

Australian Government

Australian Transport Safety Bureau



ATSB TRANSPORT SAFETY INVESTIGATION REPORT Marine Occurrence Investigation No. 249 Final

Independent investigation into the collision between the Australian registered fishing vessel

Allena

and the Antigua and Barbuda registered container ship

Northern Fortune

off Bowen, Queensland 21 January 2008



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The photographs of *Allena* (Front cover and Figure 4) are courtesy of the Townsville Water Police.

Abstract

At about 2102 on 21 January 2008, the Australian fishing vessel *Allena* collided with *Northern Fortune*, an Antigua and Barbuda registered container ship, off the Queensland coast. The fishing vessel's bow was badly damaged but the crew were able to control the ingress of water and return the vessel to Bowen, Queensland, its home port.

The investigation determined that the lookout on board both *Allena* and *Northern Fortune* was ineffective and that neither vessel's watch keeper saw the other vessel in sufficient time to avoid the collision.

Additionally, the fishing vessel was not required to be fitted with an Automatic Information System (AIS) unit or a radar reflector and, consequently, it may have been difficult for the ship's third mate to detect the fishing vessel electronically.

After the collision, *Northern Fortune*'s third mate did not stop to render assistance or ensure that the fishing vessel and its crew were safe because he claimed that he believed a collision had not occurred, only a close quarters passing.

The ATSB investigation report also found that the Queensland regulations for fishing vessel certificates of competency are ambiguous and are not consistent with current national standards. The regulations allowed *Allena*'s skipper to operate the vessel up to 200 miles from the coast without appropriate training in navigation or the application of the collision regulations.

The ATSB has issued one recommendation and two safety advisory notices to address these safety issues.

THE AUSTRALIAN TRANSPORT SAFETY BUREAU

The Australian Transport Safety Bureau (ATSB) is an operationally independent multi-modal Bureau within the Australian Government Department of Infrastructure, Transport, Regional Development and Local Government. ATSB investigations are independent of regulatory, operator or other external bodies.

The ATSB is responsible for investigating accidents and other transport safety matters involving civil aviation, marine and rail operations in Australia that fall within Commonwealth jurisdiction, as well as participating in overseas investigations involving Australian registered aircraft and ships. A primary concern is the safety of commercial transport, with particular regard to fare-paying passenger operations.

The ATSB performs its functions in accordance with the provisions of the *Transport Safety Investigation Act 2003* and Regulations and, where applicable, relevant international agreements.

Purpose of safety investigations

The object of a safety investigation is to enhance safety. To reduce safety-related risk, ATSB investigations determine and communicate the safety factors related to the transport safety matter being investigated.

It is not the object of an investigation to determine blame or liability. However, an investigation report must include factual material of sufficient weight to support the analysis and findings. At all times the ATSB endeavours to balance the use of material that could imply adverse comment with the need to properly explain what happened, and why, in a fair and unbiased manner.

Developing safety action

Central to the ATSB's investigation of transport safety matters is the early identification of safety issues in the transport environment. The ATSB prefers to encourage the relevant organisation(s) to proactively initiate safety action rather than release formal recommendations. However, depending on the level of risk associated with a safety issue and the extent of corrective action undertaken by the relevant organisation, a recommendation may be issued either during or at the end of an investigation.

The ATSB has decided that when safety recommendations are issued, they will focus on clearly describing the safety issue of concern, rather than providing instructions or opinions on the method of corrective action. As with equivalent overseas organisations, the ATSB has no power to implement its recommendations. It is a matter for the body to which an ATSB recommendation is directed (for example the relevant regulator in consultation with industry) to assess the costs and benefits of any particular means of addressing a safety issue.

TERMINOLOGY USED IN THIS REPORT

Occurrence: accident or incident.

Safety factor: an event or condition that increases safety risk. In other words, it is something that, if it occurred in the future, would increase the likelihood of an occurrence, and/or the severity of the adverse consequences associated with an occurrence. Safety factors include the occurrence events (e.g. engine failure, signal passed at danger, grounding), individual actions (e.g. errors and violations), local conditions, risk controls and organisational influences.

Contributing safety factor: a safety factor that, if it had not occurred or existed at the relevant time, then either: (a) the occurrence would probably not have occurred; or (b) the adverse consequences associated with the occurrence would probably not have occurred or have been as serious, or (c) another contributing safety factor would probably not have occurred or existed.

Other safety factor: a safety factor identified during an occurrence investigation which did not meet the definition of contributing safety factor but was still considered to be important to communicate in an investigation report.

Other key finding: any finding, other than that associated with safety factors, considered important to include in an investigation report. Such findings may resolve ambiguity or controversy, describe possible scenarios or safety factors when firm safety factor findings were not able to be made, or note events or conditions which 'saved the day' or played an important role in reducing the risk associated with an occurrence.

Safety issue: a safety factor that (a) can reasonably be regarded as having the potential to adversely affect the safety of future operations, and (b) is a characteristic of an organisation or a system, rather than a characteristic of a specific individual, or characteristic of an operational environment at a specific point in time.

Safety issues can broadly be classified in terms of their level of risk as follows:

- Critical safety issue: associated with an intolerable level of risk.
- Significant safety issue: associated with a risk level regarded as acceptable only if it is kept as low as reasonably practicable.
- Minor safety issue: associated with a broadly acceptable level of risk.

- x -

At about 2100¹ on 17 January 2008, the Queensland registered fishing vessel *Allena* departed Bowen, Queensland, with five people on board for a seven day fishing trip near Gould Reef, about 38 miles² to the northeast of Bowen.

On 21 January, the skipper noted that the weather forecast for the following day included a strong wind warning so he decided to return to Bowen that evening. At 1815, *Allena* departed Gould Reef on a course of 220° (T) with the skipper at the wheel while the fishermen ate a meal before going below to sleep. In addition to the mandatory navigation lights for a power driven vessel underway, the skipper kept the aft deck working lights illuminated.

At about the same time, the Antigua and Barbuda registered container ship *Northern Fortune* was near Townsville, Queensland, following the charted preferred route south, inside the Great Barrier Reef, en route from Singapore to Brisbane. At 2000, *Northern Fortune*'s third mate relieved the chief mate and a relieving lookout also came on watch. At the time, the ship was on a course of 117° (T) and *Allena* was 21 miles ahead of the ship.

By about 2030, the last of *Allena*'s fishermen had gone to bed, leaving the skipper alone in the wheelhouse. The vessel's radar had failed about 30 minutes earlier so the skipper stepped out of the wheelhouse and looked to see if there was any traffic in the area before he switched on the wheelhouse interior lights and started tallying the catch to report it to the Queensland fishing authorities. At this time, *Northern Fortune* was 10.4 miles away from *Allena* and the two vessels were approaching each other on a constant relative bearing, a collision course.

At 2100, *Northern Fortune*'s third mate recorded the ship's position on the chart. At about 2101, when he returned to the bridge from the chartroom, he saw a fishing vessel very close to the ship. He immediately changed over to hand steering and took avoiding action.

At about 2102, *Allena* collided with *Northern Fortune*'s port side, just forward of the bridge. *Northern Fortune*'s third mate claimed that he did not feel or hear the collision. After the fishing vessel had passed, he switched the steering back to autopilot and resumed the ship's original course. He could see the fishing vessel's lights astern and he considered that his actions had prevented a collision, resulting only in a close quarters passing, so he did not report the incident to the ship's master.

