

THE PILOT

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Editorial

This quarter's feature focuses on four MAIB reports into Fog related incidents. Tragically, one of these resulted in the loss of three lives on board a tug which capsized whilst towing in fog. The relevance of all of these investigations to members is that all the vessels involved were being conducted by experienced pilots and all had begun as routine acts and even though fog provides additional challenges, all pilots should be sufficiently trained to cope with reduced visibility and lack of training for fog navigation was not identified as a factor in any of the investigations. Indeed one of the key reasons for any pilotage service is to provide well qualified, highly skilled, pilots to ensure the vessel arrives / departs on time regardless of the weather conditions but therein lies one of the key risks! With the arrival of a pilot on the bridge, the Master and his bridge team invariably relax and place their trust in the competence of the pilot. This is understandable because in pilotage waters the vessel is operating in an environment for which it was not designed and both the Master and his bridge team are also in an unfamiliar environment for which they haven't been trained. This places enormous responsibility on the pilot and he is grave danger of being left unsupported not just by the bridge team but also by all others involved in bringing ships in and out of port such as the Harbour Authority, VTS and tugs. It is here that the MAIB's findings can be summed up in two words, "procedures" and "communication"! Pilots must include the bridge team in the Master / pilot exchange and monitoring of the passage and pilots should communicate any changes to passage plan to the Master and encourage him to discuss any concerns.

Finally, the major fog incident that will inevitably affect us all is the *Cosco Busan*. Although the NTSB has yet to publish its full report, a very worrying development is that the pilot has been charged with, and pleaded guilty to, causing pollution. (See page 10)

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FOG & PILOTAGE

Fog has always been one of the elements to cause most concern to the mariner, especially in coastal waters, and in the days before radar the prudent navigator would frequently stop or anchor and wait until the fog cleared before continuing on passage. Similarly, once in pilotage waters, pilots would also anchor and await clearer visibility rather than risk a collision or grounding by continuing on passage. The advent of radar enabled vessels to proceed in fog and, as watchkeepers became familiar with using it, vessels were able to maintain schedules and then commercial pressures to proceed at full speed regardless of the visibility inevitably impinged upon safety. A series of fog related disasters led to new Collision Regulations (COLREGS) which dramatically reduced collisions and groundings in fog and these fog rules are also applicable in pilotage waters. As radar and GPS technology improved and with VTS able to provide traffic overviews, the primary limiting factor became the ability of tugs to manoeuvre vessels in fog but although vessels requiring tug assistance were unable to proceed, other vessels continued to navigate normally in order to maintain schedules. The very nature of pilotage waters results in reduced safety parameters and these are obviously further eroded in fog. Four MAIB investigations have taken place during the last three years into fog related incidents, one of which resulted in a tragic loss of three lives and so all pilots would be well advised to read the full reports and take careful note of the findings.



In fog proceed with caution and obey the COLREGS! Photo: MAIB

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The following are edited from the "synopsis" and "conclusions" from the MAIB reports. The relevant sections within the full text are shown in brackets.

SKAGEN & SAMSKIP COURIER

www.maib.gov.uk/cms_resources/Skagern_Samskip%20Courier.pdf

In June 2006, the general cargo ship *Skagern* and the container ship *Samskip Courier* collided in the Humber estuary in dense fog. *Samskip Courier* sustained minor damage to her bow but *Skagern* was extensively damaged.

Skagern had embarked her pilot at the Spurn and following the master/pilot exchange the vessel proceeded inbound towards King George Dock at a speed of 11.5 kts.

Samskip Courier had embarked a pilot at King George Dock, and after leaving the dock proceeded seaward at speeds of up to 12.5kts, in thick fog.

Both pilots were experienced and aware that the vessels would meet each other at some point; they had talked to each other on mobile telephones, and VTS also informed them of each other's location. The vessels acquired each other on radar when some 2 miles apart but neither vessel plotted the other on radar as they converged.

VHF radio communications between the two pilots, together with the radar images, revealed that the vessels were on a collision course. The subsequent attempts at emergency avoidance were unsuccessful, and the ships collided head-on.

The ensuing MAIB investigation identified contributing factors to the accident which included:

- Failure to apply long established collision avoidance methods by the masters and pilots of both vessels.
- Pilot /master relationships: the masters' over reliance on the pilots.
- Poor interaction and communications among the bridge teams.
- Loss of situational awareness by *Samskip Courier*'s pilot.
- The positioning of Sand End light float.
- Use of mobile telephones on the bridge.

CONCLUSIONS

3.1 Safety Issues

1. Humber Estuary Services' (HES) Port and Vessel Information System (PAVIS) recorded erroneous information about the master of *Samskip Courier*'s PEC status. [2.6]
2. Neither master exercised his right to take the con of their ships when it became apparent that a serious situation was developing. [2.8]
3. The bridge manning levels on both vessels were inadequate for the prevailing circumstances and conditions. [2.9]
4. Neither pilot queried the bridge manning levels on their respective vessels. [2.9]
5. Masters frequently take the opportunity to relax their vigilance

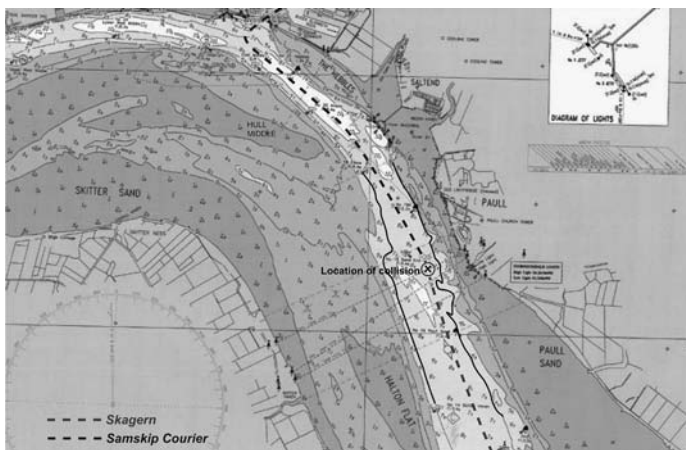


Chart showing the tracks of the *Samskip Courier* & *Skagern* prior to the collision Photo: MAIB

when they have a pilot on board. [2.9]

