

CHIRP FEEDBACK

Issue No: 8

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Number of Reports Since the Last Issue: - 38

Report Topics Have Included:

Near Collisions
 Engine Room Fires
 ISPS Code Issues
 Engine Room Flooding
 Commercial Pressure
 Inaccurate Berth Information
 Free-fall Lifeboats
 Grounding and Sinking

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

NOT SO FAST.....

Report Text: On this day, we witnessed the near grounding of two container ships in the approaches to this port.

We departed the berth at 0500 hrs and had what was a relatively quiet pilotage out, there being very little coastal traffic at this time. We had two pilots onboard, one undergoing training. It was raining, and the visibility was from 7 cables to 1 mile.

The plan was for us to arrive at the pilot station around 0730 hrs to disembark both pilots, who would then proceed to one of four inbound ships due at the time. The inbound lead ship was a large container ship, the Captain of which had been previously advised to arrive off the entrance racon at 0730 hrs.

The approaches to the port lie between a group of rocky islands, one lies to the NE and one to the SW of the channel. The entrance channel is approximately 1.3 miles wide, but gradually narrows down to about 4 cables a few miles further on towards the port. The pilot book indicates strong currents in the channel and that morning, the tide was flooding at about 3 knots. Depths range from 80 to 114 meters in the channel, so there is no chance to use an anchor should the need arise.

Prior to 0700 hrs, in consultation with the pilot, we had allowed a larger and faster container ship to pass us prior to the narrow channel outbound. He was quite fast and the pilot boat was thus not able to keep up with him. We followed this ship out and saw the boat lagging well behind.

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

A Maritime Safety Newsletter

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

Meanwhile, the first of the inbound ships had already arrived at the racon, the pilot boarding ground, at 0715, 15 minutes earlier than anticipated. The pilots were a little upset by this. Closely following the lead ship was another container ship, smaller than the first. Neither ship had a pilot onboard.

The first ship must have tried to stop in the channel, but with a 3 knot current from astern, there was little chance of this happening. At 0730, when he should have been at the pilot boarding ground, he was already well on his way into port and approaching the narrows quickly. The second ship passed by us in the wider part of the channel and was already taking action to stop and turn. The first ship was swept further up towards the narrow channel. I noticed from the bridge wing that she was beam on in the channel and when I pointed this out to the pilot, he went straight to the VHF and called her up. From the conversation, it was obvious that they were in some difficulty.

The second ship, meanwhile, was making a turn to port and to head back out to sea behind us. She was also swept along by the current. The pilot called up the second ship. It was obvious, again, from the Master's reaction that they, too, were in trouble, heading towards the rocks on the SW side of the channel.

The pilot boat eventually took off the pilot from the large ship ahead of us, then had to go right back up the channel, past us, to the first ship, all of which took an awfully long time. We were left in mid channel awaiting the pilot boat, which eventually arrived at 0820.

Both the inbound ships came within a hair's breadth of running onto the rocks and it was probably down to sheer luck that they didn't.

So what can be learnt from this incident?

Well, firstly, never trust pilots to be there when they say they'll be there. In this case, they weren't. In the approaches to this port, and with the strong currents, it would be best to wait outside of the channel east of the islands and ensure your pilot boat is there first before proceeding in.

Secondly, in this instance, if you make the run in and find the pilot is still not there, what contingency is there for getting out of the situation before the channel narrowed down?

Thirdly, you can stop your ship and hold a reasonable position when heading into the current, but NOT when it is from astern, especially at 3 knots.

Fourth, why did the first ship try and stop so close to the bottleneck between the islands? Under the circumstances, it would probably have been wiser for the Captain to bite the bullet and take the ship safely through the narrows without the pilot and suffer their wrath later. There is plenty of water beyond the narrow channel.

Finally, schedules are NOT the be all and end all when it comes to a safe operation. In their impetuosity to get into port, both ships risked all.