Allena's fishermen were awakened by the sound of the collision and the skipper quickly told them to prepare to abandon ship. Once it was apparent that the vessel was not sinking, the fishermen used all available pumps to control the ingress of water through the damaged bow. The skipper attempted to contact the ship using his VHF radio and then he activated the vessel's Emergency Position Indicating Radio Beacon (EPIRB). *Allena* was able to continue its voyage to Bowen, accompanied by the Bowen Volunteer Sea Rescue vessel and it arrived at about 0130 on 22 January.

¹ All times referred to in this report are local time, Coordinated Universal Time (UTC) + 10 hours.

² A nautical mile is 1852 m.

Northern Fortune continued its voyage to Brisbane and by 1600 on 23 January was all fast alongside its berth.

The investigation determined that the lookout on board both *Allena* and *Northern Fortune* was ineffective and that neither vessel's watch keeper saw the other vessel in sufficient time to avoid the collision.

The investigation report identifies the following safety issues and makes one recommendation and two safety advisory notices to address them:

- *Northern Fortune*'s third mate did not contact *Allena* or take any steps to determine if a collision had occurred and did not inform the ship's master of the incident. Therefore, he disregarded his legal and moral obligations to ensure the safety of the fishing vessel's crew. It is a requirement for flag States to ensure that their ships' masters effectively implement the United Nations Convention of the Laws of the Sea (UNCLOS) requirements to stop and render assistance to those who are in danger of being lost at sea.
- The Queensland regulations for fishing vessel certificates of competency are ambiguous and are not consistent with the Uniform Shipping Laws Code (USL Code) or the National Standard for Commercial Vessels (NSCV). The regulations allow a fishing vessel to be operated up to 200 miles from the coast by a skipper who may not have been appropriately trained, experienced or qualified for that operational area.
- It was not a requirement for *Allena* to be fitted with either a radar reflector or an Automatic Identification System (AIS) unit. Consequently, the vessel was probably difficult to detect electronically in the prevailing weather conditions.

1 FACTUAL INFORMATION

1.1 Allena

The Australian fishing vessel *Allena* (Figure 1) was owned by its skipper and registered with Maritime Safety Queensland as a class 3B vessel³.

The vessel was built in Gladstone, Queensland, in 1974. It was constructed of hardwood planks over hardwood frames. It is 13.54 m long, has a beam of 4.34 m and a gross tonnage of 20.22. At the time of the incident, the hull and wheelhouse were painted white with beige trim.

The wheelhouse is located forward of the working deck. The wheelhouse has two access doors, one on each side, leading to the deck. The helm and autopilot unit, the engine controls, radar, echo sounder and radio are located on the port side of the wheelhouse, adjacent to portside access door. A central companionway leads forward from the wheelhouse to sleeping accommodation located beneath the forecastle deck.



Figure 1: Allena

At the time of the incident, the vessel had five people on board, the skipper and four fishermen. The fishermen did not form part of the vessel's crew in the traditional sense but used *Allena* as a means of transportation to and from the fishing grounds.

³ A fishing vessel surveyed to operate in 'Offshore' waters, limited to 200 miles from the coast.

The usual routine on board was for the fishermen to use handlines to fish for coral trout from each of the vessel's four dories⁴ from dawn until lunch time and then again from after lunch until sunset. *Allena* acted as a mother ship for the dories and towed them to the fishing grounds. The fishermen offloaded their catch into refrigerated holding tanks twice per day.

Allena's skipper had worked on a variety of small vessels for about 34 years. He held Queensland certificates of competency as a coxswain and as a marine engine driver grade three.

1.2 Northern Fortune

Northern Fortune (Figure 2) is a cellular container ship registered in Antigua and Barbuda, West Indies. It was owned and operated by Reederei Karl Schlueter, Germany, and was classed with Germanischer Lloyd (GL).



The ship was built in 1991 and has a capacity of 1939 TEU⁵. It is 202.4 m long with a beam of 31 m and, at its summer draught of 10.55 m, has a deadweight of 30 685 tonnes.

Northern Fortune is powered by a single Sulzer 6RTA76 single acting, direct reversing, two-stroke diesel engine, delivering 16 260 kW. The main engine drives a single fixed pitch propeller to give the ship a service speed of about 19 knots⁶.

⁴ Lightweight, shallow-draught boats, about 5 m long.

⁵ Twenty-foot Equivalent Unit, a standard shipping container. The nominal size of a ship in TEU refers to the number of standard containers that it can carry.

⁶ One knot, or one nautical mile per hour equals 1.852 km/hr.

Northern Fortune's chartroom is located at the after end of the navigation bridge and is separated from the wheelhouse by a curtain. The ship's navigation bridge is equipped with navigational equipment consistent with SOLAS⁷ requirements; including an x-band (9 GHz) Automatic Radar Plotting Aid (ARPA) equipped radar and an s-band (3 GHz) ARPA equipped radar, an automatic identification system (AIS), Global Positioning System (GPS) units, global maritime distress and safety system (GMDSS) communications equipment and a voyage data recorder (VDR).

At the time of the incident, *Northern Fortune* had a crew of 27, including a master and three mates. The master, one fitter and all of the officers, except the third mate, were Croatian nationals. The third mate was a Serbian national, with the remaining crew being Filipino nationals.

While at sea, the mates kept a watch keeping routine of 4 hours on, 8 hours off. During the hours of darkness, a seaman was assigned to each watch to act as a lookout. The seaman also routinely undertook safety rounds of the ship at about mid watch.

The master had been at sea since 1989 and held a certificate of competency as master, issued in Croatia in 1997 and endorsed by Antigua and Barbuda. It was his third, six month assignment with the ship's operator and he had been on board the ship for about four months.

The third mate had been at sea for about 10 years. He held a certificate of competency as officer in charge of a navigational watch, issued in Yugoslavia in 1999 and endorsed by Antigua and Barbuda. It was his fourth assignment with the ship's operator and he had also been on board the ship for about four months.

1.3 The incident

At about 2100 on 17 January 2008, *Allena* departed the Bowen boat harbour with the skipper and four fishermen on board and four dories in tow. It was bound for Gould Reef, about 21 miles to the northeast, to fish for coral trout for the live export market. The vessel was fuelled and provisioned for a seven day round trip. At about 0200 on 18 January, *Allena* arrived at Gould Reef and anchored so that the fishermen could rest until daybreak, when they began fishing.

On 21 January, *Allena*'s skipper noted that the weather forecast for the following day included a warning for strong winds (20 to 30 knots). After discussing the forecast with the fishermen, it was decided that they could continue to fish through the day and then return to Bowen that evening, before the weather deteriorated.

At about 1730, all of the dories returned to *Allena* and each of their catches was unloaded into the fishing vessel's holding tanks. The dories were then secured astern of *Allena* for the voyage back to Bowen. By 1815, *Allena* had departed Gould Reef on a course of about 220° (T) at a speed of about 7 knots. The fishing vessel was displaying the mandatory lights for a power driven vessel underway. The skipper also kept the aft deck working lights illuminated, as was his usual practice, so that he could monitor the dories.