6. Bridge team management was weak on both ships. [2.10]

7. Both pilots took over the con of their respective vessels without any formal handover taking place. [2.10]

8. The pilot master exchange on *Samskip Courier* was inadequate. [2.10] [2.11]

9. There was poor bridge teamwork and interaction culminating in a failure of the groups to operate as a team and in particular, monitor and question the actions of the pilots. [2.10]

10. There were repeated failures of key personnel to communicate with each other throughout. [2.11]

11. VHF radio familiarisation did not take place on *Samskip Courier* despite there being adequate time to do so whilst the ship was in the lock. This ultimately led to the pilot losing situational awareness at a crucial time. [2.12]

12. Pilots' mobile telephones were used as the means of communication between the two vessels before and after the accident, resulting in the masters being excluded from the information exchange regarding their own ships. [2.13]

13. There was a failure to apply established collision avoidance measures by the pilots and masters of both vessels, namely:

- The vessels were travelling at an unsafe speed for the prevailing circumstances and conditions.
- There was a failure to determine early risk of collision by using systematic radar plotting or long range scanning techniques.
- Evasive actions to avoid collision were inadequate.
- *Samskip Courier* strayed from her side of the channel
- Accepted radar navigation principles for the prevailing circumstances were not applied.
- Restricted visibility sound signals were not used despite the prevailing conditions. [2.14]

14. The excessive speeds were possibly indicative of complacency through habitual risk-taking and a failure to perceive approaching danger. [2.15]

15. The vessels were steered from buoy to buoy using radar as the primary means of navigation without applying parallel indexing, long range scanning or clearing bearings. [2.17]

16. Positional information was not queried or relayed by the master of *Samskip Courier* to the pilot. [2.17]

17. *Samskip Courier*'s radar had a mapping facility which, if used appropriately, would have helped maintain situational awareness and possibly prevent the accident. [2.17]

18. Sand End light float was not best placed to indicate the proximities of the navigational channel. [2.18]

19. Both masters and pilots failed to take positive decisive action when it became apparent a serious situation had developed. [2.19]

20. The ship masters did not verbally query the actions of their pilots. [2.19]

21. The pilot of *Samskip Courier* misjudged the effect the tide. [2.20]

22. *Samskip Courier* did not standby the stricken vessel, *Skagern*, until other assistance arrived. [2.21]

RECOMMENDATIONS

The Port Marine Safety Code Steering Group is recommended to:

2007/121 Promulgate to pilots, by way of Port Authorities, a reminder on the importance of abiding by the International Collision Regulations at all times.

2007/122 Promulgate to Port Authorities the need for pilots to maintain dialogue with the bridge team regarding the conduct and execution of the passage plan.

2007/123 Highlight to Port Authorities the risks in using mobile telephones for passing operational information.

ABP Humber Estuary Services is recommended to:

2007/124 Discourage its pilots from using mobile telephones for discussing operational matters pertinent to the safe navigation of vessels.

The International Chamber of Shipping is recommended to:

2007/125 Through its member organisations, emphasise the need

for shipowners to ensure masters are given clear guidelines which detail the importance of effective dialogue with pilots, and identifies the need for masters to challenge or question decisions or actions taken by pilots at an early stage so that, when required, effective corrective action can be taken to prevent accidents.

SEA EXPRESS 1 & ALASKA RAINBOW

www.maib.gov.uk/cms_resources/Sea%20Express%20Alaska%20Rainbow.pdf

At 1138 on 3 February 2007, the high speed ferry *Sea Express 1* and the general cargo vessel *Alaska Rainbow* collided on the River Mersey in thick fog. The collision holed the starboard hull of the ferry, causing her to list and trim significantly within seconds.

Alaska Rainbow was bound for Birkenhead Docks. Two tugs were attached before the vessel arrived off the lock. Here, the pilot turned the vessel to stem the tide and await the scheduled docking time, and for the visibility to clear enough for a safe approach to be made.

Sea Express 1 was bound for Liverpool Landing Stage. At 1033, as *Sea Express 1* approached the Bar Light Buoy, the trainee captain made contact with Mersey Radio (VTS), who passed the positions of other traffic and advice that visibility in the river was poor. No mention was made of *Alaska Rainbow*.

Sea Express 1 proceeded inwards, reducing her speed over the ground to about 7 knots. At 1138, in the vicinity of Alfred Lock, *Sea Express 1* took action to avoid *Alaska Rainbow's* forward tug, which had suddenly appeared out of the fog directly ahead. Seconds later *Alaska Rainbow* appeared, and *Sea Express 1* took further avoiding action. However, this was too late, and *Sea Express 1's* starboard quarter and *Alaska Rainbow's* bow collided. The collision tore a large hole in the starboard hull of *Sea Express 1*, immediately flooding the engine room and jet pump room effectively disabling the vessel. *Sea Express 1* was towed to the Liverpool Landing Stage, where the passengers were disembarked.

Mersey Docks and Harbour Company (MDHC) and Isle of Man Steam Packet Company Limited (IMSPCL) have taken a number of actions following the accident, particularly with respect to VTS operations, pilotage training and the allocation of bridge team duties in preparation for type rating examinations.

