



香港商船資訊

HONG KONG MERCHANT SHIPPING INFORMATION NOTE

Collision between two vessels at waters close to Kaohsiung, Taiwan

To : *Shipowners, Ship Managers, Ship Operators, Masters, Officers and Crew*

Summary

A collision occurred between a Hong Kong registered container ship and a fishing vessel at waters close to Kaohsiung, Taiwan. It resulted in the death of the coxswain and the missing of a fisherman of the fishing vessel. This Note draws the attention of shipowners, ship managers, ship operators, masters, officers and crew to the lessons learnt from this accident.

The Incident

1. A Hong Kong registered container ship collided with a fishing vessel at waters close to Kaohsiung, Taiwan. The collision caused the fishing vessel to capsize. The coxswain was trapped and drowned inside the wheelhouse. Another fisherman fell into the sea and went missing.
2. The investigation revealed that the main contributory factors of the accident were as follows:
 - (a) both vessels failed to comply with Rule 5 (Look-out) of the International Regulations for Preventing Collisions at Sea 1972 (COLREGS), i.e. to maintain a proper look-out. The target echo of the fishing vessel first appeared on the radar of the container ship at a distance of more than 6 nautical miles away, but the duty officer failed to utilize the radar to plot or check the target in order to determine the risk of collision;
 - (b) the fishing vessel, being a give-way vessel to the container ship, failed to comply with Rule 16 (action by give-way vessel) of the COLREGS, i.e. to take action to keep well clear of the container ship; and
 - (c) the container ship, being the stand-on vessel in a crossing situation, failed to comply with Rule 17 (action by stand-on vessel) of the COLREGS, i.e. to keep her course and speed, or take such action as will best aid to avoid collision.

3. The investigation also found the following safety factors:
- (a) before the collision, the container ship proceeded at a cruising speed of about 15 knots under the command of a junior officer in a port approaching area of high traffic density without making her main engine ready for manoeuvring. The bridge team members did not follow the requirements of the shipboard safety management manual to: -
 - (i) make the engine ready for manoeuvring; and
 - (ii) record the time and position of the commencement and termination of the navigation in high-density traffic area in the log book.
 - (b) the voyage plan was not prepared or executed properly. Although the duty officer checked all the boxes of the Check List for Navigation in High-Density Traffic Areas and the Arrival and Departure Check List for Bridge, some items were irrelevant to the voyage concerned and some checked items had in fact not been performed.
 - (c) the bridge resource management and teamwork on bridge of the container ship were weak and ineffective.

Lessons Learnt

4. All masters and deck officers should be fully conversant with the Rules of COLREGS and take appropriate action to avoid ship collision.
5. Ship management companies should conduct internal audits on board their fleet in order to ensure that the shipboard safety management system is implemented effectively and provide additional training on the bridge team management if found necessary.
6. The attention of shipowners, ship managers, ship operators, masters, officers and crew is drawn to the lessons learnt above.

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19 June 2019