Volume 22: Number 2
August 2015

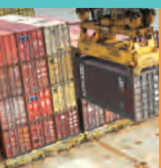
RISK WATCH

Britannia

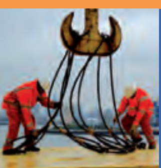
The Britannia Steam Ship Insurance Association Limited

Navigation and seamanship

Personal injury

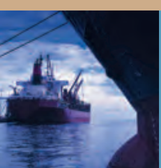


Containers and cargoes



Loss prevention

Regulatory update



Miscellaneous

Collision

The use of sound signals and keeping a proper look out could have prevented this collision between a car carrier and a fishing vessel.

NOCC OCEANIC

On 22 June 2013, at around 17:00, *NOCC OCEANIC*, a 12 deck car carrier, left Keihin Port, Japan, bound for Balboa, Panama.

On Sunday 23 June at 07:30 the master visited the bridge. The weather was good with clear visibility, the ship was in open water and there was no traffic. With this in mind the master decided that the conditions were appropriate for the officer of the watch to act as sole lookout in order that the crew could take their allotted rest periods and the deckhand was accordingly dismissed from the bridge. This was in line with the Bridge Procedures Manual for the ship (drawn up by the ship's management company) which allowed for sole bridge watch keeping in circumstances of daylight, open water, and very light traffic (among other qualifying conditions).

At 07:50 the third officer came to the bridge and was told by the chief officer that visibility was good and that there were no ships in the area. The third officer confirmed the course and speed (063 degrees, 15.8 knots) and commenced sole lookout. He set the starboard radar to 12m range.

At around 09:15 the third officer saw that rain had started to fall and observed a thick rain cloud approaching from the forward port side. At about 09:30 he called the master to suggest that off duty crew be asked to close the outside doors to the accommodation. Soon after, an announcement to this effect was made over the ship's tannoy.

At 09:33 *NOCC OCEANIC* entered a heavy squall. Visibility deteriorated such that the bow mast (approximately 30m forward of the bridge) could barely be seen. Because he could see so little out of the window, the third officer moved to the radar to continue his look out. He could see no other ships in the vicinity, either by radar or by AIS data (which was configured to display on the radar). He did not call the master to advise him that the range of visibility had changed and he maintained the same course and speed without using sound signals as appropriate in restricted visibility.

Collision (continued)

The VDR data picked up the sound of intense rainfall at 09:34 which weakened until 10:01 when the sound of rain could no longer be heard. At 09:44 the VDR picked up a loud sound, different to the sound of rain, for about 3 seconds. This sound was registered on the outside bridge wing microphones only and not on the microphones positioned inside the bridge. The rain died down, according to the ship's report, at 11:00 and the remainder of the third officer's watch and the subsequent 12:00 – 16:00 watch were uneventful.

At around 16:30 *NOCC OCEANIC* received a VHF call from a Japan Coast Guard aircraft reporting that there were scratches on the ship's hull. The master asked the crew to check for any damage but nothing was found.

At around 19:10 the master was contacted by satellite phone and told that the ship had been requested to save the VDR data and return to Japan. The ship proceeded to Sendai Siogama Port, where she anchored for what turned out to be a collision investigation. At this point the crew on board the *NOCC OCEANIC* were not aware a collision had occurred.

YUJIN MARU No.7

At around noon on 22 June 2013, fishing vessel *YUJIN MARU No. 7* (a tuna long-liner) left Shiogama Port bound for fishing grounds east of the Mariana Islands. She had on board a master, a chief engineer and seven other crew.

A sister ship, *YOSHI MARU No. 55*, was scheduled to fish in the same area, also left that afternoon. Prior to departure the masters discussed the route they would be taking and in the early morning of 23 June they made contact with each other, identifying their ships as being approximately 30 nautical miles apart, with the *YUJIN MARU No. 7* to the east of the *YOSHI MARU No. 55*.

The master of the *YUJIN MARU No. 7* ordinarily adopted a bridge watch keeping system of eight two hour shifts covered by the eight crew members (other than the master). He did not permit any of the crew (other than the chief engineer) to operate the navigation equipment on board. Instead they were instructed to call him if they observed another ship.