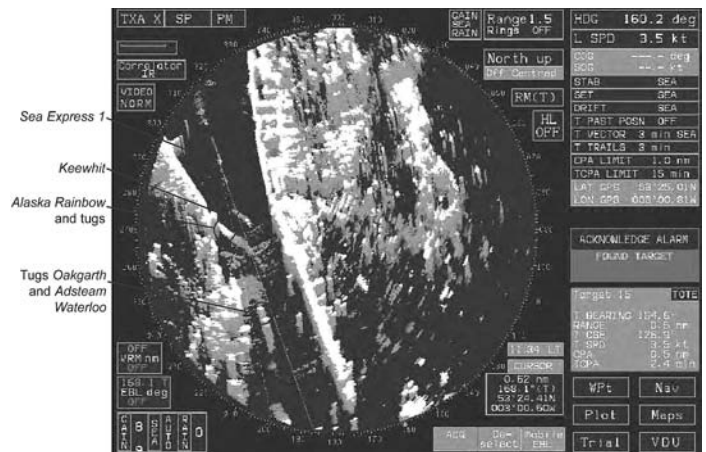
CONCLUSIONS

Factors related to *Sea Express 1*:

- A ground stabilised radar display was not used in the confined waters of a river transit, thereby making it difficult for the operator to distinguish moving targets from land radar returns. [2.2.1]
- The initial communication made by *Sea Express 1's* captain to VTS lacked urgency, thereby delaying an appropriate external emergency response. [2.5.5]
- The allocation of bridge team duties was unclear, resulting in the presence of other vessels in the vicinity to be missed. [2.2.1] [2.2.2] [2.2.3]



The *Sea Express 1* being towed to Liverpool Landing Stage.
Photo: MAIB



The radar image from *Sea Express 1* prior to the collision showing radar "clutter" Photo: MAIB

Factors related to *Alaska Rainbow*:

- The pilot did not proactively communicate with *Sea Express 1* and VTS at an early stage to ensure that all parties were aware of the hazard that *Alaska Rainbow* presented to other traffic. [2.3.1]
- The pilot was not proactive in requiring support, and neither the master nor the OOW was proactive in providing support to the pilot, thereby increasing the pilot's workload. [2.3.3]
- Neither the pilot nor the master ordered fog signals to be sounded, thereby omitting a means by which *Sea Express 1* might have been alerted to the presence of *Alaska Rainbow*. [2.2.2]
- The pilot was insufficiently practiced in maintaining *Alaska Rainbow's* position in the prevailing circumstances, resulting in the vessel moving significantly between the west bank and mid-river. [2.3.2]

Factors related to the VTS station:

- No fog routine was in place, thereby preventing a closer watch on vessel movements being maintained. [2.4.3] [2.4.4]
- The VTS duty staff were expected to absorb the additional workload that operation in restricted visibility demands. [2.4.5]
- A review of the Mersey Channel Collision Rules on the sound signals required of vessels manoeuvring in close proximity during periods of restricted visibility would appear to be appropriate. [2.2.2]
- The VTSOs were not proactive in ascertaining further information following the initial report of the collision and in notifying Liverpool Coastguard, thereby delaying an appropriate emergency response. [2.5.4] [2.5.5]
- Additional workload created by the VTSOs having to take pilotage bookings at a time when performance of their normal duties was at a peak, had the potential to result in the VTSO responsible for the Information Service becoming distracted. [2.4.2]
- Specific risks associated with the carriage of passengers had not been separately assessed, particularly with regard to emergency response. [2.5.4]

RECOMMENDATIONS

The Isle of Man Steam Packet Company Limited is recommended to:

2007/185 Review its Safety Management System.

2007/186 Ensure that the passenger safety instruction card illustrates the lifejacket to be found under the seat for which the card is provided.

J.G. Goumas (Shipping) Co. S.A. is recommended to:

2007/187 Ensure its masters are given clear guidelines which detail the importance of effective dialogue with pilots and identify the need for the ship's bridge team to:

- be proactive in providing support to pilots;
- challenge decisions or actions taken by pilots at an early stage so that, when required, effective corrective action can be taken to prevent accidents.

Mersey Docks and Harbour Company is recommended to:

2007/188 Complete its review of compliance with the requirements of the PMSC with particular reference to:

- VTS operations, ensuring that an effective fog routine is established.
- Pilotage best practice, highlighting the need for pilots to proactively communicate with approaching vessels and VTS at an early stage, to be proactive in requiring support from the ship's bridge team and to sound appropriate fog signals.

2007/189 Invite the MCA to conduct a PMSC verification visit to the Port of Liverpool.

2007/190 Review the Mersey Channel Collision Rules with respect to sound signals required by vessels manoeuvring in close proximity during periods of restricted visibility.

AUDACITY & LEONIS

www.maib.gov.uk/cms_resources/Audacity_Leonis.pdf

At 1351 on 14 April 2007, the UK registered product tanker *Audacity* was involved in a collision with the Panama registered general cargo ship *Leonis*, in very poor visibility, in the precautionary area at the entrance to the River Humber. Both vessels sustained damage to their bows. Fortunately there were no injuries and no pollution was caused. *Audacity* had been outward bound from Immingham Oil Terminal and was approaching the precautionary area in order to disembark her pilot. *Leonis* had entered the precautionary area from seaward and had just completed embarking her pilot. The MAIB investigation found that the operation of the bridge team on *Audacity* was inadequate, and the extent of the VTS area and VTS powers was not clearly understood by the VTS operators.

The investigation identified contributing factors to the accident; these included:

- The pilots and bridge teams, on both vessels, did not make a full assessment of the risk of collision.
- VTS procedures for managing traffic in the precautionary area were insufficient.
- VTS operators were unaware of the poor visibility in parts of the VTS area.
- Humber VTS did not have a formal operating procedure for periods of reduced visibility.
- Communications were poor.
- The Port Authority misunderstood how risk assessment could be used to improve the effectiveness of the VTS operations. As a result of this accident, Associated British Ports Humber Estuary Services (ABP HES) has taken several actions to improve the performance of the VTS, pilots and pilot boarding operations.

