Annual Report for 2017

Prepared for the Chief Inspector of Marine Accidents, Guernsey



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Foreword

The Bailiwick of Guernsey is blessed with superb coastline and sits at the centre of a cruising ground regarded by many as the finest in Northern Europe. More importantly, the sea is our lifeline and, for many, the source of their livelihood.

Whether we use the sea for pleasure or profit, it is vital that we have a healthy regard for its moods and conditions. The evidence of past shipwrecks is all around us, highlighting that the sea and the marine environment, must always be treated with respect.

As Harbourmaster, maritime safety is my primary concern. Accidents can and do happen, but it is important that we learn from each incident, identify the causes and avoid repeating them. This is why the work of marine accident investigators locally, and around the world, is so important. By sharing their findings, we may save lives and livelihoods within the Bailiwick and beyond.

In compiling this report for the Chief Inspector of Marine Accidents, it is encouraging to note the downward trend of reportable marine accidents in Guernsey in 2017, with just two recorded compared to five in both 2015 and 2016.

This report will highlight the findings of the reportable accidents in Bailiwick waters in 2017, the lessons identified, and any recommendations to prevent future occurrences.

Captain David Barker **Harbourmaster**Guernsey Harbours

Introduction

Under Bailiwick of Guernsey Law, there is a requirement to examine and investigate all types of marine accidents to or on board Guernsey vessels worldwide, and other vessels in Bailiwick territorial waters, including Sark and Alderney.

The objective of an accident investigation is to determine its circumstances and causes, with the aim of improving the safety of life at sea and avoiding similar accidents in the future. It is not its purpose to apportion liability, nor, except so far as is necessary to achieve the fundamental purpose, to apportion blame.

The Chief Inspector of Marine Accidents is an independent statutory official and can call upon a number of accident investigators. All are professionally qualified and experienced in the nautical, engineering, naval architecture and/or fishing disciplines of the marine industry.

The powers of Accident Investigation Inspectors, and the framework for reporting and investigating accidents, are set out in the Merchant Shipping (Accident and Reporting) (Bailiwick of Guernsey) Regulations 2002. The Merchant Shipping (Accident and Reporting) (Bailiwick of Guernsey) Regulations 2009 put the framework into effect. These regulations apply to merchant ships, fishing vessels and (with some exceptions) pleasure craft. They define accidents, set out the purpose of investigations and lay down the requirements for reporting accidents. They make provision for the ordering, notification and conduct of investigations, but allow inspectors a good deal of discretion - necessary, given the wide variety of cases.

What is an Accident?

An accident is an undesired event that results in personal injury, damage or loss. This may include: loss of life or major injury to any person on board, loss of a person overboard, the actual or presumed loss of a vessel, her abandonment or material damage, collision or grounding, disablement, and material damage caused by a vessel. An accident can also be an occurrence, which might realistically have caused serious injury or damage to the health of any person. This can range from the collapse of lifting gear, an unintended movement of cargo or ballast sufficient to cause a list, a loss of cargo overboard or a snagging of fishing gear that results in the vessel heeling to a dangerous angle. It is the duty of every master or skipper to examine, and report as necessary, any accident occurring to, or on board, his/her vessel.

What is a Major Injury?

A major injury includes any fracture to, or loss of, a limb, loss of sight, or any other injury requiring resuscitation or leading to hypothermia or admittance to a hospital or other medical facility for more than 24 hours.

What is a Serious Injury?

A serious injury is an injury, other than a major injury, when the injured person is incapacitated for more than three consecutive days.

What is a Hazardous Incident?

A hazardous incident is when an accident nearly occurs in connection with the operation of a vessel. In other words, it is what is often known as a "near miss".

The Reporting Process

Accidents, including major injuries, must be reported to the Chief Inspector of Marine Accidents (CIMA) by the quickest possible means. This is so that they can be investigated immediately, before vital evidence decays, is removed or is lost. The vessel's master and owner must investigate serious injuries, and report the findings to the CIMA within 14 days. Hazardous incidents do not have to be reported, but the CIMA encourages owners, masters and skippers to report them. Hazardous incidents often provide lessons that are every bit as relevant as those arising from accidents.

Accidents can be reported to Guernsey Harbours on 01481 720229, or outside office hours on 01481 720481, or directly via Guernsey Coastguard or Guernsey Port Control, which are both open 24 hours a day. Reports are referred to an inspector for a decision on what action to take. In some cases, the initial report contains all the information that is needed. In others, the inspector will conduct further enquiries, make a preliminary examination, or complete a full investigation.

In some cases, the ship's owner's or officers' own investigation will be sufficient. The CIMA may, however, conduct an administrative enquiry by correspondence and telephone to seek further details on any accident. The regulations require owners, masters and other relevant people or organisations to provide any such information when requested.