The *YUJIN MARU No. 7* had a steering room mid-ships, above which was a small watch room. There were significant blind areas when watch keeping from the steering room, but a watch keeper could sit on the floor with his back against the wall of the watch room and see from dead ahead to about 45 degrees on either side of the bow. There was no navigation equipment in the watch room, although the radar in the steering room below was positioned so that the screen could be seen through the hatch joining the two rooms.

One of the deckhands took over the bridge watch in the watch room at 08:00, confirming the course set on the automatic pilot (125 degrees) and the speed (approx 9 knots). At around 09:00 the deckhand noticed that he could not see very far as rain had started falling. At 09:30 he climbed down to the steering room to check the radar display, which showed approaching clouds and one other ship six miles off, at 60 degrees on the starboard quarter.

At 09:35, on the assumption that no other ships were present forward of the beam, the deckhand climbed back up to the watch room, sat on the floor and leaned against the rear wall, continuing to look out, despite the fact that there was a blind area caused by the watch room wall, from 45 degrees to starboard to aft. Soon after he sat down, the deckhand felt a sudden impact as the watch room was torn open from the outside, causing the deckhand to be thrown into the water.

Below deck, the chief engineer and six other crew members had been resting in the crew quarters behind the engine room. Immediately after feeling the impact they saw sea water coming in from the bottom of the door to the engine room and escaped to the deck. They inflated the life raft stowed at the port stern and all boarded, including the watch keeping deckhand who had been able to swim to the surface and was helped into the raft from the sea by the other crew.

Noticing that the master was not with them, the crew shouted in the direction of the living quarters but received no response, despite calling repeatedly. When it became clear that the fishing vessel was about to sink, the chief engineer released the line that connected the life raft with the fishing vessel and activated the EPIRB.

At around 11:15 *YOSHI MARU No. 55* received a satellite phone call from the Japan Coast Guard advising that *YUJIN MARU No. 7* was in distress. Immediately she headed towards the location of the distress signal (as advised by the Japan Coast Guard) in order to offer assistance. At around 13:45 she discovered the life raft, rescued the eight crew members on board and began to search for the master. Despite her efforts, and those of the Japan Coast Guard for a three further days, the master was never found.

When later questioned, the crew reported that they had been hit by a large blue ship, and one crew member recognized the letters *'OCEANIC'* on the bow.

Summary

A collision occurred between the bow of *NOCC OCEANIC* and the starboard centre of *YUJIN MARU No. 7* when *NOCC OCEANIC* was heading east northeast and *YUJIN MARU No. 7* was heading southeast off the coast of Kinkazan, Japan, at a point about 160 nautical miles from Kinkazan Lighthouse.

NOCC OCEANIC's third officer did not see the other ship by sight (because of restricted

Diagram of watch room

Steering room of *YUJIN MARU No.7*

External view of steering and watch room

Plan view of watch room showing deckhand's limited visibility when sitting with his back against the wall visibility caused by rainfall) or by radar (due to rain clutter). He had not properly utilised the anti clutter settings on the radar equipment, which may have improved radar detection (although it is not known to what degree). It is also not clear whether the S-band or X-band radar was in use, S-band being better able to detect targets through rain clutter.

The deckhand of *YUJIN MARU No. 7* did not notice *NOCC OCEANIC* because he kept watch by sight in a position where there was a blind area caused by a wall in the watch room. He did not see *NOCC OCEANIC* approaching on a bearing of 83 degrees on the starboard bow. He was not permitted by the master to adjust the settings of the radar himself.

It is possible that had the watch keepers on either or both ships used sound signals, as appropriate in restricted visibility, then the risk of collision would have been realised sometime before the collision occurred. The incident illustrates the importance of sound signals and the apparent reluctance of watch officers to use them.