Safety issues directly contributing to the accident which have resulted in recommendations

1. The procedure for a pilot/coxswain briefing prior to embarking the

vessel was not conducted efficiently. [2.11]

Other safety issues identified during the investigation also leading to recommendations

1. From historical data, incidents in the Humber Estuary are occurring more frequently than weighted in their current risk matrix. This indicates the risk is greater than initially allowed for or that the safety barriers are insufficient or ineffective. [2.3 / 2.5.2]
2. There were no detailed marine policies applied throughout the group. [2.5.1]
3. Risk analysis should be reviewed as a matter of routine after any serious incident. [2.5.1]

Safety issues identified during the investigation which have not resulted in recommendations but have been addressed

1. Due to a combination of circumstances the VTS operator allowed *Leonis* to drift into a dangerous position close to the exit from the outbound TSS. This action was compounded by the lack of traffic information to either *Leonis* or *Audacity* about the position of the other. [2.10.1 / 2.10.4]
2. *Main Highway's* transit of the precautionary area, at speed, and with substantial alterations of course during the pilot boarding operation, was not good seamanship, nor was it commented on by VTS. [2.8.1]
3. The powers of the AHM to give advice and guidance to vessels operating inside the VTS area, but outside the port limits, were not fully understood. [2.6.1 / 2.10.1]
4. It was incumbent on VTS to ensure that its plan for boarding of pilots recognized the need for vessels to be properly separated both geographically and in time. [2.6.2]
5. The VDR recording from *Leonis* was incomplete. [2.4]
6. Routine information broadcasts, including visibility reports, were made every 2 hours. There were no formal reduced visibility procedures and no requirements for reduced visibility to be reported. [2.6.2]
7. Humber VTS had no formal procedures for the preservation of records in the event of an incident. [2.6.3]
8. *Leonis* altered course towards the northwest because both master and pilot were unaware of the presence of *Audacity*. As a result, no assessment of the risk of collision was made before manoeuvring. [2.7.1 / 2.7.4]
9. ARPA was not used effectively on either vessel to assess risk of collision. [2.7.4 / 2.9.5]
10. Effectively, no-one held the con on the bridge of *Audacity* because both the master and pilot had deferred to the other, there was no discussion or questioning of the intentions of *Leonis*, and at a critical time they involved themselves with tasks that were inappropriate given the impending close quarters situation. [2.9.1 / 2.9.2]

11. The bridge on *Audacity* was insufficiently manned in the circumstances and conditions. It did not comply with company requirements or HES instructions to pilots, however no additional resources were requested by the pilot. [2.9.2]

12. Despite advising the pilot of *Leonis* that he would take action and come to the south, the pilot of *Audacity* did not alter course. [2.9.2 / 2.10.3]

13. The communication between all parties involved was unclear and prone to misunderstanding. [2.10]

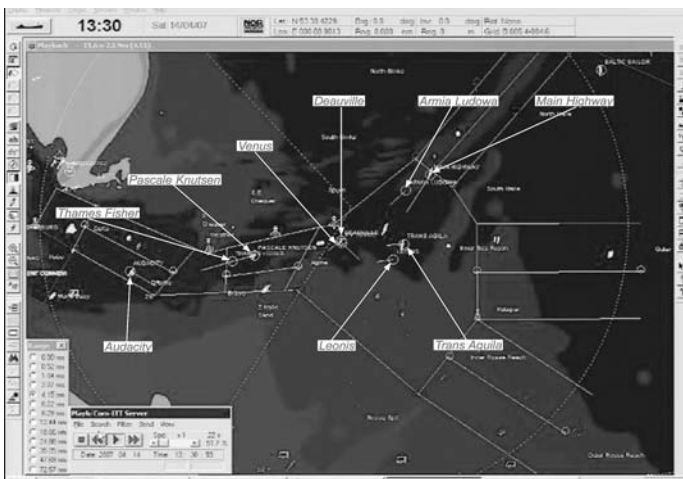
14. VTS operators did not consider they were able to give advice and guidance to vessels with pilots on board. It was considered that the pilot would know what he was doing and that the operator did not need to be further involved once a pilot was on board. [2.10.2]

15. Communications from the VTS operator and P/L *Venus* were ambiguous and confusing. [2.10.5 / 2.11]

RECOMMENDATIONS

UK Major Ports Group and British Ports Association are recommended to:

2008/103 Inform their members of the MAIB's advice that they should consider how pilots can be helped to gain proper orientation



The VTS picture showing a dangerous situation developing
Photo: MAIB

of the traffic and navigational situation prior to boarding vessels.

Associated British Ports Group is recommended to:

2008/104 Develop Group Marine Policies which should encompass, but not be limited to, training, risk assessment, and development and promulgation of best practice.

2008/105 Develop an auditing process to verify compliance with the group marine policies.

LOSS OF TUG *FLYING PHANTOM* WHILST TOWING THE *RED JASMINE* IN FOG

www.maib.gov.uk/cms_resources/Flying%20Phantom.pdf

On 19 December 2007, the tug *Flying Phantom* was girted and sank while acting as a bow tug. She was assisting the bulk carrier *Red Jasmine* during a transit of the River Clyde in thick fog. Three of the tug's four crew were lost; only the mate managed to escape from the tug's wheelhouse and was subsequently rescued.

After *Flying Phantom's* tow line had parted during the capsize, the pilot on board *Red Jasmine* completed the transit to the berth safely, in the thick fog, with only a stern tug to assist him.