The skipper navigated the vessel while the fishermen ate a meal and watched a movie in the wheelhouse before they went below to sleep.

⁷ The International Convention for the Safety of Life at Sea, 1974, as amended.

Meanwhile, *Northern Fortune* was en route from Singapore to Brisbane. The ship was southbound, east of Townsville, following the charted preferred inner route through the Great Barrier Reef on a course of 128° (T) and making good a speed of about 18 knots.

At 2000, the third mate relieved the chief mate on the bridge and the lookout was relieved at the same time. The third mate was advised that there was little traffic in the area and that the last traffic report received from the Great Barrier Reef and Torres Strait Vessel Traffic Service (REEFVTS) had indicated that they should next expect to pass a ship at about 2205.

Both of *Northern Fortune*'s radars were in use. The s-band radar was set on the 12-mile range and the x-band radar on the 6-mile range. Both of the bridge VHF radios were tuned to channel 16.

At that time, *Northern Fortune* was on a course of 117° (T) and *Allena* was 21 miles away on a relative bearing of about 21° to port.



Figure 3: Section of navigational chart Aus 825

Visibility was recorded in *Northern Fortune*'s deck log as between 5.5 and 10 miles. The wind was force six⁸ (22 to 27 knots) from the southeast and it was

⁸ The Beaufort scale of wind force, developed in 1805 by Admiral Sir Francis Beaufort, enables sailors to estimate wind speeds through visual observations of sea states.

raining. The sea was about 3 m and choppy on a 1 m south-easterly swell, with whitecaps and some spray.

At about 2000, *Allena*'s radar stopped working. The skipper turned it off and on several times but the unit failed to restart so he left it switched off.

At about 2028, Northern Fortune passed Holbourne Island (Figure 3).

By about 2030, the last of *Allena*'s fishermen had gone to bed, leaving the skipper alone in the wheelhouse. Even though he believed that he had passed the main shipping route, the skipper looked out of the wheelhouse through the portside door to see if there was any traffic in the area. At this time, *Northern Fortune* was 10.4 miles and about 56°, or five points⁹, to starboard of *Allena*. The two vessels were approaching each other on a constant relative bearing, a collision course (Figure 3).

Having seen no vessel in the area, the skipper switched on the wheelhouse interior lights. He then started checking the fishing log in order to tally the catch in preparation for making his mandatory catch report to the Queensland Department of Primary Industries and Fisheries (DPI&F).

At about 2045, *Northern Fortune*'s third mate instructed the seaman on watch to leave the bridge and conduct his safety rounds so that he would be back on the bridge when the next ship was expected to pass them at about 2200.

At 2100, *Northern Fortune*'s third mate recorded the ship's GPS position in the log book and plotted it on the chart. At about 2101, he saw a fishing vessel ahead and very close to the ship's port side. He immediately changed over to hand steering and put the helm hard-to-starboard. Then, in order to swing the ship's stern, and therefore the propeller, away from the fishing vessel, the third mate swung the helm hard-to-port until he thought that the fishing vessel had passed astern.

At about 2102, in position 19°47'S 148°30'E, *Allena* collided with *Northern Fortune*'s portside, just forward of the ship's bridge.

Having passed the fishing vessel, *Northern Fortune*'s third mate switched the steering control back to autopilot to resume the ship's original course. He then went out onto the port bridge wing and looked aft at the fishing vessel. He could see that it its deck lights were still illuminated and it appeared to be crossing *Northern Fortune*'s wake. He subsequently claimed that had not heard any impact sounds and believed that his actions had prevented a collision; resulting only in a close quarters passing.

Immediately after the collision, *Allena*'s skipper pulled the engine control lever to full astern and put the helm hard over to starboard. Once his vessel and the dories were clear of the ship, he put the engine control to neutral.

Once the vessel had stabilised, after about three or four minutes, he tried to call the ship on VHF channel 16 but the call was not answered. He tried calling a second time but again there was no response. He then made a single MAYDAY¹⁰ call on VHF channel 16 which also went unanswered. The skipper then activated the vessel's EPIRB.

⁹ A compass point of 11¹/₄°.

¹⁰ A distress signal sent by radiotelephony consisting of the spoken word MAYDAY.

Allena's fishermen were woken by the sound of the collision. The skipper quickly told them to gather lifejackets, flares and other emergency equipment and place it in one of the dories. He then instructed the men to wait in the dories until he had assessed the situation.

Once it was apparent that the vessel was not sinking, the skipper recalled the fishermen. The lower accommodation was flooding and the bow was badly damaged (Figure 4). The bilge pump had started automatically with the ingress of water. The skipper switched it over to manual in case its float switch became jammed by debris in the water.



Figure 4: Allena's damaged bow

The fishermen helped to secure the paravanes¹¹ and other loose equipment. They then lifted up the decking in the lower accommodation and used all of the available pumps to control the ingress of water through the damaged bow.

They then filled the aftermost fish holding tanks at the aft end of the main deck to raise the bow as far as possible. The skipper continued the voyage to Bowen, maintaining the best speed that he could without increasing the flooding forward.

As *Allena* made its way back to Bowen, the skipper called his wife using his mobile telephone and explained the situation to her. She, in turn, informed the Townsville Water Police.

At 2125, about 20 minutes after the collision, *Northern Fortune*'s master came to the bridge and saw a fishing vessel's lights astern. The third mate said nothing to him about the incident with the fishing vessel.

In response to the activation of the *Allena*'s EPIRB and the Townsville Water Police information, the Australian Rescue Coordination Centre (RCC) in Canberra tasked a fixed-wing aircraft and a helicopter to locate the vessel and to guide the Bowen Volunteer Marine Rescue (VMR) vessel, despatched earlier by the Townsville Water Police, to rendezvous with it.

Allena was able to make its way to Bowen, escorted by the VMR vessel, where it arrived at about 0130 on 22 January. The crew unloaded the catch and they then removed most of the portable equipment from the vessel in case it sank during the night.

Northern Fortune continued its voyage to Brisbane and by 1600 on 23 January, the ship was all fast alongside its berth.

¹¹ A towed underwater 'kite' that acts as a stabiliser for slow vessels, such as fishing trawlers.

2 ANALYSIS

2.1 Evidence

On 23 January 2008, investigators from the Australian Transport Safety Bureau (ATSB) attended *Northern Fortune* in Brisbane. On 24 January, the ATSB investigators attended *Allena* in Bowen. The relevant crew members from both vessels were interviewed and they provided their accounts of the incident. Copies of relevant documents were obtained, including log book entries, procedures, navigational charts and statutory certificates.

The ATSB investigators removed *Northern Fortune*'s voyage data recorder (VDR) capsule from the ship and took it to Canberra to download the data. The master had not been aware of the incident until he was notified of the investigation by the ATSB so the VDR data was not backed up¹² after the incident. Consequently, the VDR capsule did not contain any data covering the time of the collision.

Information relating to the incident was also obtained from the Great Barrier Reef and Torres Strait Vessel Traffic Service (REEFVTS) and the Townsville Water Police.

Paint samples were taken from *Allena*'s anchor (Figure 5) and from recently created contact marks on *Northern Fortune*'s port side, about 8 m forward of the bridge (Figure 6). The contact marks were consistent with the ship being struck by a metal and wooden object which then slid partway down the ship's side.



