. A nearby yacht was also

thrown about. I am puzzled to explain these actions – except to imagine that the helmsman wanted to liven up his day by seeing what his wash would do to a small sailing boat.

CHIRP Comment: **This incident was forwarded to the tug operator, who responded:**

> **"....we take safety issues very seriously we would like further details on this matter so that it can be followed up with the Master and crew of the vessel involved and we also can close the loop. I have already issued a notice to all our Tug Masters reminding them of their responsibilities and professionalism in approaching smaller vessels."**

The issue of wake-wash and its impact on other vessels and the shoreline is by no means restricted to tugs; CHIRP has received and published a number of reports on the subject across a range of vessel types and this serves as another reminder to be aware of the impact of wake-wash on others, whether afloat or ashore.

LEISURE

FISHING GEAR INCIDENTS

CHIRP Comment: **Thirteen reports of encounters with fishing gear were received in 2006; bringing the total to forty-eight since the data collection initiative by the RYA commenced in 2003.**

As in previous years, CHIRP will collate the reports received and send them to the MCA, MAIB, NFFO and RYA for consideration with their own data. The following "disidentified" reports are good examples of the types of incident reported involving pot markers.

Report Text: On passage from France to UK, my yacht had just cleared the main shipping channel and was approaching harbour with about three miles to run. We came across about 12 assorted dark blue plastic household cans some of which appeared to be tied to rope lines with wire and were being used as fishing pot marker buoys. The spring tide was quite strong and some of the plastic cans were level or even just below the water surface. Luckily we managed to spot them and could steer to miss them. But this would probably be impossible in darkness as the dark colour cans would not be visible. I feel that these are a dangerous obstacle to the many leisure craft using the harbour and for any other small craft that may be motoring or sailing in that area.

Report Text: We were participating in the Round the Island Race under sail, attempting to get past the Needles tidal gate in the company of 30 or 40 other yachts. When approximately 2 cables north north-east of the Needles Lighthouse we were caught up by a fish marker. The grey plastic 5 litre container that was being used was submerged by the new flood and only visible once you were on top of it, at which stage it was too late to take avoiding action. Fortunately being under sail, with the propeller folded, we were able to disengage ourselves. Had we been under motor, it would have been a different story. At the time of the incident we had a full complement of alert crew on continual lookout. The marker, being submerged, showed no wake and was not spotted until alongside and then almost immediately, under the keel. It is worth pointing out that despite 6 eagle eyed watch keepers, this grey marker, even in good visibility and bright sunlight was virtually invisible, whilst during the race other white and orange markers were successfully identified and avoided.

Report Text: I do many deliveries in yachts by sail and power and have a massive fear of fouling the prop on fishing gear. There seem to be more and more of them out there but on this particular occasion I was horrified and very lucky not to be caught. In between two buoys of the navigating channel (100m wide) slightly south of centre was a lobster pot marking buoy. It was low water slack tide and 4 metres of rope was floating across the channel giving a very high chance of catching it. It is common on well trod paths such as Dungeness to Beachy Head to find very many pots on the straight line particularly off Hastings. The situation is getting very bad.

CHIRP Comment: **These reports provide evidence that a part of the fishing community continues to place gear with inadequate marking and little regard for safety of navigation. Even if safety of navigation is not sufficient motivation; the gear costs money and surely it must make sense to mark it properly so that it is not lost unnecessarily?**

Other reported incidents have involved encounters with parts of nets and trawls and, whilst some resulted in the loss of propulsion and damage, they do not relate to the issue of gear marking. CHIRP is nevertheless grateful for these reports as they provide an opportunity to remind the fishing and leisure communities of the potential for harm where gear is lost or not disposed of properly. Vessels may foul various types of debris and it is important to have an idea of how such fouling will be dealt with as part of required passage planning.

Report Text: We were motoring because there was no wind and the vis was excellent. Whilst watching carefully for lobster pot buoys we managed to catch a large piece of stray green trawler net around the propeller. We stopped dead; none of us had seen it floating just below the surface. It was too big for us to shift and without any wind to sail with we were disabled and forced to call out the lifeboat. They told us that we were their third rescue that week caused by discarded trawler net. Apparently it was the bottom end of a beam trawl net. It cost us three days, but fortunately nothing else and we were able to dry out alongside the wall and untangle the net without any other cost and no damage to the prop or engine. The motor cruiser (the second rescue) was

not so fortunate and the repair bill looked like being enormous.

EDITORIAL

There are some great reports and responses contained in this edition. There are also many reports in progress where companies are responding enthusiastically to the information provided through CHIRP.