The investigation has identified a number of factors which contributed to the accident, including:

- The emergency release system for the towing winch on board *Flying Phantom* had operated, but not quickly enough to prevent the tug from capsizing.
- There were no defined operational limits or procedures for the tug operators when assisting/towing in restricted visibility.
- The routine observed by the tug's crew prior to towing or entering fog was ineffective, resulting in the watertight engine room door being left open and the crew not being used in the most effective manner once the fog was encountered.
- The port risk assessment was poor, and the few control measures that had been put in place after a previous similar serious accident in thick fog proved ineffective.
- The port's reliance on their ISO9001 quality management system audits to highlight safety concerns was fatally flawed.
- The lack of an individual to fulfil the role of "designated person" had resulted in major shortcomings in the port's safety management system being overlooked.
- UK ports appear to have been failing to learn lessons from accidents at other ports.
- The lack of an accepted international industry standard for tug tow line emergency release systems.

CONCLUSIONS

Safety issues directly contributing to the accident which have resulted in recommendations

1. Although the tow line emergency release mechanism operated after the mate activated the system, it did not act quickly enough to prevent the girting of *Flying Phantom*. [2.4.1].
2. Towing winches are not generally regarded as equipment that should be the subject of class surveys. Additionally, there is no clear standard defining the time or loading within which the towing winch brake should release. [2.4.3]
3. There were no defined limits for tug towing operations in restricted visibility and there was no appropriate procedure or training provided to ensure tug crews could continue to operate safely. [2.5]
4. The bridge ergonomics of *Flying Phantom* were not suited to conducting blind pilotage operations in fog. [2.5]
5. There were no formal pre-towing checks to ensure the necessary preparations had been completed. This resulted in the engine room watertight door being open, which reduced the tug's ability to right herself when experiencing a heeling load. [2.6.1]
6. Once *Flying Phantom* had entered the fog bank, her personnel were not used to best advantage to ensure the vessel navigated safely in the narrow confines of the River Clyde. [2.6.2]
7. Although the area in which the accident occurred was known to be

susceptible to fog, there was no reliable means of detecting the arrival of fog on the River Clyde, or warning river users of its presence. [2.7.3]

8. While a procedure for operating in restricted visibility was provided in the port's safety management system, it was ineffective. Specifically, although a lay-by berth was detailed for consideration, it was not appropriate for a vessel of *Red Jasmine's* size, and the pilot had little choice other than to continue to the ship's intended destination. [2.7.4]

9. Clydeport's risk assessment was immature, and many of the control and counter measures put in place were ineffective. It is vital that a comprehensive review of the port's risk assessment is conducted urgently by an independent marine expert to rectify this position. [2.8.1]

10. Many of the recommendations from the *Abu Agila* accident, which occurred in thick fog, were not followed up, and the subsequent control measures were not implemented or were ineffective. [2.8.2]

11. There were a number of inconsistencies and conflicts within Clydeport's SMS documentation. [2.8.3]

12. Clydeport's ISO9001 audits were not effective at highlighting any gaps in safety procedures or the adequacy of the safety procedures in place and did not provide a means of checking that the underpinning risk assessments were adequate. [2.8.4]

13. Clydeport's board was receiving a false impression of the safety performance of the port by relying on the ISO9001 system acting as the designated person. It is considered essential that Clydeport needs to appoint an appropriately qualified individual to the post of designated person. [2.8.5]

Safety issues identified during the investigation which have not resulted in recommendations but have been addressed

1. The liferaft painter was attached to the tug directly without a weak link. Although having no bearing on this accident, if *Flying Phantom* had been lost in deeper water, the liferaft, even if it had inflated, would have been lost with the tug. [1.7.7]

2. Lessons from an accident at one port are not always being learnt by other. [2.9]

RECOMMENDATIONS

Clydeport Ltd is recommended to:

2008/161 Appoint an appropriately qualified individual to the post of designated person.

2008/162 Conduct an urgent review of its port risk assessment and safety management system to ensure:

- Requirements, conditions, controls and operational limitations for the safe transit of large vessels on the Clyde are clearly defined.
- Ambiguities or conflicts within its SMS documentation are removed.
- The company's SMS is subject to routine audits by an independent and appropriately qualified marine professional.
- Limitations and/or working procedures relating to the operation of tugs in restricted visibility are agreed with the port tug operators and incorporated into standard operating procedures.

Lloyd's Register is recommended to:

2008/163 Take forward a proposal to IACS to develop a standard for tug tow line winch emergency release systems, to ensure tow lines can be released effectively when under significant loads in an emergency.

Svitzer Marine Ltd, in association with the BTA is recommended to:

2008/164 Derive limitations and associated necessary guidelines and training for the operation of tugs in restricted visibility. Ensure that ports and pilots are aware of such limitations and guidelines.

The British Tugowners Association is recommended to:

2008/165 Highlight to its members the importance of tug crews' emergency preparedness, including:

- maintaining watertight integrity
- functionality of tow line emergency release systems
- limitations and procedures for operating in restricted visibility.

68th Technical & Training Committee Meeting:

2nd April 2009

MarNIS project – the project officially ended in March and Nigel Allen brought along the DVD of the MarNIS concept and how things will/should change. MarNIS should be phased in by 2020. The DVD lasts about 15 minutes and should be available on our web site soon.

Azipilot project – there has been some contractual problems, mainly due to our association “status”, which prohibits us from being a “full partner”. These contractual problems are presently being resolved. The T&TC will have the same input and remuneration as was agreed some months ago, but we will not have the same glory when the project is completed. Gareth Rees is leading the project and Nigel will act as his deputy.