CHIRP Comment: In the view of the Maritime Advisory Board this incident highlights two main areas of concern; the first relates to passage planning and the need for navigators to allow for contingencies by identifying possible anchorages and/or the points at which manoeuvres may be safely aborted. It is not unusual for delays to occur at pilot boarding areas and a good passage plan will allow for this. Particular attention should be paid to the presence of strong currents or tidal streams.

The second aspect relates to port control and the need to plan vessel arrivals and monitor the execution of the plan, communicating changes in good time. CHIRP was unable to establish an appropriate contact in this non-UK port, so the Maritime Advisory Board decided it should be forwarded to the International Harbour Masters' Association. The traffic management lessons to be learned from this incident are likely to be of wider interest than just one port.

The IHMA responded positively to the report and published the incident on its own membership forum and also undertook to publish further relevant incidents in the future.

SAFE OVERTAKING?

Report Text: Vessel was navigating in the Dover Straits; I observed on radar a vessel on my port quarter at a distance of 4.0 nm. I began plotting using ARPA; CPA was 0.0nm. I continued plotting and when it seemed no action was being taken I tried to call on DSC 70 and got no response. At a distance of 1.5nm I managed to contact the vessel, but the OOW told me that I had to alter course to starboard so he could overtake and he would alter course in 10 mins at his waypoint. I told him he had an obligation to me to alter course as he was the overtaking vessel. I then tried to contact Gris Nez Traffic on VHF 13, but then the OOW on the other vessel came on the radio and said he was overtaking and would be clear in 10 mins!!! [Ed: Vessels were < 8 mins from impact.] At this point I had no choice, but to put my helm hard to starboard to avoid a collision. Another near-miss in the Dover Strait by another seemingly inexperienced OOW, with no regard for the colregs.

CHIRP Comment: The overtaking vessel had elected to attempt to pass on the port side of the slower vessel with the Sandettie Bank close to port. This incident was brought to the attention of the overtaking vessel's Operator, who responded as follows:

"This company recognizes that the most important contribution towards safer ships and cleaner oceans is the safe navigation of ships. To achieve

this, the Company commits itself towards the goal of navigational excellence.

It is our aim to employ well trained officers and crew onboard ships and to support our seagoing staff with on-going training in order to permanently update their knowledge on navigational practices and equipment.

The reported near-miss will be investigated and the responsible Master or Officer will be made aware of his responsibilities under the law and good seamanship.

Furthermore we will circulate the report (depersonalised) to all persons in our company involved with the navigation of ships. The safety of life, the ship or the environment are the most important factors to be taken into account when taking decisions for ship navigation or operation."

The Board believes this is an appropriate Safety Management System response to an incident such as this and wishes to emphasise that the practice of good seamanship and the collision regulations may require a departure from the charted course and waypoints. Additionally, officers should not hesitate to call the master if in any doubt.

SAFETY CAN BE GARBAGE

Report Text: On a recent voyage, our Master, ordered the deck crew to throw overboard the used oil and oily rags and other garbage including plastic into the sea with his presence without the knowledge of our Chief Engineer or our Chief Mate. Our Captain did not go away until the deck crew finished throwing the said garbage into the sea.

The next day our Chief Engineer learned that their garbage was thrown overboard as per order of the Captain, he was very angry and upset, and said that those garbage is almost three weeks all in all. I learned that the Chief Engineer ordered to hide their garbage into the tunnel which is also one of our emergency exit and it obstruct the way and also makes engine crew more difficult jobs to do because it's little bit far when giving ashore for disposal.

CHIRP Comment: This incident took place in international waters. As an emergency escape was involved CHIRP forwarded the report to the vessel operator, confident they would be equally, if not more interested in the environmental aspects. Given the severity of the penalties and the incentives for seafarers to go directly to the authorities in some countries, CHIRP believed the operator would be pleased to receive a discreet indication that there might be issues of concern with respect to the environmental elements of their Safety Management System.

This was not the case and after lengthy correspondence with the operating company and their lawyers, the Maritime Advisory Board decided

the vessel operator should be advised the information would be passed to their P&I Club for their assessment. The P&I Club was contacted to ensure they were willing to deal with the issue.

On being informed this was going to take place the operator engaged in positive dialogue and took certain steps which it believed would address the issues raised.