Figure 5: Allena's anchor showing paint scrapings

¹² *Northern Fortune*'s VDR can record 12 hours of data. Old data is overwritten on a 'first in-first out' basis unless it is manually saved, or backed up, following an incident.



Figure 6: Contact marks on *Northern Fortune*'s port side

Inconsistencies between the times reported in interviews were resolved using the Automatic Identification System (AIS) data from REEFVTS and log book entries. All times stated in this report are corrected times.

2.2 Collision avoidance and lookout

There is an obligation on all seafarers to maintain a proper lookout, assess the risk of a collision and to take appropriate actions to avoid a collision. That the collision occurred at all means that neither *Allena*'s skipper nor *Northern Fortune*'s third mate fulfilled those obligations.

Rule 5 of the COLREGS, 'Lookout', states:

Every vessel shall at all times maintain a proper lookout 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 the risk of collision.

The key words in this rule are 'every vessel' and 'at all times'. In this instance, the crew members on board both vessels were obliged to maintain a proper lookout and thereby avoid the collision. However, the actions of the crew of both vessels did not meet this basic navigational requirement.

2.2.1 Allena

Allena's return course from Gould Reef to Bowen resulted in it crossing the charted preferred routes for ships in the area. Therefore, it was reasonably foreseeable that the skipper would see other vessels following those routes on his return voyage and that crossing traffic could pose the risk of a collision.

The skipper was alone in the wheelhouse and was navigating the vessel visually, following the course indicated by the GPS unit to Bowen. He was not using navigational charts to plan or monitor his return voyage and he was unsure of the vessel's position with respect to the charted preferred shipping routes. Without a functioning radar, there were no electronic navigation aids to assist the skipper with keeping a lookout.

At about 2030, he switched on the wheelhouse lights to attend to the mandatory reporting of his catch. He had originally planned to wake a fisherman to act as lookout before tallying the catch but he chose not to at the time. After he turned on the wheelhouse lights, his night vision would have been compromised by the brightness of the lights and from the reflections inside the wheelhouse windows. Although aware of the limitations posed by having no aids to assist with keeping a lookout, the skipper became preoccupied with the task of tallying the catch after he switched on the wheelhouse lights and did not keep a lookout by any means. Ultimately, he was not aware of *Northern Fortune* until the collision actually occurred.

While *Northern Fortune*'s hull was below the skipper's visible horizon at 2030, its masthead lights would have been above the horizon. Rule 22 of the COLREGS requires that a masthead light for a ship 50 m or more in length shall have a minimum visible range of 6 miles. While the lights may have been sufficiently bright to be seen at a distance of 10.4 miles on a clear night, it is unlikely that they would have been visible to *Allena*'s skipper in the prevailing conditions before he switched on the wheelhouse lights.



Figure 7: Recreation of the relative positions of Allena and Northern Fortune

On 21 January, a crossing situation existed between *Allena* and *Northern Fortune*. *Northern Fortune* was about five points, or 56°, to *Allena*'s starboard side at about 2030 (Figure 7) and the vessels maintained a constant relative bearing to each other until the collision. *Allena* was not engaged in fishing and, thus, was a power driven vessel for the purposes of the COLREGS. According to Rule 15 of the COLREGS,

Allena was the 'give way' vessel and responsibility for taking early avoiding action rested with its skipper.

Allena's radar was not operational and there were no other electronic navigation aids to assist with watch keeping and, in particular, with keeping a lookout. Therefore, it was imperative that an effective visual lookout was maintained on board the fishing vessel. While there were four other people on board the fishing vessel, the skipper did not call any of them to the wheelhouse to assist him. Therefore, the skipper was alone in the wheelhouse at the time of the collision. It is possible that the fact that the other men on board the vessel were fishermen rather than ordinary crew may have influenced the skipper's decision not to wake them while he tallied the catch. If that were the case, then it may have been prudent to have the fishermen tally the catch while the skipper maintained an effective visual lookout.

2.2.2 Northern Fortune

The Australia Pilot¹³ advises that inshore commercial and recreational fishing takes place off much of the east coast of Australia from vessels operating from the ports and harbours of New South Wales and Queensland. While *Northern Fortune*'s third mate had seen fishing vessels elsewhere in the Great Barrier Reef and had been informed that there was an oncoming ship that would pass at about 2200, he did not adequately consider that a risk of collision might exist with other vessels and, therefore, did not actively look out for them.

The evidence shows that *Northern Fortune*'s third mate took avoiding action at about 2101, suggesting that he first saw *Allena* just after he finished plotting the ship's position at 2100. That the fishing vessel was not seen before that time suggests that the standard of lookout was not adequate. If the third mate had seen *Allena* then he did not adequately assess the risk of collision and subsequently allowed a dangerous close quarters situation to develop without additional monitoring or intervention.

Although *Northern Fortune* was the 'stand on vessel'¹⁴ according to the COLREGS, under Rule 17, there was still an onus on *Northern Fortune*'s third mate to take any necessary action to avoid a collision. *Northern Fortune*'s third mate did not see *Allena* either visually or on radar until immediately before the collision. While he took avoiding action when he saw the fishing vessel, this was too late to prevent the collision.

Allena was approaching Northern Fortune on a constant relative bearing. Allena was about 21° on Northern Fortune's port bow (Figure 7). The fishing vessel had its aft deck lights illuminated but the reflectors in those lights were pointing away from Northern Fortune. From Northern Fortune's bridge, the loom of Allena's lights should have been visible even though the lights themselves would not have been directly visible. The third mate and the seaman on watch should have seen Allena, before the seaman left the bridge at 2045 to conduct his ship safety rounds, when it was about 4.5 miles away.

¹³ Australia Pilot Volume III, Admiralty Sailing Directions NP 15, Tenth Edition 2005, p 2.

¹⁴ The vessel not initially required to give way to another vessel in a crossing situation but which should maintain its course and speed.

At the time of the collision, both of *Northern Fortune*'s radars were in use. The sband (3 GHz) radar was set on the twelve mile range and the x-band (9 GHz) radar on the six mile range. Typically, S-band radars are used for long range early detection of targets while x-band radars are typically capable of greater target discrimination.

When *Northern Fortune* passed Holbourne Island at 2028, *Allena* was about 10.4 miles away and it should have been visible on the s-band radar's display. However, because of its timber construction it probably presented an intermittent or weak radar echo in the sea clutter and rain in the area. *Allena* was beyond the range that the x-band radar was set on at the time. However by 2045, when the seaman lookout left the bridge, *Allena* was less than 6 miles away and it should have been at least intermittently visible on both of *Northern Fortune*'s radar displays, although the prevailing conditions of sea and swell would also have negatively impacted on *Allena*'s already poor radar detectability.

The difficulty in detecting small wooden or fibre reinforced plastic vessels using marine radar has been highlighted in a number of past ATSB investigation reports and safety bulletins, including Safety Bulletin 01 'Ships and Fishing Vessels', investigation report number 240¹⁵ and investigation report number 247¹⁶. Radar detectability can be greatly enhanced by a passive radar reflector or an active radar transponder that transmits a pulse when activated by an incoming radar signal. Smaller SOLAS vessels (less than 150 gross tons) are required to be fitted with a reflector however, *Allena* as a state registered fishing vessel of 20.22 gross tonnes, was not. It is likely that had *Allena* been fitted with a radar reflector, it would have been more readily identified by *Northern Fortune*'s third mate on the ship's radars before the collision and at a greater range.