Nav 55 “Pilot Transfer arrangements” – our input to the revision of A889 and SOLAS V/23 went down very well world wide and a lot of what we are pushing for is on the revised changes we feel are required to make transfer processes safer. Thanks to all the districts that assisted in completing my survey. All incidents and suspect ladders should be reported to your CHA, Port State and also if possible e-mail me a photo and brief resume. We have very few statistics of bad ladders although we know there are many out there. Nav 55 takes place in July and if all is successful a new resolution could be in place for this December. We hope to be part of the UK government delegation.

Pilot boat survey – There are still some districts who have not returned their boat details. It is important to all that we maintain accurate records which will assist districts in upgrading their boats and safety gear. The information when complete will be available on the web site.

Boarding procedures – there was discussion regarding pilots “clipping on” and the merits and disadvantages of doing so. The code states the following:

“7.3 It is strongly recommended that whilst on deck the deckhand is secured to the pilot boat by an approved method which does not restrict his freedom of movement.”

There is no mention regarding the pilot clipping on and it was felt that this was a personal decision which should be left to each individual pilot. The deckhand is involved in many tasks when on the deck of the pilot boat, and he may not have the luxury of being able to have one hand for himself while he is tending the ladder. His clipping on may also be a requirement under MGN50 for the reduction in crew size. We believe he should always be clipped on but this was changed to “strongly recommended” by other stakeholders in the last review.

One point is on the length of the safety strop – the manufacturers of the Hadrian system do

not recommend the standard yacht length 2 meter strop for attachment since this length of strop will result in anybody falling overboard to be suspended at about sea level. On a cutter his legs could come dangerously close to the pilot boat’s propellers or he could get squashed between the pilot boat and the hull of the ship. The manufacturers of the Hadrian system recommend a certified strop of between 500mm and 800mm depending on the height of the rail and the pilot’s height. I have had great difficulty in sourcing a short strop, but now believe “High Level safety” make them. Their web site: www.highlevelsafety.co.uk

Bridge Resource Management (BRM) & Marine Resource Management (MRM) – Jonathan Mills’ paper was discussed as per the last meeting minutes. This agenda item is now being dealt with by the Section Committee.

One point that I would like to bring to the attention of members is that Liverpool Pilots now conduct a MRM course which has P&I Club approval. I was lucky enough to attend one of the courses and found it very interesting. I believe the 2 day course more than covers the requirements of IMO A960 for pilots. Liverpool pilots must be congratulated for the initiative in developing this course which is a positive step towards “pilot training pilots” which I passionately believe in. For further details contact Dave Williamson at Liverpool pilots.

Personal locator beacons – Some of you may have seen that the 121.5 MHz satellites have been switched off so this will affect your

PLBs. The following is an extract from the “Sea Marshall” web site which should explain.

There is a lot of confusion about 121.5MHz at the moment, the frequency of 121.5MHz is and will always be the Internationally Recognised Search And Rescue Homing Frequency. Satellite coverage of 121.5MHz through the Cospas-Sarsat satellite system will be switched off in the coming years, this does not however affect in any way non satellite based locally managed Search & Rescue Systems such as the Sea Marshall® Self Managed Maritime Survivor Locating Devices. In fact it has the positive affect of reducing false alerts.

The following is a quote from the COSPAS SARSAT website:

Cospas-Sarsat Phase-Out of 121.5/243 MHz Alerting Services “However, other devices (such as man overboard systems and homing transmitters) that operate at 121.5 MHz and do not rely on satellite detection will not be affected by the phase-out of satellite processing at 121.5 MHz.”

For further information please visit the Cospas-Sarsat website at: <http://www.cospas-sarsat.org/FirstPage/121.5PhaseOut.htm>

The next meeting of the T&TC has been scheduled for the 24th November 2009.

Again I ask that all incidents are reported to me or any of the committee. If we don't know we can't help.

Brian Wilson

Chairman T&TC – Belfast Pilots Ltd.
bjwilson@talktalk.net or mob 07815 083101

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PENSIONS NEWS

By the time you read this Easter will have been and gone so I hope you all had a happy one and did not overdose on chocolate eggs and bunnies.

The Secretariat

February saw the end of Richard Williamson's three year term as Chairman of the PNPf and I am sure he could not hand over the reins fast enough as it certainly had not been the easiest three years for the Fund. Mrs Heather McGuire took over as Chairman of the PNPf on 12 February and Richard Williamson is now the Deputy Chairman.

Benefit Statements 2008

We have delayed issuing the annual benefit statements to the active members of the Fund until we have all the 2008 pensionable earnings information confirmed. At the time of writing this article there are still two districts outstanding but we hope to be sending them out this month.

Tax Code Changes

Some of you will have received notification of your 2009/10 tax code changes recently. No matter what the notification says there is no need to ring the Secretariat to update us as we download the information direct from HMR&C's website. If you have a query on the calculation of your tax code the HMR&C telephone number to ring is 0845 300 0627, quoting reference 951 PI 74.

REMEMBER

It is in your interest, if involved in any accident or injury, however trivial it may seem at the time, to inform:

Circle Insurances Services

WITHIN 30 DAYS

Contact: Drew Smith
Circle Insurance Services plc
71 Berkeley Street, Glasgow G3 7DX
Tel: 0141 249 9914 • Email via website:
www.circleins.com/ukmpa

Full policy details for all the insurances can be viewed on both Circle and UKPMA websites

Deferred Pensions

From 6 April 2009 there will be a reduction in the rate of required revaluation of the deferred pensions of members who leave the scheme before reaching their normal retirement date. The maximum inflation protection (LPI) for deferred pensions will be reduced from 5% to 2.5%. This only applies to the portion of the deferred pension attributable to pensionable service accrued after 6 April 2009.

AVCs Benefit Statements

The annual statements in respect of your AVCs investments have been sent out to all members who have investments with either, Equitable Life, Clerical Medical or Norwich Union. If you have any queries Loretta is more than happy to deal with them.