Preliminary Examination and Full Investigation

Following notification of an accident, inspectors will start to collect evidence and the decision whether or not to conduct a preliminary examination (PE) will be made. A PE is the first stage of a full investigation, and identifies the causes and circumstances of an accident to see if they meet the criteria required to warrant further investigation and a publicly available report. Every effort is made to examine a wide range of accidents each year.

All PEs and accident investigations seek answers to four basic questions:

- What happened?
- How did it happen?
- Why did it happen?
- What can be done to prevent it happening again?

Once the decision to proceed has been made, all available evidence is gathered. No two cases are ever the same, and the process may take different forms. Inspectors will usually wish to see logbooks, charts and other documents. They will invariably interview those who may be able to shed light on what happened and are likely to take photographs and examine computer records. If the vessel contains a 'black box', the data will be removed and examined.

Inspectors consider evidence from as many sources as possible. If necessary, they will call in external technical experts. Particular emphasis is placed on identifying human factors in the causes of an accident. It can take up to a year to complete an investigation and publish a report. This might seem a long time, but it may be necessary to interview a wide range of individuals, crosscheck evidence, examine suspect equipment and consult with technical experts. Often the true cause of an accident turns out to be very different from initial assumptions. A full investigation or PE is entirely independent of any enquiries made by the police or other authority collecting evidence for a possible prosecution.

Families

The CIMA is very conscious of the hurt and bewilderment that a marine accident causes to the families of victims. Inspectors make every effort to contact next of kin after an accident to explain their role. Once the investigation is complete, the next of kin are given the conclusions before they are made publicly available.

Reports

The CIMA aims to improve safety for all those who work at, or travel by, sea. The investigation findings usually lead to recommendations aimed at preventing similar accidents. If a decision has been made to investigate an accident, the CIMA will make the results publicly available in a full report. The accident investigation report is not written with liability in mind and is not intended to be used in court for the purpose of litigation. It endeavours to identify and analyse the relevant safety issues pertaining to the specific accident, and to make recommendations aimed at preventing similar accidents in the future. From time to time, the CIMA may also publish a report highlighting, for example, specific safety problems, safety trends, or any other issues that should be brought to the attention of the maritime community and the public.

Incidents in 2017

The Merchant Shipping (Accident Reporting and Investigation) (Bailiwick of Guernsey)
Regulations, 2009 requires production of a summary of an annual report of the Chief
Inspector of Marine Accidents work, and any investigation outcomes. These are as follows:

01/2017 Berthing Incident – HSC Condor Liberation

At approx. 1545 on 3rd May 2017, *HSC Condor Liberation* was manoeuvring within St Peter Port harbour in order to moor at No 1 berth. The vessel made contact with the small craft pontoon in the outer pool area of the port, as well as a private sailing catamaran and the starboard hand lateral mark. This caused damage to the pontoon and a catamaran berthed on the pontoon's south side. *Condor Liberation* subsequently berthed without further incident. Following above water and underwater inspection it was established that *Condor Liberation* had sustained only minor damage to the stem (approx. one metre above waterline). The vessel continued with operations and sailed on passage to Poole after a delay of approximately one hour.

A company investigation was conducted and the following conclusions and observations made:

- a. The Master served on *Condor Liberation* as Chief Officer, Relief Master and Master since its delivery to the UK in 2014, and holds a Guernsey Special Pilots Licence. He had recently completed routing simulator training and had received an excellent score during a Bridge Team Management Assessment the previous day.
- b. Contact with the Pontoon (and thus with the moored yacht) occurred because of an initial positioning error during the approach to the turn inside the port. Although the initial position was not unreasonable given the wind conditions on the day, it did lead to a sequence of actions that resulted in the incident.
 - a. The Master became concerned about the proximity of the *Victor Hugo* on the X-Berth¹ during the swing, at the same time being prompted as such by the Chief Officer (when requested the Boatswain reported 20m off and steady).
 - b. The Master saw the face to the White Rock pier-head beginning to close and interpreted that the vessel was gathering sternway. He therefore applied ahead thrust and the vessel began to gather headway assisted by the wind.

¹ The X Berth is situated at the end of the New Jetty in St Peter Port Harbour and allows safe passenger access between passenger ferries and the terminal.

- c. By the time, that confirmation was received that the distance off the Victor Hugo was 20 metres and increasing, the vessel had already picked up headway, which was not immediately reduced.
- d. The Master did not have a direct view of ECDIS, RADAR and CCTV while operating from the bridge wing positions.
- e. Astern thrust was applied, as the Master became concerned with the proximity of the starboard hand buoy of the small boat channel, and the vessel being influenced by the wind. It was done with the Master still being wary of the vessels proximity to the Victor Hugo astern.
- f. Contact was made with the pontoon at a speed of less than one knot.
- g. There was no material failure of the vessel itself.
- h. The position of the small craft pontoon is not considered a hazard and has been in place for many decades.
- i. The Master undertook a review of his own notes regarding marks and identification of go/no go areas as well as contingency plans. He also conducted a period of duty with an additional master sailing in support.
- j. The company will be introducing a role-based system to their bridges, this will ensure briefings involve the entire team and the master is fully supported during manoeuvres.