I believe this enthusiasm comes from a real desire to see Company procedures implemented in practice and not left on the shelf to gather dust. This may be motivated by a genuine interest in quality ship operations or the fear of the consequences of failure. Whilst the former is hoped for; the latter works too!

The difficulty in some cases is in convincing crews that this is in fact the case and it is here that the real life incidents from within their own fleets can help Companies in achieving their safety goals. There is often a great deal of external information made available to crew members, but they have always learned most from their immediate surroundings and experience and there is no reason to doubt this will continue to be the case.

CHIRP does not deal with employment terms and conditions issues as a matter of policy, but it cannot be denied that they can have a significant motivating or de-motivating impact on crew members. For example, do professional and casual labour environments support corresponding safety management cultures? Are those manuals and procedures more likely to come off the shelf in the former or the latter?

On another note, it is interesting that two of the operators in this edition have set out minimum CPA in their procedures. It is also interesting to observe the differences in those CPA which arise from the characteristics of their particular operations. What is the permitted CPA in your operation? Is it constant or does it change with circumstances e.g. in restricted visibility, ocean or coastal passages?

REPORT UPDATE

MARINE OPERATING & MAINTENANCE MANUALS – ARE THEY GOOD ENOUGH?

CHIRP has been advised the UK plans to submit a paper on this topic endorsing many of the concerns raised in this report to IMO MSC 83 in 2007. The CHIRP Trustees and Maritime Advisory Board are grateful for this significant development and the potential it offers to address this longstanding issue.

VHF COMMUNICATIONS & PORT OPS

CHIRP FEEDBACK 10 contained a report on this topic in March of this year which was forwarded to the Maritime and Coastguard Agency (MCA). The MCA have subsequently issued guidance on the subject of VHF Communications through **MGN 324 (M+F) – Radio: Operational Guidance on the Use of VHF Radio and Automatic Identification Systems (AIS) at Sea**, which may be downloaded from their web-site, www.mcga.gov.uk. CHIRP acknowledges this positive response to the concern and would also like to thank the UK Maritime Pilots Association for the survey of its Members in relation to this issue.

CURRENT MAIB INVESTIGATIONS

The following accidents/incidents are being investigated by the MAIB as at 07.12.06:

Vessel's name	Accident/incident type	Date of Incident
Peadar Elaine	Accident to crewman onboard UK registered fishing vessel	01/12/06
Pride of Bilbao	Inadvertent release of the forward hook of a lifeboat while in a stowed position	14/11/06
Fri Stream	Cargo vessel broke down off Orkney	13/11/06
FR8 Venture	Fatal accident to two crewmembers aboard a Singapore-flagged tanker in Pentland Firth.	11/11/06
Aqua Boy	Grounding of Norwegian-flagged live fish carrier in the Sound of Mull.	11/11/06
Perth	Grounding of container vessel off Izmir, Turkey.	08/11/06
fv Our Roseanne	Fire aboard Plymouth-registered fishing vessel.	04/11/06
Ben-My-Chree	Grounding of Isle of Man-flagged ro-ro vessel off Heysham.	03/11/06
Harvest Caroline	Grounding of fish farm supply vessel off the Summer Isles, West Coast of Scotland.	31/10/06
Kocatepe S	Fire aboard Turkish-flagged general cargo vessel while alongside in Cardiff.	27/10/06
Clarity	Grounding of St Vincent and the Grenadines-flagged general cargo vessel on the River Tay, Scotland.	26/10/06
Bro Gratitude/ fv Lady Matilda	Collision off the south coast of Cornwall.	26/10/06
fv Meridian	Vessel missing with crew of four in North Sea while on oil well patrol duty. One body recovered.	26/10/06
Ennerdale	Gas leak from Hong Kong registered gas tanker at Fawley, resulting in one casualty suffering freeze burns.	17/10/06