Trustee Annual Report & Accounts 2008

As I write the 2008 annual accounts are being audited by PKF. We hope that the final version will be signed off at the Trustees' quarterly meeting in May and a printed copy sent out to all active members and pensioners during the month of June.

Equitable Life

In response to the publication of the Parliamentary Ombudsman's report on the regulatory failure in respect of Equitable Life the Chief Secretary to the Treasury agreed that there had been maladministration in areas and that an ex gratia payment would be made to those who had suffered "disproportionally". A former Appeal Court judge is to advise the government on the payouts. Unfortunately all celebrations are put on hold as the payment of compensation looks set to be delayed, possibly for years, as the process of getting data and assessing relative losses will be very slow, cumbersome and complex. The resulting compensation payment may be miniscule.

The Public Sector GMP Error

In December 2008 the House of Commons were advised of an error in the payment of some public sector pension entitlements. It appears that since 1978 inaccurate data resulted in higher annual pension increases being paid than should have been. The five public sector schemes affected are the NHS, Teachers, Armed Forces, Judicial and Civil Service pension schemes. An estimated 95,000 people are affected across the five schemes or 5% of the total number of pensioners within those

schemes. The overpayment is estimated at £126m. The government has been advised that there is not a cost-effective method for recovering these monies, but correct pension payments will be effected from April 2009. If this had happened in the private sector legislation requires scheme administrators to pursue any overpayment of more than £250 or face a minimum 40% unauthorised surcharge levied by HM Revenue & Customs on the member.

"Pension Apartheid"

The media coverage of the overpayment of public sector pensioners has succeeded in highlighting the disparity between public and private pensions. In response to mounting pressure the three main parties came out in support of a review to look at ways of cutting down the costs of MPs pensions.

The Conservatives say they would move all new MPs into a defined contribution pension scheme if it won the next election as well as scrapping future accrual into the MPs' final salary scheme. It would also bring public sector schemes in line with cheaper arrangements in the private sector. Why should judges who only contribute 2% of their salary to their pension be given overly generous pensions from the taxpayers' pocket when private sector employees are being forced to buy annuities from pension 'pots' that have fallen in value as a result of the recession and falling stock markets?

Benefits of Deflation

Pundits are predicting that rapidly falling inflation risks tipping over into deflation, but this could prove beneficial to the country's pensioners. The latest Retail Price Index (RPI) inflation figures show headline inflation fell from 3% to 0.9% in December, thanks largely to falls in mortgage rates and the cut in VAT to 15%. The high levels of inflation seen over the past year have had a negative impact on pensioners, but with deflation the falling food and energy prices could help increase pensioner spending power.

Debbie Marten
debbie@pnpf.co.uk

Retirements

November 2008 to January 2009

JL Curry	Liverpool	December
DA Keenan	Tees	December
JR Smith	Tees	December

THE PILOT CUTTER *PROTECTOR*

Following publication of the article "Tyne Pilots: End of an Era" in the April 2008 issue, I was contacted by local historian Wendy Cummin who had researched the loss of the pilot cutter *Protector* referred to in the article and has kindly agreed for her research to be published in the magazine. It is almost impossible to imagine the grief that such a loss of so many pilots, many of whom were related, must have caused in the local community. Wendy's research therefore provides a valuable and fitting tribute to those lost and their families.

JCB



Although not as common as in WW2, there were many civilian deaths in WW1. People died as a result of Zeppelin raids or naval bombardment; they died from explosions in munitions factories; and they also died serving the war effort in other ways, with the Red Cross, the YMCA, as chaplains, as civilian staff of the Admiralty and as pilots on the river, among others.

River pilots, aboard cutters, were employed to guide ships safely into harbour, and in this capacity they ran the gauntlet of mines laid by the enemy during WW1. One such was the pilot cutter *Protector* built in 1907 by Rennoldson at South Shields on the Tyne.

On New Year's Eve 1916, *Protector* left the Tyne with pilots on board to take up station at the boarding ground but was devastated by a mine in the entrance to the Tyne and was sunk with the loss of all 19 men aboard. The oldest man lost was aged 70 and the youngest was just 16. All of these men were from Tyneside.

It seems that only one body was recovered: Robert Phillips, Pilot 1st class, the oldest man on board at the age of 70, is buried in Tynemouth cemetery.

The other men were lost, and are all commemorated on the Tower Hill Memorial.

They were, in alphabetical order:

John Swinney BONE - John was a Pilot 1st class, and he was 36 when he died. He was born in South Shields, the son of Thomas and Ann [Alice?] of 155 Lawson Terrace, South Shields.

In 1901 the family lived in Henry Street. John's father Thomas was also a pilot, as was his brother Thomas. His brother Robert was a fireman on a tugboat. All the family were born in South Shields.

Charles BURN - Charles was a Pilot 1st Class, and he was 53 when he died. He was born in South Shields, the son of Charles and Catherine of 21 The Lawe, South Shields. His father and four brothers all worked on the pilot vessels. All were born in South Shields.

Charles married Margaret Elliott Wright

in 1893 and they lived in Roman Road in 1901 with children Catherine, Margaret, Charles, and Lancelot. The family later lived at 41 Trajan Avenue in South Shields.

John Hart BURN - John was a Pilot 2nd class, and he was 39 when he died. He was born in North Shields, the son of Ralph and Annie of 13 Walker Place, North Shields.

John was one of at least 9 children, some born in North Shields and some in South Shields. His father Ralph was also a pilot, born South Shields. He married Charlotte Louise Garred in 1903 and their last known address is 15 Coburg Terrace, South Shields. A daughter Ellen was born in 1912.