The third officer on board *NOCC OCEANIC* was relatively experienced, having sailed as a third officer for seven years following his navigation training. Before that he had sailed since his late teens as an oiler. He was 41 at the time of the incident. Despite his experience he failed to call the master when the conditions of visibility changed, presumably comforted by information from the radar display, indicating that the rain would soon pass. He was navigating in open water and did not expect there to be any risk of collision, not having observed any other ships earlier in the watch. Nevertheless, the instruction to call the master in case of restricted visibility was incorporated into the master's standing orders and was also in the Bridge Procedures Manual which indicated the qualifying conditions for sole watch keeping. Sole watch keeping was not permitted in restricted visibility. It is possible that if the third officer had called the master to the bridge then sound signals would have been used as prescribed in rule 35 of the collision regulations.

If AIS had been installed on the fishing vessel, it is likely that she would have been observed by the third officer on board *NOCC OCEANIC* on his radar display. *NOCC OCEANIC* could also have been spotted by the *YUJIN MARU No. 7* deckhand in the same way. The third officer may have been over-reliant on the AIS data, expecting it to show him every ship in the area. The fact that there could be other ships in the vicinity without AIS installed does not appear to have occurred to the third officer.

VDRs: make sure that the correct data is recorded

Members are reminded that the use of VDRs on ships is subject to the regulations contained in Chapter V of SOLAS.

To fully protect a Member's interests following a collision it is important that accurate information is available. On ships that are required to be fitted with VDR or S-VDRs, Members are advised to ensure that the required data items are recorded and to be fully aware of the requirements of SOLAS.

The Club has recently handled a collision case where the ship's VDR did not record any radar, despite one of the radars being in use. As a result, the Club was put at a disadvantage in investigating the circumstances and causes of the collision. In addition, the failure to record was possibly in breach of SOLAS.

Current Marine Safety Committee (MSC) Resolutions in force relating to performance standards of VDRs and S-VDRs are Resolution A.861(20) and Resolution MSC.333(90). Guidelines on VDR ownership and recovery are provided in MSC/Circ.1024.

Section 5.5 of Resolution MSC.333(90) lists the data items which are to be recorded and includes under Section 5.5.7.(Radar) the electronic signals of the main displays of both ship's radar installations as required by SOLAS regulations. The recording method should be such that, on playback, it is possible to present a faithful replica of the entire radar display that was on view at the time of recording, albeit within the limitations of any bandwidth compression techniques that are essential to the working of the VDR.

For VDRs that were installed before 1 July 2014, Resolution A.861(20), as amended by Resolution MSC.214(81), lists data items which are to be recorded by the VDR.

Section 5.4.7. provides:

'This should include electronic signal information from within one of the ship's radar installations which records all the information which was actually being presented on the master display of that radar at the time of recording. This should include any range rings or markers, bearing markers, electronic plotting symbols, radar maps, whatever parts of the SENC or other electronic chart or map that were selected, the voyage plan, navigational data, navigational alarms and the radar status data that were visible on the display. The recording method should be such that, on playback, it is possible to present a faithful replica of the entire radar display that was on view at the time of recording, albeit within the limitations of any bandwidth compression techniques that are essential to the working of the VDR'.

S-VDRs fitted both before and after 1 June 2008 are also required by Resolution MSC.163(78)/MSC.214(81) to record radar data similar to that of VDRs under Resolution A.861(20), as amended by Resolution MSC.214(81), which is quoted above.

VDRs and S-VDRs under Regulation 18.8 should be subject to an annual performance test conducted by an approved testing or servicing facility to verify the accuracy, duration and recoverability of the recorded data. A copy of the certificate of compliance issued by the testing facility, stating the date of compliance and the applicable performance standards, must be retained on board the ship.

Narrow channels: danger of over-reliance on pilots

The Club has had recent experience of several cases where over-reliance on the pilot to monitor the speed and position of the ship when in narrow channels has resulted in incidents of capsizing and grounding.

Masters are recommended to discuss the passage plan with the pilot thoroughly before commencing pilotage so that the master is aware in advance of the points of the river that can be particularly hazardous. Also, the pilot must be well-briefed on the handling characteristics of the ship. During transit of the river, masters are advised to maintain awareness of their ship's speed, the depth under keel (and the potential for squat) as well as the position of their ship in relation to the charted dredged area.