IDENTIFIED FLYING OBJECTS

Report Text: The incident occurred during a cruise in late May in the pool area. There is a balcony (mezzanine deck) above the pool which is protected by a handrail with composite glass panels underneath; there is a 30-50mm gap between the base of the panels and the deck. The area is used as a self-service cafeteria and passengers collect trays and take them to tables.

The incident involved a tray being dislodged from the table, through the gap under the composite glass panels and into the pool; fortunately without injury to a swimmer. The trays used are of robust construction and could have caused injury.

I reported the incident onboard and have subsequently been dealt with by customer relations, but I (a former professional seafarer) have not been entirely satisfied with the outcome.

Onboard the incident was reportedly discussed by the Staff Captain at a meeting where it was decided that the incident was a "one off" and unlikely to recur. I dispute this judgement.

Customer relations have informed me that there is 1500m of this type of railing on the ship and modifications would be unreasonable. My concern relates to the cafeteria area around the pool, where the risk exists.

CHIRP Comment: CHIRP forwarded the report to the vessel operator, who responded as follows:

"We do take safety issues very seriously on our ships and having visited the area your correspondent mentions I can understand his concern. In response to this issue we do not consider 'filling' the gap between the composite glass panel and the deck is appropriate in this instance.

However, steps have been taken to coat the underside of the trays with a non-slip material to ensure that they will not be as easily dislodged in the future. The ship's staff also try to encourage the passengers to remain in the open deck area of the cafeteria with their trays rather than carry them up to the deck above the pool.

This issue will continue to be monitored to ensure that appropriate steps are taken in the unlikely event of there being a similar occurrence in the future."

Some Administrations require passenger vessels to maintain risk registers or similar documents and the Board wishes to emphasise the importance of identifying and mitigating the risks of "routine" activities.

ONBOARD COMMUNICATIONS

Report Text: The company employs British masters and I had a good, mixed complement of nine nationalities. I, as master, was the only Brit onboard. Fortunately for us Brits, English remains the language of the sea and my senior officers all spoke it to a greater or lesser degree, even some conversation, while I learned helm orders and a few other important words, like "Please" and "Thank You", etc in other languages.

Conducting the required monthly safety meetings was interesting. The second mate and I devised a pantomime, which we would put on to the assembled crew - all hands not on duty - in the crew mess room. Many shipboard accidents are caused by thoughtlessness - leaving a bucket of water near the foot of a ladder, not changing a lamp bulb properly, not roping off newly painted or dangerous places, leaving bits of wood, shackles, all kinds of spare parts lying around the deck for people to trip over - not checking that a lifeboat is safe to lower before you lower it - and so on.

While on the subject of lifeboats and emergency drills, it is essential to carry these out frequently and so that every man aboard knows what to do - so that when he has to do it for real on a dark night with the ship on fire and rolling heavily - he'll know what to do almost by instinct. Regardless of often ill-written manuals, everyone on board must be taught in their own language what and how to do by the master via their own bilingual language-speakers.

For our pantomime audience, I came down a ladder and stepped into a bucket of water placed nearby, causing me to fall over. To my surprise several sailors gasped with horror and rushed forward to pick me up! But our panto seemed to work, got the safety message across. A ship is a potentially dangerous workplace, especially at sea - liable to move in all three dimensions without warning. If all hands realise this and THINK what they are doing, accidents become less common.

CHIRP Comment: Multi-national crew complements have become a feature of modern shipping and a number of companies employ such complements as a matter of policy. Nevertheless, poor onboard communications often feature in accident investigations, so it would appear the standard of management of this policy varies.

The master's attempts to accommodate the various languages spoken onboard are understandable, but could cause confusion.

The Maritime Advisory Board wishes to stress the importance of a common working language adequate for routine operations, training delivery and emergency response. Communications failings in the first two areas are often emphasised in the last.

CHIRP would be interested to hear more on this important subject; both positive and negative and will be writing to relevant organisations.