Similarly, *Allena* was not fitted with an AIS unit and nor was it required to be. Had the fishing vessel been equipped with an AIS unit, it may have been detected and positively identified by *Northern Fortune*'s third mate much earlier than 2101 and, as a result, he could have taken timely avoiding action to prevent the collision. Automatic identification system (AIS) units work by integrating a VHF radio transceiver with an electronic navigation system, such as a GPS, and other on board navigational equipment so that they are able to transmit vessel information such as identity, position, course and speed using radio frequencies. They are independent of radar and provide another electronic means of keeping a lookout. It is not a requirement for small fishing vessels to be fitted with an AIS unit and fishermen tend not to install them because of concerns that AIS units would reveal their vessel's position to other fishing vessels, possibly compromising the location of a favourite fishing ground in a highly competitive industry.

Had *Northern Fortune's* third mate and seaman on watch kept an effective and proper lookout, they would have seen *Allena* at some time between passing Holbourne Island at 2028 and when the third mate needed to take avoiding action at 2101. After the seaman on watch left the bridge, the third mate was alone on watch

¹⁵ ATSB Transport Safety Report, Marine occurrence investigation No. 240, 'Independent investigation into the collision between the Panamanian registered bulk carrier *Silky Ocean* and the Australian fishing vessel *Peter Crombie* off the South Australian coast on 23 April 2007'.

¹⁶ ATSB Transport Safety Report, Marine occurrence investigation No. 247, 'Collision between Namhae Gas and Rexandra 30 November 2007'

and, given that visibility was reduced due to the rain and darkness, he should have been more vigilant in his lookout duties both visually and using the ship's radars.

2.2.3 Previous collisions

The ATSB, and its predecessor the Marine Incident Investigation Unit (MIIU), has investigated 34 collisions involving ships and small vessels since 1990. This represents about half of the 74 similar collision and near-miss incidents that were reported to the ATSB during that period. In nearly all of these cases, the investigations revealed similar contributing factors, in particular, the failure to keep a proper lookout on one or both vessels involved.

The ATSB has an ongoing safety awareness campaign directed at both commercial shipping and fishing vessels which highlights the need to maintain an effective and proper lookout at all times. As part of this campaign, the ATSB has produced a number of safety bulletins including Safety Bulletin 05, 'Fisherman and Safety Awareness at Sea', which was published in December 2004 in an effort to further highlight the common factors identified in some of those investigations.

Since the publication of Safety Bulletin 05, the ATSB has investigated a further six collisions, including three in the 12 months leading up to this collision, that can be directly attributed to a failure to maintain an effective and proper lookout. Copies of all ATSB safety investigation reports and safety bulletins can be downloaded from the ATSB's website at: <u>http://www.atsb.gov.au/</u>.

While fishing vessel skippers believe that commercial ships are better manned and better equipped than fishing vessels and should be able to keep a better lookout, the onus rests with all seafarers.

2.3 Actions taken after the collision

Northern Fortune's third mate stated that he did not see, feel or hear the collision between the ship and *Allena*. At interview, he stated that he thought his last minute course alteration had been sufficient to avert the collision and that the two vessels had only 'passed very close by one another'. He also stated that his impression that a collision had not occurred was reinforced when he looked astern and saw *Allena*'s lights still illuminated and that he did not hear any subsequent radio transmissions, including *Allena*'s MAYDAY call.

Despite being so close to the fishing vessel that he needed to take immediate avoiding action, the third mate did not attempt to slow the ship, turn back, contact the crew of the fishing vessel by radio or by any other means, or in any way attempt to positively establish that the fishing vessel and its crew were safe. Consequently, he was unaware of the extent of the damage caused to the fishing vessel and the imminent danger posed to its safety and, thus, he disregarded his obligation to ensure the safety of the fishing vessel's crew. Furthermore, the third mate did not report the incident to the master, who only became aware of it when he was notified by the ATSB of its intention to investigate the collision about 18 hours after it had occurred. In incidents where a merchant ship has a close quarters passing¹⁷ with a small vessel, the ship's bridge watch keeper may have difficulty determining whether a collision has occurred, especially if it has not been heard or felt. However, if it is necessary for the watch keeper to take immediate avoiding action to prevent an imminent collision, the watch keeper should, at the very least, positively establish by radio communication or other means, that the other vessel has safely passed and that its crew are in no danger. In such circumstances, assumptions about the welfare of the smaller vessel should not be based on scant information or incorrect observations by which the watch keeper hopes to confirm that a collision has not taken place.

Of the 34 collisions and near misses involving trading ships and smaller vessels investigated by the ATSB and the MIIU since 1990, 20 of the ships involved did not stop and render assistance or take any reasonable steps to positively establish the safety of the crew of the smaller vessel. In 22 of the 34 incidents, the smaller vessel actually attempted to contact the ship or make a MAYDAY call using VHF channel 16 after the collision. In 14 of those cases, despite this positive action by the smaller vessel's crew to establish communications, the ship's crew did not respond to the VHF radio calls and did not stop to render assistance. In a number of those cases, the smaller vessel was lost or had been severely damaged in the collision and the crew were left in the water and were rescued later. In other incidents, the small vessel did not make contact using VHF radio because the vessel either sank too quickly or the VHF radio was not operational after the collision.

The evidence from those investigations shows that crews of a fishing or recreational vessel will usually attempt to make contact using VHF channel 16 following a collision. It should therefore be reasonably concluded by ship's watch keepers that the absence of a radio message may indicate that the small vessel is damaged or its crew are in danger rather than evidence that a collision has not occurred and that the vessel and its crew are safe.

The internationally designated VHF radio channel for contacting other ships and for making distress or urgency messages is channel 16 (156.8 MHz). Ships are required to carry VHF radios as are smaller, state registered, commercial vessels such as fishing vessels. Many recreational vessels are also equipped with VHF radio equipment.

Coastal radio stations monitor VHF channel 16 for distress calls and, according to SOLAS, so should ships. SOLAS Chapter IV, Regulation 12.3 states:

Every ship while at sea shall maintain, where practicable, a continuous listening watch on VHF Channel 16.

Allena's skipper stated that shortly after the collision, he attempted to call the ship twice using VHF channel 16. These calls were not answered so he made a MAYDAY call on VHF channel 16. Once he had controlled the water ingress and resumed the voyage to Bowen, *Allena*'s skipper contacted other fishing vessels in the area using VHF channel 16 and VHF channel 10, the radio channel usually used by the local fishermen to call each other. His radio transmissions included the fact that his vessel had been involved in a collision. At about 2300, he contacted the Bowen Volunteer Marine Rescue craft to coordinate his rendezvous with it. Those

¹⁷ A situation where one vessel is in such close proximity to another that immediate avoiding action is necessary to prevent a collision or where an imminent risk of collision exists.

radio transmissions took place over a period of about 2 hours and some of them should have been heard by *Northern Fortune*'s third mate.