In one case, in a busy Vietnamese river, a barge capsized in a surge wave caused by the excessive speed of a larger container ship which was transiting the river. The stern line of another ship, alongside further up the river, was broken by the surge.

After the event, the pilot of the container ship reported that he had found it difficult to control the ship's speed at a constant 12 knots (the official speed limit) whilst still maintaining steerage way against the river current. With only the options of full or half ahead on the ship's telegraph (one of which being too fast, the other too slow) he had struggled to keep the ship at about 12 knots, sometimes reaching 11.9 knots, sometimes over 12 knots, instead of using 12 knots as a maximum. The master had presumed that the pilot was aware of the speed limit and would ensure that the ship remained at a safe speed.

It may be that it was not just the effect of the surge wave that caused the barge to capsize (there are indications that the barge was overloaded) but this was hard to prove as all the cargo and the barge's documents were lost in the water when the barge capsized. However, it was very easy to determine the speed of the container ship via the ship's ECDIS and by the VTS data provided by the authorities. The fact that the speed limit was exceeded (even if only by less than one knot) has had serious consequences in terms of liability and damages paid for the loss of the barge and her cargo.

The master must retain responsibility for the ship and for maintaining a safe speed, despite the fact that the pilot may take the con during a river transit. The master, with the support of the bridge team (in this instance the third officer was also on the bridge for the river transit) should remain aware of the speed limit for the relevant leg of the voyage and must be prepared to ask the pilot to slow down if necessary.

The Club also has been made aware of a number of groundings in the Parana River, Argentina, where four ships have grounded in recent months at a sharp bend on the section of the river known as 'Paso Abajo Los Ratones'. At this particular bend there is a prevalent current of approximately 2.5 knots.

Lifting with ship's gear

Check the object weight and make sure it does not exceed your safe working load (SWL).

The Club recently assisted Members with a case where a ship was preparing to take on bunkers from a bunker barge. The ship was in ballast and therefore the length of hose that needed to be lifted to reach the manifold was quite long, about 10.5 metres. The crane on the bunker barge could not reach and therefore the crew of the Member's ship were requested to assist by using a ship's stores crane. That stores crane was intended for lifting items such as ship's spares and packaged goods, not for lifting bunker hoses, and had a SWL of 500kg. No estimate was done by the crew or the supervising officer of the weight of the 10.5 metres of bunker hose that needed to be lifted. Investigations later revealed that the bunker hose weighed 700kg and so exceeded the SWL of the stores crane.

When the bunker hose was lifted high, the crane wire snapped and the bunker hose crashed down onto the barge. The results could have been very serious but fortunately, on this occasion, the damage was fairly minor (and only to the bunker hose itself) and there was no personal injury or oil pollution.

The incident does, however, illustrate the importance of the crew:

a) Knowing or calculating the weight of objects to be lifted with any ship's crane; and

b) Knowing the SWL of the lifting gear (including the wire); and

c) Making sure that (a) does not exceed (b).

The crew should also have referred to the on board SMS and the risk assessment required for carrying out such lifting. Diligence applicable to lifting larger objects, such as cargoes, using the ship's cargo cranes, should be applied to all lifting operations.

As the ship was in ballast, the height of the ship's deck above the barge deck was approximately the same as the length of hose available. The possibility existed that the crew continued to hoist when the hose length had already been lifted to its maximum extent. Again, the crew seemed not to have assessed the situation nor did they place a crew member as a 'spotter' to make sure that the lifting was done properly.

The hazards of working aloft

A recent incident resulted in serious injuries to a seaman working at height while painting the ship's funnel.

To carry out the work, the seaman stood on a pallet which was placed in a cargo net which was then lifted by the stores crane. In the absence of any other available securing points, a safety line was attached to the stores crane hook. The lifting wire parted during the operation and the seaman fell six metres onto the deck and suffered serious spinal injuries. The most likely cause for the parting of the wire was the friction created when the wire came into contact with the crane's structure. As the safety harness was attached to the crane hook, it failed to halt the fall and the hook itself plunged to the deck, narrowly missing the seaman.