CRANKSHAFT BEARING FAILURES

Report Text: My pet hate is crankshaft bearing failures. The connecting rod bottom end bearing is the one most prone to failure and since the very beginning of the diesel engine, it has been possible to measure the temperature of the oil coming out of the bearing, and detect a temperature rise in the event of a bearing problem. Crankshaft bearing failures remain the most common category of insurance claim, and yet this technology is still not a requirement. There is a requirement for an Oil Mist Detector on some engines, but by the time there has been an overheating bearing sufficient to create an oil mist, the damage has been done.

Again, such an improvement is just a matter of a few lines of writing within SOLAS or Class rules, it is basic technology that has existed for years.

CHIRP Comment: Initially the Maritime Advisory Board were not certain this report fell within the scope of the Programme, so an open letter inviting opinions was written to the membership of IMarEST, through their publication MER.

Two views emerged; one related to the immediate safety risk to personnel close to a bearing and crankshaft failure, which was generally considered to be slight and another related to the safety risk associated with the impact of a bearing and crankshaft failure on the operational viability of the ship, which, in certain circumstances, could be significant.

On the balance of responses, the issue is considered to be one of safety, falling within the ISM Code. CHIRP is now seeking to gain some understanding of the frequency of bearing and crankshaft failure, the contributory factors and the extent to which the measure suggested, or others, might mitigate the risks. Once these enquiries are complete the information will be forwarded to relevant organisations for their assessment.

SECURITY/EMERGENCY ESCAPE CONFLICT

The Owners have recently had fitted to all the class "A" machinery escape trunks a padlock system that allows the trunk hatch doors to be opened only in the way of escape. I believe this to be in contravention of SOLAS Reg 13 general requirements:-

- “3.1.5. Doors in escape routes shall, in general, open in way of direction of escape, except that;
- .2 doors in vertical emergency escape trunks may open out of trunks in order to permit the trunk to be used for both escape and for access.”

I fail to see how access can be achieved in an emergency if the trunk is locked from the outside. It is my opinion that the locking of these hatches poses a greater threat to the vessel and its crew than any implied attack on the vessel. These hatches have two independent functions: Firstly every Class "A" machinery space is required under SOLAS to have two means of access; one by stairway, and one, may be, by vertical ladder, the second is as a means of escape, under SOLAS the hatches may open outwards, but must be operable in both directions.

The idiocy of locking emergency escape/access in the name of security should be stopped before someone is injured as a result.

CHIRP Comment: We asked the UK Maritime and Coastguard Agency for an opinion and the following is an extract from their reply, more of which will be published in the next edition:

“The potential conflict between safety and security can be eliminated with some thought being given to both requirements. The November 1997 explanatory note to AMSA Direction 25A/96 identified examples of techniques used by operators which remain valid solutions:

- Digital locks with one way and fail open operation (on bridge doors, engine rooms, radio rooms).
- Fixed locks or bolts where possible (as above).
- Remote locking of car deck doors (with fail to safe or unlocked status) by means of hydraulics, compressed air, electronic systems or a combination of these.
- Micro switches or other electronic Intruder Detection Systems.
- Closed circuit TV (including video recording).
- Alarms (local or remote).
- Seals.
- Dedicated manual/physical guarding.

In MCA the solutions to this dilemma have been the matter of discussions with UK companies during and since the ISPS implementation. Additionally our surveyors are aware of the situation and have given advice to ships' masters. We have not been specific in requiring one solution over another, it being dependent on pragmatism, the ship type and trading pattern. What is appropriate for a cruise ship may prove inappropriate for a sand dredger.

The situation that your correspondent identifies; escape hatches being padlocked shut from the outside, would be unacceptable on UK ships, or on ships in UK ports.

The MCA's 24hr Infoline is on 0870 6006505.

LEISURE

USE OF RADAR 1

Report Text: Whilst anchoring vessel; unable to proceed due to thick fog, on running into the anchorage an echo was seen on the 3M range on the radar. The echo was seen to be tracking clear of the vessel, but would pass close. We had a patrol boat ahead of us and this was dispatched to see what the echo was and advise them of our intention to anchor. The patrol boat found the echo to be a yacht. It had a chart plotter, but no radar. The person in charge of the yacht was happy that he knew where he was in the fog and therefore ok. He was happy crossing a busy waterway/port approach. He obviously thought that everyone was going to keep out of his way. The worry is how many yachtsmen have this attitude?