Northern Fortune's third mate stated that he did not hear anything on the VHF radio following the collision. It is possible that he was out on the bridge wing looking at the fishing vessel's lights when the initial radio calls were made and there was no one left in the wheelhouse to hear the calls. However, *Allena*'s initial radio calls, including the MAYDAY, were made over a period of about 10 minutes and it seems unlikely that the third mate would not have heard at least some of this radio traffic. This suggests that the third mate did not maintain a proper radio listening watch or that he ignored the radio calls from a vessel in distress.

Article 98 of the United Nations Convention of the Laws of the Sea (UNCLOS), 'Duty to Render Assistance', outlines the responsibilities of a ship's master to render assistance. It states that:

- 1. Every State shall require the master of a ship flying its flag, in so far as he can do so without serious danger to the ship, the crew or the passengers:
 - (a) to render assistance to any person found at sea in danger of being lost;
 - (b) to proceed with all possible speed to the rescue of persons in distress, if informed of their need of assistance, in so far as such action may reasonably be expected of him;
 - (c) after a collision, to render assistance to the other ship, its crew and its passengers and, where possible, to inform the other ship of the name of his own ship, its port of registry and the nearest port at which it will call.

The recent SOLAS requirements for ships to carry both a Voyage Data Recorder (VDR) and AIS units have made ships' crews more accountable in the event of a near miss or collision. While it is now relatively easy to establish a ship's position accurately in coastal waters using AIS data and to analyse the actions of watch keepers objectively using VDR data if it is available, instances of ships not stopping to render assistance following a collision continue to occur.

In several of the collisions that were investigated by the ATSB, such as the recent collision between the tanker *Namhae Gas* and the fishing vessel *Rexandra*¹⁸, the watch keepers on board the ship at the time of the incident denied that a collision had occurred, informing the investigators and the ship's master that only a close quarters passing had occurred. Consequently, they did not take any action to render assistance. Similar incidents have occurred overseas, suggesting that this issue is by no means unique in Australian waters. Two recent international cases are detailed below. In each case, it was considered that the death of members of the crew of the smaller vessel probably occurred because the ship did not stop and render assistance.

In January 2006, a collision occurred involving the French fishing vessel *Klein Familie*. The fishing vessel subsequently sank and only one of the six crew was rescued. The subsequent investigation¹⁹ revealed that the ship in the area most

¹⁸ ATSB Transport Safety Report, Marine occurrence investigation No. 247, 'Collision between *Namhae Gas* and *Rexandra* 30 November 2007'.

¹⁹ BEAmer 'Report of the inquiry into the collision between the longliner *Klein Familie* and the chemical products carrier *Sichem Pandora* on 05th January 2006 in the northeastbound lane of the off Casquets TSS'.

likely to have been involved in the collision was the chemical tanker *Sichem Pandora*. The watch keeper on the ship had taken evasive action to avoid a flashing light around the estimated time of the collision and reportedly did not realise that the ship had collided with a fishing vessel and, therefore, did not stop to render assistance. It was only through a review of AIS recordings that *Sichem Pandora* was named as the probable ship involved.

Similarly, in August 2006, the yacht *Ouzo* and the vehicular passenger ferry *Pride* of *Bilbao* either collided or passed at very close quarters off the coast of the United Kingdom²⁰. The three crew of the yacht were probably left in the water following the accident and they subsequently drowned. The officer on watch at the time of the accident was acquitted of the charge of manslaughter because it could not be proven with sufficient certainty that *Pride of Bilbao* was the ship involved in the collision. He stated that he believed that the yacht was in no difficulty after seeing its lights astern following the incident and did not positively establish the safety of the smaller vessel or stop to render assistance.

In many of these incidents, the officer on watch has strongly denied that a collision has taken place, stating that it was only a close quarters passing. In many cases, if the ship's master or officers believe that the ship has not collided with another vessel, they will not stop. It is only after a subsequent investigation that the identity of the ship involved in the collision is revealed and, by that time, it is too late for the ship to stop and render assistance.

In response to the draft report, the Australian Maritime Safety Authority stated that:

In these cases, there appears to have been no lack of application of Article 98 by the relevant flag States, but perhaps a lack of training or monitoring of officers aboard their registered ships to ensure that they inform the master of a collision or "near miss" in a timely manner and to require them always to make effective contact with the other vessel to verify if it is in need of assistance.

Every ship's master carries the obligations set out in Article 98 of UNCLOS. While the master cannot always be present on the ship's bridge, he is always responsible for the actions of the ship's officers who are also his representatives. Ships' masters should, therefore, ensure that all officers are actively fulfilling the ship's UNCLOS obligations and, at the very least, inform the master of any collision or close quarters passing so that he can fulfil his UNCLOS obligations.

It is a requirement for flag States to ensure that their ships' masters effectively implement the UNCLOS requirements to stop and render assistance to those who are in danger of being lost at sea. The number of similar occurrences, both in Australian and international waters, suggests that flag States can do more to address this issue. In addition, it is clear that ship operators and maritime training institutions need to reinforce the need for ship's officers to act responsibly, inform the master of any collision or 'near miss', and by so doing fulfil the UNCLOS requirements and their moral obligations to render assistance to fellow seafarers in distress .

²⁰ MAIB 'Report on the investigation of the loss of the sailing yacht *Ouzo* and her three crew South of the Isle of Wight during the night of 20/21 August 2006.'

2.4 Queensland fishing vessel licenses

Allena's skipper held a certificate of competency as coxswain, valid in perpetuity, issued in Queensland in November 1998.

Allena is a 13.56 m long, 3B survey fishing vessel that was registered in Queensland and limited to operating up to 200 miles offshore. The operation and qualifications required to operate fishing vessels in Queensland are defined under the Queensland *Transport Operations Marine Safety Act 1994* and *Transport Operations Marine Safety Regulations 2004* (Regulations).

Section 92 of the Regulations, 'Required licences for fishing ships', states:

The appropriate licence for a person to hold for a fishing ship operating in an area is, at least, the class of certificate stated for the area in the USL^{21} Code, section 3, part 4, clause 24.

The USL Code, section 3, part 4, clause 24 is a table that lists the certificates of competency required for different operating areas. It includes the requirement that the skipper of a 3B survey fishing vessel is required to hold a Skipper Grade Three certificate to operate up to 100 miles offshore and to have completed the navigational assessment for the Skipper Grade Two certificate to operate up to 200 miles offshore.

The National Standard for Commercial Vessels (NSCV), that is replacing the USL Code, also lists the certification requirements. Under NSCV Part D, the skipper of a fishing vessel between 12 and 24 metres in length must hold, as a minimum, a Skipper Grade 3 for all operating areas up to 200 miles offshore²².

However, under Section 93 of the Regulations, 'Licensing exceptions relating to operating fishing ship as master', the skipper of a fishing ship less than 15 m long that is operating up to 200 miles from the coast, within the 'fishing ship operational area' may be master of the vessel with a certificate of competency as coxswain.

The Queensland 'fishing ship operational area' is defined under Schedule 15 of the Regulations and it encompasses an area outside the Great Barrier Reef (Figure 8). At its limit, it is almost 250 miles from the coast. This is an operating range that is not consistent with the limitations stated by either the USL Code or the NSCV.