Good practice for working at height can be found in the Code of Safe Practice issued by the UK Marine and Coastguard Agency, chapter 15, the relevant parts of which are set out below:

- Working at height should only be undertaken if there is no other practical alternative. All work at height must be planned and supervised. Risk assessment should take into account the risk of a fall and that of falling objects.

- Persons working aloft should wear safety harnesses connected to a secure part of the ship's structure. If working outboard, additional buoyancy aids should be worn and a lifebuoy with sufficient line should always be near at hand. A person should be placed on deck to observe the operation.

- Before working near a ship's whistle or funnel the power should be shut off and engineers should prevent the emission of any harmful gases and fumes. Transmissions should be avoided when such work is being carried out in close proximity to radio aerials and radar scanners.

In this case, it would have been preferable for cradles and stages to be rigged or a bosun's chair utilised, rather than the crane and cargo net which were not designed for this task. When using these, Members are urged to bear the following points in mind:

Cradles and stages

- Anchoring points for safety lines and gantlines for staging must be of adequate strength and where practical form part of the permanent fixtures to the ship's structure.

- Portable rails and stations should not be used as anchoring points. Any anchoring points should be treated as lifting points and should be inspected/tested and recorded appropriately.

Bosun's chair

- A bosun's chair should be secured with a double sheet bend and the end seized to the standing part.

- Hooks should be of a type that cannot be accidentally dislodged and must have the safe working load marked.

- If the worker is required to lower themselves whilst using the bosun 's chair this should be secured before making the lowering hitch.

Summary

A risk assessment should be completed every time a seafarer is required to work aloft and a competent person must examine and approve the equipment identified for the work. The operation should be monitored from deck level and it is recommended that the guidance provided by the Code of Safe Working Practices should be followed.

Al Jubail: manifold samples forbidden by shore side

This is a reminder that it is not possible to take manifold samples at the SABIC terminal in Al Jubail when loading mono and diethylene glycol (MEG and DEG) cargoes.

In addition to issuing a protest, Members are advised, if possible, that the crew should take samples at the cargo pump during the start of loading, in place of manifold samples. It is our understanding that most modern tankers have a sampling point in the pump room. Ideally a closed loop sampling unit such as a DOPAK sampler can be attached to this sampling point. If it is not possible to attach a closed sampling unit to the cargo pump sampling point, then, if possible, the sampling containers should be flooded with nitrogen whilst being filled with cargo.

Obviously the cargo in these samples will not have entered the cargo tanks at this point but will have been transferred through a section of the ship's piping, which can be a potential source of contamination. While this type of sampling is not ideal, in circumstances where manifold samples cannot be taken, this is the next best method of sampling that can be achieved during loading.

Where manifold samples cannot be taken, it is even more important that the crew take first foot samples. Again, the best way of doing this would be by using a closed loop sampling device such as a DOPAK sampler. Members will then need to ensure that the tank atmospheres are maintained at the correct low oxygen levels, as per the voyage instructions, and that nitrogen overpressure is maintained in the loaded cargo tanks to prevent the ingress of moisture and air. The ship's voyage tank atmosphere records will be a key document should any claim be brought against Members when carrying MEG or DEG cargoes.

Loss prevention

Tanker contamination claims

This article continues our series highlighting good practices that can be shared with Members and looks at contamination claims from tankers.

We have recently reviewed and investigated a number of tanker contamination claims against Members with a total value of USD 4 million. In this article we highlight some common causes of these claims which can be traced to failures in shore side and shipboard management.

In the conclusion, we look at some recommended best practices on board the ship before loading cargo and also suggest preventative measures that can be taken once the cargo is on board the ship in order to reduce exposure to these claims.