CHIRP Comment: Restricted visibility may be encountered at any stage of a voyage and all mariners must be prepared to take appropriate measures based on their particular circumstances and their assessment of the risks involved.

It is not clear from the details of this report, but there would be scope to criticise an individual who chose to leave port under these conditions, in this location, without radar.

The Maritime Advisory Board believes Rule 19 is most effective where both vessels are radar equipped. Radar equipped craft need to bear in mind that other vessels may not be; particularly in areas frequented by leisure sailors, and navigate accordingly.

Sound signals should be used.

USE OF RADAR 2

Report Text: I've completed a single-handed trans-Atlantic circuit on my yacht & would like to raise a general point about use of radar. Accepting that there are issues around single-handed and watchkeeping, I found that I could sleep for 40 mins and then pop up to check for shipping; this was ok in mid-Atlantic & obviously changed in busier waters. My back-up for this is a "Watchman" radar detector, which sounds an alarm when it detects radar. However, I came across a significant number of ships; large & small, day & night, which were not operating radar. I was told, via VHF, by one ship that I couldn't rely on the detector as radar wasn't always used. This seems to me a significant safety issue.

CHIRP Comment: The Maritime Advisory Board repeats its emphasis on the requirements of Rule 5:

“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.”

The answer to the reporter’s concern lies within the words “by all available means appropriate in the prevailing circumstances and conditions”, which may, or may not, include radar. Radar and other aids may not be in use for any number of operational reasons, including, in the current security climate, avoiding detection!

A theme common to this and the previous report is that it is not safe to rely upon the operation of technology on somebody else’s boat to ensure the safety of your own.

EDITORIAL

NEW METHOD OF REPORTING TO CHIRP

It is now possible to send reports to CHIRP via our website. Log on to www.chirp.co.uk and click on the button 'Submit Report'. Enter your contact details then complete your report in the window that appears. On submitting, the report will be emailed directly from the website to the CHIRP offices.

Using this method will not result in any information being retained on the computer that you use; however, as with other e-mail transmissions, we are unable to guarantee the safety or integrity of the information whilst in transit. You will receive confirmation that your report has been received by the method that you request.

The CHIRP database now contains over 200 reports. Recently we have received a large number of near-miss collisions, giving rise to concerns as to the standard of knowledge and application of the collision regulations. In most cases CHIRP has been able to notify the relevant management of these incidents and how their multi-million dollar assets are being navigated. We will continue to do this, as long as you continue to report and this can only assist in raising awareness and standards.

REPORT UPDATE

ENGINE INTEGRATION ISSUES

The CHIRP report on this subject is now available from our web-site www.chirp.co.uk and has been addressed to the following organisations:

- The British Chamber of Shipping
- The Community of European Shipyard Associations
- The European Community Shipowners’ Associations
- The European Maritime Safety Agency

- The Engine Manufacturers’ Association
- EUROMOT
- The International Association of Classification Societies
- The International Chamber of Shipping
- The International Council on Combustion Engines
- The International Underwriting Association
- Lloyd’s Register
- The Maritime and Coastguard Agency
- The Shipbuilders’ & Ship Repairers’ Association

The report highlights some potentially significant areas of concern with respect to new build and retro fit processes and a very small number of the listed organisations have responded positively to them. It is disappointing that many organisations have yet to even acknowledge receipt of the report.

NEAR-GROUNDING UPDATE

MFB4 contained a report of a near-grounding incident, which was forwarded to the operational management for assessment; highlighting procedural, bridge resource management and familiarisation issues.

Correspondence with the company led to serious doubts with respect to the functioning of its safety management system and the Maritime Advisory Board recommended the information be passed to the Flag Administration. The three Administrations involved in the company’s operation were notified and have undertaken to investigate the issues further at Flag State and ISM inspection and audits.