However, the holder of a certificate of competency as coxswain cannot, under the Queensland Regulations, operate a trading vessel further than 15 miles offshore. Under the Queensland regulations, the master of such a vessel must hold a Master Class 5 certificate of competency to operate the vessel more than 15 miles from the coast²³, the trading ship equivalent of the Skipper Grade 3 certificate of competency.

²¹ Uniform Shipping Laws Code, 1989 as amended.

²² National Standard for Commercial Vessels, Part D, p 33.

²³ Maritime Safety Queensland, (2008), Marine Information Bulletin, '*Minimum licence requirements for fishing and trading/commercial ships in Queensland*'.

The training and assessment requirements for navigation and the COLREGs for a certificate of competency as coxswain are common for both trading and fishing vessels. Despite this fact, the holder of a certificate of competency as coxswain is not permitted, under the Queensland regulations, to operate a trading vessel further than 15 miles offshore but is permitted to operate a fishing vessel up to 200 miles offshore.

US4060 2852 399 2876 3193 a lalanda 332: SEA 1802 166 1866 IL 308 (13) 112 238 1884 sland 2623 238 2396 2804 1521 1940 3914 ORAL 4531 1769 3310 197 2879 3956 2079 Osprey Reef SOUTH SUB - TROPIC SEA 1665 4050 1940 QUEENSLAND 2559 AUSTRALIA EE7 3978 1891 BASIN PLATEA 9131 267 2169 1082 ORA S Ĉ L EA 653 1538 20 367 1820 1562 1956 Avo 022 n 32 3122 200 miles 18 205 offshore 1478 18036 500 Cato Island 1551 2207 1218 all'F 330 Buin 3714 1382 4698 2200 Brisbane Tal Queensia Seamoun BRISBANE 1049

Figure 8: Section of navigational chart Aus 4060 showing the eastern boundary of the Queensland fishing ship operational area

Candidates for a certificate of competency as coxswain are required to demonstrate an understanding of the COLREGS and to 'Plan and navigate a short voyage within inshore limits'²⁴, which is also the requirement for the NSCV – Part D²⁵. The candidate for a Skipper Grade 3/Master Class 5 certificate should have a better understanding of the COLREGs and is required to 'Plan and navigate an offshore passage within limits of responsibility of a Master 5'²⁶ or plan a voyage between two ports at least 200 miles apart²⁷. The inshore navigational skills required for a coxswain's certificate do not adequately prepare the holder of a certificate of competency as coxswain to navigate a vessel up to 200 miles offshore.

In submission, MSQ stated that:

Section 93: This section details exceptions that Queensland has enabled for the benefit of the seafood industry. The fishing industry has traditionally operated throughout the Great Barrier Reef, Torres Strait and adjacent areas. These areas have been gazetted in Queensland as the Fishing Ship Operational Area. Conditions in this area are significantly less severe than open oceans found off other states.

Access to this area by small fishing ships is necessary for the viability of the Queensland seafood industry. The exception relating to ship length and qualification reflect an analysis of the risk relating to this sector of the industry operating in these waters.

The Queensland regulations for fishing vessel certificates of competency are ambiguous and, while based on the USL Code, are not consistent with it or with the NSCV. The regulations allow a fishing vessel to be operated up to 200 miles from the coast by a skipper who may not have been adequately trained, experienced or qualified in offshore navigation.

²⁴ The National Marine Safety Committee, (2005), *National Record of Practical Experience and Sea-Service (ROPES) - A record book for candidates for the award of a Certificate of Competency as a Coxswain*, p 30, (2005).

²⁵ Maritime Safety Queensland, (2008), 'TDM20307 Certificate II in Transport & Distribution (Coastal Maritime Operations – Coxswain) in '*Licence profiles for TDM07 units of competence*'.

²⁶ Maritime Safety Queensland, (2008), TDM30407 Certificate III in Transport & Distribution (Coastal Maritime Operations – Master Class 5) in '*Licence profiles for TDM07 units of competence*'.

²⁷ The National Marine Safety Committee, (2005), National Record of Practical Experience and Sea-Service (ROPES) - A record book for candidates for the award of a Certificate of Competency as a Master Class 5/Skipper Grade 3, p 32, 33 and 38.

3 FINDINGS

3.1 Context

At about 2100 on 21 January 2008, *Northern Fortune*'s third mate saw a fishing vessel that he had not previously identified, *Allena*, very close to the ship. He immediately took avoiding action. Despite his use of the ship's helm, *Allena* collided with the ship's port side and was extensively damaged. *Northern Fortune*'s third mate claimed he did not feel or hear the collision and believed that his actions had prevented it and so he did not report the incident to the ship's master.

From the evidence available, the following findings are made with respect to the collision between *Allena* and *Northern Fortune* and should not be read as apportioning blame or liability to any particular organisation or individual.

3.2 Contributing safety factors

- *Allena*'s skipper was not keeping an effective visual lookout. The vessel's radar was not operational and he did not ask another member of the crew to assist him when he switched on the cabin lights to prepare his catch report.
- *Northern Fortune*'s third mate was not keeping an effective visual or radar lookout and did not detect *Allena* until immediately before the collision.
- It was not a requirement for *Allena* to be fitted with either a radar reflector or an Automatic Identification System (AIS) unit. Consequently, the vessel was probably difficult to detect electronically in the prevailing weather conditions. *[Safety issue]*
- Northern Fortune's third mate did not contact Allena or take any steps to determine if a collision had occurred and did not inform the ship's master of the incident. Therefore, he disregarded his legal and moral obligations to ensure the safety of the fishing vessel's crew. It is a requirement for flag States to ensure that their ships' masters effectively implement the United Nations Convention of the Laws of the Sea (UNCLOS) requirements to stop and render assistance to those who are in danger of being lost at sea. [Safety issue]

3.3 Other safety factors

• The Queensland regulations for fishing vessel certificates of competency are ambiguous and are not consistent with the Uniform Shipping Laws Code (USL Code) or the National Standard for Commercial Vessels (NSCV). The regulations allow a fishing vessel to be operated up to 200 miles from the coast by a skipper who may not have been appropriately trained, experienced or qualified for that operational area. *[Safety issue]*

4 SAFETY ACTIONS

The safety issues identified during this investigation are listed in the Findings and Safety Actions sections of this report. The Australian Transport Safety Bureau (ATSB) expects that all safety issues identified by the investigation should be addressed by the relevant organisation(s). In addressing those issues, the ATSB prefers to encourage relevant organisation(s) to proactively initiate safety action, rather than to issue formal safety recommendations or safety advisory notices.

All of the responsible organisations for the safety issues identified during this investigation were given a draft report and invited to provide submissions. As part of that process, each organisation was asked to communicate what safety actions, if any, they had carried out or were planning to carry out in relation to each safety issue relevant to their organisation.

4.1 Department of Marine Services and Merchant Shipping - Antigua and Barbuda, West Indies

4.1.1 Implementation of the United Nations Convention of the Laws of the Sea (UNCLOS)

Safety issue

Northern Fortune's third mate did not contact *Allena* or take any steps to determine if a collision had occurred and did not inform the ship's master of the incident. Therefore, he disregarded his legal and moral obligations to ensure the safety of the fishing vessel's crew. It is a requirement for flag States to ensure that their ships' masters effectively implement the United Nations Convention of the Laws of the Sea (UNCLOS) requirements to stop and render assistance to those who are in danger of being lost at sea.