Our claims review revealed the following issues:

Off specification (off spec) cargo delivered from shore side

50% of dirty oil claims and 44% of clean/chemical oil claims originated from the terminal or were otherwise pre-existing. The most common contaminant is water delivered with the cargo. Fresh water derived from the manufacturing process can settle in a shore tank during storage or may already be present in the shore lines.

Cargo can also be off spec before reaching the ship in respect of the sulphur content or the flash point. Other contaminants (which might have originated from lines ashore or shore tanks) include rust, suspended matter or contaminants from previous cargoes in the shore line.

Ship staff must remain vigilant to ensure that the correct method of testing is applied to the cargo. As an example, for determining water content in high density cargoes, using ullage temperature interface detectors (UTI) rather than colour cut water finding paste could be more effective.

Suitability of tank coatings

Due to the range of cargoes being carried, particularly chemical cargoes, the investigations show how important it is to check that the tank coating is suitable for the booked cargo and the crew should also verify this with the manufacturers' tank coating cargo resistance lists.

In one incident the coating specification included a limit to the number of days that a cargo could be stored at a higher temperature. The time limit was ignored and the tank coating peeled off and contaminated the cargo.

Other problems have included cargo discoloration and tank cleaning issues caused by the nature and condition of the tank coating.

Preparation of the tanks

Cargo tanks and lines must be carefully prepared to load the nominated cargoes. The claims review revealed the following issues:

- Tanks and lines contaminated with cleaning materials, including water.

- Water being found in the tanks and lines which could come from the cargo system, inert gas, leaking heating coils or via the hatches and tank lids.

- Lines not being cleaned between products.

- Previous cargo residue or vapour remaining inside the hose or line.

- Vapour lines of common inert gas systems not being segregated, leading to the vapours from one grade of cargo putting another grade of cargo out of specification.

Inadequate maintenance

- Poor physical condition of tanks, with structural failings such as bulkhead cracks.

- Rust in the tank or generally poor tank condition due to lack of effective maintenance.

- Tank coating damaged due to poor preparation during application and by not curing properly. Failure to repair this in time could lead to previous cargo becoming ingrained into the coating and contaminating the next cargo.

- Valve leakage, which could lead to cross contamination between grades of cargo.

Deterioration of tank coating.

Damaged 'O' rings due to corrosive nature of the cargo.

Damaged drop valve.

Sampling procedures

Sampling is extremely important when monitoring the quality of products carried on board the ship. In addition, the methodology employed to extract the sample and to store it may be vital in defending spurious contamination claims.

Sampling varies with the cargo type but must always be representative of the product and samples must be taken using appropriate equipment.

Bottles and equipment should be clean and suitable for the cargo. Ship's officers should check how the shipper's surveyors are taking samples and make a written note protest if any malpractices are found, for example, using dirty or rusty equipment. Comparisons and tests should be conducted using the same standard and the agreement between the shipper and the consignee should specify the test method. In one case, the shore tank sample was analysed at the discharge port using ASTM method D5443. However, the analysis carried out at the shipper's lab used ASTM method D2360. The use of two different tests meant that the results could not be directly compared.

Sample bottles and seal numbers should be noted and a sample log kept up to date. All bottles should be labelled, sealed, witnessed and countersigned. Samples should be stored securely and for a length of time which complies with company procedures.

In case of any off spec allegation or notification, it is crucial to inform both the shipper and the consignee, without delay, to retain all their sample bottles until the issue is satisfactorily resolved.

Conclusion

Most tanker claims can be prevented by effective pre-planning and preparation of the tanks and by ensuring that all relevant ship staff are aware of potential hazards.

On product and chemical tankers, ship staff should carry out regular inspections, particularly of areas that are not readily visible, such as the bell mouth, for signs of discoloration, bubbles or flaking paint. Excessive corrosion may also be visible in the adjacent double bottom or side tanks.

An effective cargo plan, an observant cargo watch and appropriate sampling procedures can help Members avoid contamination claims against the ship or defend spurious contamination claims.

Properly prepared sample bottles.

Tank coating damaged due to excessive heat.

Loss prevention poster campaign:
COLREGs 7, 8, 15, 16 and 17

Continuing the series of posters to remind bridge watch keeping officers of the requirements of COLREGs, a further poster is being sent out with this edition of *Risk Watch*.