Where necessary, CHIRP’s Maritime Advisory Board will continue to support Administrations in their efforts to promote safer shipping.

CURRENT MAIB INVESTIGATIONS

| The following accidents/incidents are being investigated by the MAIB as at 06.10.05: | | |
|--|--|------------------|
| Vessel's name | Accident/incident type | Date of Incident |
| Border Heather | An explosion onboard BP tanker whilst loading petrol/kerosene, Grangemouth | 31/10/04 |
| British Enterprise | Grounding of tanker in anchorage near Istanbul. | 11/12/04 |
| Amenity/Tor Dania | Collision in the River Humber. UK registered tanker and Norwegian freight ro-ro. | 23/1/05 |
| Orade | General cargo vessel grounded in the River Humber. | 01/03/05 |

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| Loch Lomond RIB | Father and daughter missing after falling overboard from rigid inflatable boat (RIB). | 13/03/05 |
| Lykes Voyager/ Washington Senator | Collision in the Taiwan Strait between UK and German flagged container vessels. | 8/04/05 |
| Brenscombe Outdoor Activities Centre | Sinking of kayaks and launch during training exercise in Poole Harbour | 6/04/05 |
| Stolt Aspiration/ Thorngarth | Collision between chemical/oil tanker and tug on the River Mersey | 13/04/05 |
| Bounty | Capsize of Teignmouth registered fishing vessel Bounty, resulting in loss of vessel. | 23/5/05 |
| Portland powerboats | Collision between two junior racing powerboats in Portland Harbour | 19/6/05 |
| Auriga | Foundering of fishing vessel in the Irish Sea | 30/6/05 |
| Mollyanna | Swamping and capsize of small trailer-sailer off Puffin Island, Anglesey with the loss of two lives | 2/7/05 |
| Inseyandra | Fire in bow thruster compartment aboard 14.4m charter yacht on River Hamble, Hampshire. | 16/4/05 |
| Sea Snake | Grounding of powerboat at entrance to East Loch Tarbert, Argyle, Scotland resulting in three fatalities. | 10/7/05 |
| Carrie Kate/Kets | Speedboat collision with dory in St Mawes harbour resulting in one fatality. | 16/7/05 |
| Savannah Express | Contact with linkspan by container vessel in Southampton Container Terminal. | 19/7/05 |
| Bramble Bush Bay | Accident to person, when a young girl suffered a crush injury to her foot on Selbay Beach, Studland. | 04/08/05 |
| Abersoch RIB | Two people were thrown from speedboat and a third person abandoned the speedboat. All occupants were 16 or under. The vessel continued and one occupant received injuries by contact with the propeller. | 07/08/05 |
| Land's End | Grounding of super-yacht on a reef off the coast of Sagonne, Corsica. | 09/08/05 |
| Sovereign II | Accident to person where a diver suffered severe injuries to his legs whilst re-boarding the dive vessel Sovereign II | 13/08/05 |
| Balmoral | Grounding in Swansea | 24/08/05 |
| Big Yellow | Passenger-carrying RIB suffered serious damage and flooding in St Ives bay, resulting in 8 passengers being injured. | 26/08/05 |

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| Fertile II/Aquarius | Collision between two fishing vessels Fertile II and Aquarius, which resulted in the loss of Fertile II. No lives were lost in this incident. | 28/08/05 |
| Harvest Hope | Loss of fishing vessel after she snagged her gear on pipeline NW of Aberdeen | 28/08/05 |
| Anglian Sovereign | Grounding of the Coastguard ETV off Shetland. | 03/09/05 |
| fv Blue Sonata | Flooding of fv Blue Sonata (WH703) off Weymouth with one life lost. | 08/09/05 |
| Hatsu Prima/ Gertrude | Collision between UK flagged vessel Hatsu Prima and Panamanian flagged vessel Gertrude. | 10/09/05 |
| Belo Horizonte | Fire on board the Hong Kong flagged coal carrier while docked at Hunterston Port in North Ayrshire. | 14/09/05 |

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

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Registered in England No: 3253764

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