Maersk Dover	Close quarters situation between ro-ro ferry Maersk Dover and two other vessels tanker Apollonia and container ship Maersk Vancouver in the Dover Strait.	17/10/06
Maersk Doha	Fire in the economiser whilst in the Hampton Roads, Virginia.	02/10/06
Thomson Celebration	Crewmember was fatally injured while the vessel was alongside in Guernsey.	26/09/06
Fv Sian Elizabeth	Injury to crewmember aboard cockle dredger	14/09/06
Harald/Octopus	Grounding of jack-up barge off Orkney	08/09/06
Ouzo	Sailing yacht missing with three persons onboard. Three bodies have been recovered off the coast of the Isle of Wight.	22/08/06
Thunder	Grounding of cargo vessel whilst at anchor in the approaches to River Dee.	10/08/06
fv Pamela S (IH 308)	Capsize of 8m fishing vessel near Tenby, South Wales with one fatality and one injury.	17/06/06
Skagern/ Samskip Courier	Collision between vessels on the River Humber	07/06/06
fv Danielle	Injury sustained to crew member whilst on board fishing vessel	05/06/06
fv Brothers	Loss of fishing vessel and two crewmen	01/06/06
The Calypso	Fire in engine room of Cyprus-registered cruise ship in English Channel	06/05/06
mv Neermoor	Crew member died when hatchway fell on him	27/04/06
Arctic Ocean/ Maritime Lady	Collision between Arctic Ocean (container vessel) and Maritime Lady (general cargo vessel) in the Elbe, Germany resulting in the sinking of the Maritime Lady.	05/12/05
Hilli	Fatal accident onboard a LNG tanker. The accident was reported to the MAIB on 10/7/2006.	13/10/03

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

CONTACT US

Michael Powell Director (Maritime)

Peter Tait Chief Executive

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CHIRP
FREEPOST (GI3439) [no stamp required in UK]
Building Y20E, Room G15
Cody Technology Park
Ively Road
Farnborough GU14 0BR, UK

Free*fone (UK only)*: 0808 1003237 or
Telephone: +44 (0) 1252 393348
Fax: +44 (0) 1252 394290 (secure)
E-mail: confidential@chirp.co.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:

ADDRESS:

POST CODE: TEL:

DO YOU HAVE A PREFERRED DATE AND/OR METHOD FOR CHIRP TO CONTACT YOU?:-

1. THIS REPORT WILL ONLY BE SEEN BY CHIRP STAFF.
2. YOUR PERSONAL DETAILS ARE REQUIRED ONLY TO ENABLE US TO CONTACT YOU FOR FURTHER DETAILS ABOUT ANY PART OF YOUR REPORT.
3. YOU WILL RECEIVE AN ACKNOWLEDGEMENT AS SOON AS POSSIBLE.
4. THIS REPORT FORM WILL BE RETURNED TO YOU OR DESTROYED.

NO RECORD OF YOUR NAME AND ADDRESS WILL BE KEPT. THE REPORT WILL NOT BE USED WITHOUT YOUR APPROVAL.

PLEASE COMPLETE THE **RELEVANT** INFORMATION ABOUT THE EVENT/SITUATION

YOURSELF - CREW POSITION				THE INCIDENT			
MASTER	☐	NAVIGATING OFFICER	☐	DATE OF OCCURRENCE		TIME	(LOCAL/GMT)
CHIEF ENGINEER	☐	ENGINEER OFFICER	☐	LOCATION:			
DECK RATING	☐	ENGINE RATING	☐	AT SEA	☐	DAY ☐	NIGHT ☐
CATERING	☐	OTHER (HOTEL, ETC)		IN PORT	☐	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	☐	COASTAL	☐	COMMERCIAL TRANSPORT	☐	OFFSHORE	☐
YEAR OF BUILD / GT			INLAND WATERWAY	☐	OTHER	☐	FISHING	☐	LEISURE	☐
FLAG / CLASS										

EXPERIENCE / QUALIFICATION				WEATHER				VOYAGE PHASE			
TOTAL YEARS		YRS		WIND FORCE		DIRECTION		PRE-DEPARTURE	☐	ARRIVAL/ PILOTAGE	☐
YEARS ON TYPE		YRS		SEA HEIGHT		DIRECTION		UNMOORING	☐	MOORING	☐
CERTIFICATE GRADE				SWELL HEIGHT		DIRECTION		DEPARTURE/ PILOTAGE	☐	LOADING	☐
PEC	☐ YES	☐ NO	☐ NA	VISIBILITY		RAIN	☐	TRANSIT	☐	DISCHARGING	☐
OTHER QUALIFICATIONS:				FOG	☐	SNOW	☐	PRE-ARRIVAL	☐	OTHER (SPECIFY IN TEXT)	☐

THE COMPANY			
NAME OF COMPANY:		TEL:	
DESIGNATED PERSON ASHORE (OR CONTACT PERSON)		FAX:	

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

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

CHIRP • FREEPOST (GI3439) • Building Y20E • Room G15 • Cody Technology Park • Ively Road • Farnborough • Hampshire • GU14 0BR • UK

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

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

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