The poster illustrates a situation when the master arrives on the bridge to find a junior officer confused and unable to react decisively to the scene playing out in front of him.

The sequence shows a fishing boat on the port side which appears to be making way but is not engaged in fishing operations (this is a power driven vessel as defined by COLREGs) and a ferry crossing our bow. Both are on steady bearings.

The scene played out makes our ship the stand on ship for the fishing boat and the give way ship for the ferry. The master, whilst admonishing the junior officer, is decisive and gives the order for a bold alteration to starboard. This manoeuvre opens the bearing of the fishing boat and complies with the requirement to give way to the ferry. Once the ferry has crossed and is clear, our ship can be brought back on track provided this does not create a close quarters situation with the fishing boat.

If extra copies of the poster are required, please download them from the Britannia website or contact the Club for hard copies.

http://www.britanniapandi.com/publications/posters/

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Regulatory update

The Great Barrier Reef: be careful when disposing of rubbish

The Club has recently handled a case in Australia where a ship disposed of rubbish over board in the Great Barrier Reef Marine Park and, even though the discharge was more than 12 nautical miles from the coastline, this was in contravention of MARPOL Annex V due to the special nature of the Marine Park.

During a routine check of the ship's garbage disposal log, the surveyor from the Australian Maritime Safety Authority (AMSA) noted that a small amount of food waste had been discharged over board while the ship was in the Great Barrier Reef Marine Park region. The ship was consequently detained until security was supplied to the authorities in the amount of AUD510,000 (approx. USD400,000) which was equivalent to the maximum possible fine.

The crew had followed the ship's usual garbage management procedures and had asked for authorisation from the bridge to discharge food waste over board. The officer on duty checked the ship's location and determined that it was more than 12 nautical miles from the nearest land and not in a 'special area' and accordingly authorised the discharge of the food waste and wrote up the appropriate entry in the Garbage Discharge Log.

However, at the time of the discharge, the ship was located within the Great Barrier Reef Marine Park area. The definition of 'nearest land' in Regulation 1 of MARPOL Annex V contains a special provision relating to the east coast of Australia which effectively establishes an artificial baseline at the outer edge of the Great Barrier Reef, as opposed to the natural coastline. This means that all Great Barrier Reef waters are deemed to be on the landward side of the artificial baseline and therefore all discharges in these waters are in contravention of MARPOL Annex V.

Our local correspondents have told us that this type of incident occurs with some regularity.

It is recommended that Members with ships trading to Australia review their shipboard garbage management procedures and also review the relevant signs around the ship to make sure that these signs mention the special baseline provision relating to the Great Barrier Reef area.

Miscellaneous

Publications

Port and Terminal Regulations
The use of ports and terminals, whether by shipowners or cargo owners, has legal and financial implications. If the regulations and contractual obligations are not fully understood, the consequences can prove expensive. This book highlights the risks and how to mitigate them.
http://www.witherbyseamanship.com/port-and-terminal-regulations.html

Passage Planning Guidelines: 3rd edition
Passage Planning Guidelines focuses on the appraisal and planning stages of voyage planning using traditional methods and paper charts and looks at the evolving needs of today's navigator when using ECDIS.
http://www.witherbyseamanship.com/passage-planning-guidelines-3rd-ed.html

ECDIS Passage Planning: 2nd edition
ECDIS Passage Planning has been fully revised and updated, providing guidance on how to conduct voyage planning on ECDIS safely and it includes a new section on ECDIS watchkeeping. This publication provides practical guidance to assist the navigator through the appraisal and planning stages of the passage on ECDIS, combined with further guidance on how ECDIS should be properly utilised to assist the OOW in keeping the navigational watch.
http://www.witherbyseamanship.com/ecdis-passage-planning-2nd-ed.html

Editor's message We are always looking for ways to maintain and increase the usefulness, relevance and general interest of the articles within Risk Watch. Please forward any comments to: **rwatched@triley.co.uk**