Response from the Department of Marine Services and Merchant Shipping -Antigua and Barbuda, West Indies MO-2008-001-NSA-026

In response to the ATSB draft investigation report, the Department of Marine Services and Merchant Shipping - Antigua and Barbuda, West Indies responded:

The review of the draft report evoked affirmative opinions related to the identified safety factor...

The ADOMS IID flag State Chief Casualty Investigator intends to focus attention on the identified safety factor related to article 98 of UNCLOS. He will adequately address this issue to raise awareness and to initiate a brought discussion within the Administration and on all her ships and on the Marine Accident Investigator's International Forum (MAIIF) as well.

However, it appears to be of paramount importance as well, that fishing companies and skippers, who operate their small fishing vessels in confined waters with busy commercial traffic, understand that safety may also be a two-way road. It can be a lethal attitude to only rely on the help of others. Fishing industry and coastal authorities within their territorial limits are invited to enforce a proactive safety culture including a professional understanding and adherence of the COLREGS by means of elevated surveillance and advanced relevant legal considerations.

ATSB safety advisory notice MO-2008-001-SAN-027

The Australian Transport Safety Bureau advises that ship operators, ship masters and maritime training institutions should consider the safety implications of this safety issue and to take action where considered appropriate.

4.2 Maritime Safety Queensland

4.2.1 Fishing vessel qualifications

Safety issue

The Queensland regulations for fishing vessel certificates of competency are ambiguous and are not consistent with the Uniform Shipping Laws Code (USL Code) or the National Standard for Commercial Vessels (NSCV). The regulations allow a fishing vessel to be operated up to 200 miles from the coast by a skipper who may not have been appropriately trained, experienced or qualified for that operational area.

ATSB safety recommendation MO-2008-001-SR-028

The Australian Transport Safety Bureau recommends that Maritime Safety Queensland takes action to address this safety issue.

4.3 Fishing vessel owners, operators and skippers

4.3.1 Fishing vessel detectability

Safety issue

It was not a requirement for *Allena* to be fitted with either a radar reflector or an Automatic Identification System (AIS) unit. Consequently, the vessel was probably difficult to detect electronically in the prevailing weather conditions.

ATSB safety advisory notice MO-2008-001-SAN-029

The Australian Transport Safety Bureau advises that fishing vessel owners, operators and skippers should consider the safety implications of this safety issue and takes action where considered appropriate.

APPENDIX A: EVENTS AND CONDITIONS



APPENDIX B: SHIP INFORMATION

Northern Fortune

IMO Number	8302167
Call sign	V2AW5
Flag	Antigua and Barbuda
Port of Registry	Saint John's
Classification society	Germanischer Lloyd (GL)
Ship Type	Container ship
Builder	Stocznia Gdansk, Poland
Year built	1991
Owners	Reederei Karl Schluter, Germany
Ship managers	Reederei Karl Schluter, Germany
Capacity (TEU)	1939
Gross tonnage	30 509
Deadweight (summer)	30 685 tonnes
Summer draught	10.55 m
Length overall	202.40 m
Length between perpendiculars	195.46 m
Moulded breadth	31.0 m
Moulded depth	15.5 m
Engine	Sulzer 6RTA76
Total power	16 260 kW
Crew	27

Allena

Registration Number	1915QB
Call sign	FQDZ
Flag	Australia
Port of Registry	Bowen
Ship Type	Trawling vessel
Year built	1974
Hull material	Timber
Gross tonnage	20.22
Length overall	13.56 m
Moulded breadth	4.34 m
Moulded depth	1.68 m
Engine	Caterpillar 3208
Total power	156 kW
Crew	5

APPENDIX C: SOURCES AND SUBMISSIONS

Sources of information

Allena's skipper and crew

Australian Maritime Safety Authority (AMSA)

Bureau of Meteorology (BoM)

Great Barrier Reef and Torres Strait Vessel Traffic Service (REEFVTS)

Maritime Safety Queensland (MSQ)

Northern Fortune's master and crew

Townsville Water Police

References

ATSB Safety Bulletin 01, 'Ships and Fishing Vessels', 2000

ATSB Safety Bulletin 05, 'Fisherman and Safety Awareness at Sea', 2004

ATSB Transport Safety Report, Marine occurrence investigation No. 247, 'Collision between *Namhae Gas* and *Rexandra* on 30 November 2007'.

ATSB Transport Safety Report, Marine occurrence investigation No. 240, 'Independent investigation into the collision between the Panamanian registered bulk carrier *Silky Ocean* and the Australian fishing vessel *Peter Crombie* off the South Australian coast on 23 April 2007'.

Australia Pilot Volume III, Admiralty Sailing Directions NP 15, Tenth Edition 2005.

Bureau d'enquêtes sur les évènements de mer (BEAMER) 'Report of the inquiry into the collision between the longliner *Klein Familie* and the chemical products carrier *Sichem Pandora* on 05th January 2006 in the north eastbound lane of the off Casquets TSS

International Convention for the Safety of Life at Sea, 1974, as amended (SOLAS).

International Regulations for the Prevention of Collisions at Sea, 1972, as amended (COLREGS).

Marine Accident Investigation Branch (MAIB) 'Report on the investigation of the loss of the sailing yacht *Ouzo* and her three crew South of the Isle of Wight during the night of 20/21 August 2006.'

Marine Maritime Safety Queensland, National Record of Practical Experience and Sea-Service (ROPES) - A record book for candidates for the award of a Certificate of Competency as a Coxswain, 2004.

Maritime Safety Queensland, National Record of Practical Experience and Sea-Service (ROPES) - A record book for candidates for the award of a Certificate of Competency as a Master Class 5/Skipper Grade 3, 2004. MSQ Marine Information Bulletin 'Minimum licence requirements for fishing and trading/commercial ships in Queensland', Attachment 2.

National Standard for Commercial Vessels, Part D, Edition 1, Third Publication 2006.

Transport Operations Marine Safety Act 1994 (Queensland).

Transport Operations Marine Safety Regulations 2004 (Queensland).

United Kingdom Offshore Operators Association (UKOOA) 'Guidelines for Ship/Installation Collision Avoidance', 1st Issue, 2003.

Uniform Shipping Laws Code, 1989 as amended (USL Code).

United Nations Convention of the Laws of the Sea (UNCLOS), 1982.

Submissions

Under Part 4, Division 2 (Investigation Reports), Section 26 of the *Transport Safety Investigation Act 2003*, the Executive Director may provide a draft report, on a confidential basis, to any person whom the Executive Director considers appropriate. Section 26 (1) (a) of the Act allows a person receiving a draft report to make submissions to the Executive Director about the draft report.

The final draft of this report was sent to *Northern Fortune*'s master and third mate, *Allena*'s owner/skipper, the Australian Maritime Safety Authority (AMSA), the Department of Marine Services and Merchant Shipping - Antigua and Barbuda, West Indies, the Townsville Water Police, the Great Barrier Reef and Torres Strait Vessel Traffic Service (REEFVTS) and Maritime Safety Queensland (MSQ).

Submissions were received from AMSA, MSQ and the Department of Marine Services and Merchant Shipping - Antigua and Barbuda, West Indies. The submissions were reviewed and the submissions have been included and/or the text of the report was amended where appropriate.