02/2017 - Report on the Investigation of an alleged marine incident at La Vallette Bathing Pools, Havelet Bay

At 18:15 local time on Saturday 8th July 2017, Guernsey Police were directed by The Joint Emergency Services Control Centre (JESCC) to attend the La Valette bathing pools, Havelet Bay, St Peter Port due to reports of individuals being hurt by crashing waves. Medical assistance had already been dispatched by JESCC and was on route. Police reported on arrival that the area was very busy and that many young people were present. Many of the young people were not accompanied by an adult, although a number of adults were in the area.

It was alleged at the scene that the high-speed craft *Condor Liberation* had caused a swell, which had washed into the pools, that individuals swimming in the pools, were not able to get out quickly enough and were caused to be knocked into the walls of the pool. The main injuries were abrasions to the skin and ingestion of seawater.

Four ambulances attended and conveyed people to the Emergency Department at the Princess Elizabeth Hospital for treatment. Parents/Guardians were called and attended hospital with their children or picked them up from the area.

Under the requirements of The Merchant Shipping (Accident Reporting and Investigation) (Bailiwick of Guernsey) Regulations, 2009, the CIMA deemed it necessary and appropriate for an investigation, particularly as it was alleged that vessels may have contributed to the incident.

Conclusions and Observations

- a. It is highly likely that the change in sea conditions at the La Valette pools resulting in injuries to users were caused by waterborne activity, given the benign weather conditions.
- b. During the period preceding, the incident there was a high volume of vessel movements in the adjacent area, including both leisure and commercial craft.
- c. Some people regularly use the pools specifically when there is increased swell and wave action.
- d. Following earlier traffic avoidance action, the Master of *Condor Liberation* deviated from approved procedures by altering course to port in an attempt to regain track which, based on analysis, is likely to have generated of a wave of approximately 60cm.
- e. Considering the approach of the *Condor Liberation* in isolation, it is possible that an effect will have been felt at the La Valette pools. However, it is unlikely to have been of the magnitude reported.
- f. It is considered likely that the pressure wave arriving near the pools at a probable height of 60 cm would have been modified by the effect of the topography as is usual, by the "Gulley" in particular, but also the surrounding rocks. Furthermore, the wash effect of the vessel *Adonia*, southbound at approximately 10 Knots, is likely to have reached the pools at around the same time. It is likely that this was compounded by both the *Trident V* approach to St Peter Port and another *Unknown Leisure Craft* entering Havelet Bay at speed.

- g. Although individually the effects of the other three vessels (*Adonia, Trident V, Unknown Leisure Craft*) are unlikely to have been significant at the La Valette Pools, cumulatively they are likely to have increased any effect generated by *Condor Liberation*, which normally does not create a problematic swell.
- h. It is not possible to control all waterborne users of the area (both commercial and leisure) to the extent that their activities will not result in cumulative wash/wake effects.
- i. Warning Signs already in place advising users of potential hazards are considered appropriate and sufficient.

Recommendations and Actions Taken

As a result of the incident and investigation, the following actions have been taken:

- a. In agreement with the Harbourmaster, Condor Ferries has amended approach procedures for high-speed craft to ensure they route east of The Great Bank when approaching from the south at high speed, during daylight arrivals between 1st May and 30th September. This will be monitored for effectiveness over the following months. The purpose of this change is to ensure any wash/wake dissipates to the north when the vessel slows down, keeping it away from La Valette and Havelet Bay.
- b. The States of Guernsey's Agriculture Countryside and Land Management Services unit have fitted additional warning signage in prominent positions to try to raise awareness of the potential risk of changes in sea conditions.
- c. CCTV will be used to monitor the La Valette bathing pools, during the arrival and departures of high-speed craft, to assist in assessing the effectiveness of the amended procedures.
- d. Guernsey Harbours has initiated a public awareness campaign to highlight the risks associated with using the La Valette bathing pools during high tides and rough seas.

Reporting and Communication

The Guernsey Harbours website (www.harbours.gg) includes a section on Marine Accident Investigation. Where appropriate, this site includes a retrospective synopsis of accidents and the recommendations made by the Chief Inspector. A pro-forma reporting document is also downloadable from the website. The table below is a summary of the number of reports received over the past six years.

Year	Reports Received
2012	2
2013	1
2014	4
2015	5
2016	5
2017	2

Source: Guernsey Harbours.

There were no known investigations launched into accidents in Bailiwick waters by other authorities, such as the UK Marine Accident Investigation Branch (MAIB) in 2017.

Appendix

For further information about the Accident Investigation or for information about specific accidents, please contact the Chief Inspector of Marine Accidents using the contact details s below:

The Chief Inspector of Marine Accidents c/o Guernsey Harbours
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