Robert CHAMBERS - Robert was a Pilot 1st class, and he was 48 when he died. He was born in South Shields, the son of Robert and Ellen. His father was also a pilot, and in 1881, at the age of 13, young Robert was already a pilot assistant.

Robert married Margaret Ann Bell in 1892 and by 1901 they were living in Baring Street, South Shields with children Robert, Caroline, William and Joseph.

John Cawthorne CREE - John was a pilot assistant, and he was 19 when he died. He was born in South Shields, the son of John and Elizabeth. His father was also a pilot, born in Jarrow. In 1901 the family lived at 43 Trajan Avenue in South Shields and John's last known address was 60 Kensington Road.

William Robert FORSTER - William was 1st engineer, and he was 39 when he died. He was born in North Shields, the son of William and Margaret. His father was a publican in Middle Street, North Shields in 1881.

In 1901, William Robert was serving as an engineer aboard the vessel *TW Mould* and was unmarried. He married Edith Annie Downie in 1908 and the last known address of his wife was 115 Howdon Road in North Shields. William and Edith had three children: Edith, Kenneth, and Sidney.

Thomas HERON - Thomas was a Pilot 1st class, and he was 42 when he died. Born in

South Shields, the son of Benjamin and Esther, his father and two brothers were also pilots.

In 1901 the family lived in Edith Street in South Shields and the last known address is 114 Baring Street, South Shields.

Alexander LESLIE - Alexander was a pilot assistant, and he was 21 when he died. He was born in South Shields, the 5th of 6 children of Alexander and Mary Ellen nee Waugh. His father was also a pilot.

In 1901 the family lived in Pearson Street in South Shields. His mother died in 1900 and his father re-married to Elizabeth Jane Robson. His father died in 1912. The last known address for Alexander junior is 10 Keppell Street in South Shields.

William LESLIE - William was a pilot assistant, and he was 19 when he died. He was born in South Shields, the son of Robert and Mary [probably nee Layden].

In 1901 the family lived at Lawe Cottages and his father Robert was also a pilot. The last known address for William is 42 Collingwood Terrace in South Shields.

James Matthew MACCONNACHIE - James was a fireman, and he was 36 when he died. He was born in South Shields, the son of John and Jane Isabella. His father was a coal miner from Scotland, and in 1901 James was also working in the mines, living in Commercial Road in South Shields.

He married Sarah W. Dixon in 1913 and a son James was born in 1914. Their last known address is 77 Eldon Street, South Shields.

Thomas Haw MARSHALL - Thomas was a Pilot 1st class, and he was 36 when he died. He was born in South Shields, the son of John and Elizabeth Ann. His father was also a pilot, and in 1901 the family lived in Baring Street, young Thomas employed as a pilot assistant.

He married Elizabeth Ann Miller in 1902 in Tynemouth and they had a son John born 1912 and a daughter Elizabeth born 1915. There were probably other children born earlier.

His widow Elizabeth Ann re-married in

1921 to Arthur Smith, and her last known address is 45 Fairless Street in South Shields.

James W. NICHOLSON - James was a steward, and he was 45 when he died. He was born in North Shields, the son of John and Ann. His father John was originally a sail maker, but later worked in a factory, probably due to unemployment.

In 1901, James was also a factory worker living in Union Road in North Shields.

He married Elizabeth Ann Thompson in 1893 and they had a son James and daughters Ann and Isabella. His last known address is 27 Stormont Street, North Shields.

Robert PHILLIPS - Robert was a Pilot 1st class, and he was 70 when he died. He was born in South Shields, the son of Robert and Catherine. This family produced a long line of pilots; Robert senior, born about 1817, was a pilot, as was his brother Ralph.

Robert junior, born about 1846, married Elizabeth Scott in 1867 and they had at least 8 children including John, William, and Ralph who all became pilots.

By 1891, Robert was living in North Shields with Isabella Henderson described as his housekeeper, but there is no wife Elizabeth, and in 1901 he was living in Vespasian Avenue in South Shields with his "wife" Isabella. No marriage has been found. Several more children were born.

His last known address is 53 Trajan Avenue, South Shields.

As Robert is buried in Tynemouth [Preston] Cemetery, his appears to have been the only body to be recovered.

Sadly his grandson Ralph was with him on the *Protector*.

Ralph PHILLIPS - Ralph was a pilot assistant, and he was 20 when he died. He was born in North Shields, the son of Ralph and Jane, and the grandson of Robert.

His father Ralph was, of course, a pilot. In 1891, Ralph senior was a pilot apprentice lodging with the family of Sidney Smith in North Shields. He married Jane Ellen Smith in 1893. The family were living in Walker Place, North Shields in 1901, and Ralph's last known address is 14 East George Street, North Shields.

Thomas REED - Thomas was the master of the vessel. No age or place of birth is given for Thomas but he was probably born in about 1844 in North Shields.

There is a Thomas Reed, pilot, aged 37 living in Adamson's Broadway in North Shields in 1881 with a wife Mary and 6 children including Thomas aged 15 [pilot apprentice] and Matthew aged 14.

In 1891 they are at the same address, and in 1901 his son Matthew C Reed, a pilot, is living in Beacon Street in North Shields.

As Thomas gives his next of kin as MC Reed, this is likely to be his family. However

we cannot be completely sure; the last known address for MC Reed is 19 Toll Square, North Shields.

Bertram RUMNEY - Bertram was a cabin boy and he was only 16 when he died. He was born in 1901, registered as Bertram Thompson Rumney, in North Shields.

He was the son of William Rumney and Isabella Thompson who married in 1897. William was a coppersmith and the family lived in Dawson Street, North Shields in 1901. However, in 1891 William was with his parents William and Mary at 27 Burdon Main Row, the last known address for Bertram. William senior was a boat builder.

William H TINMOUTH - William was a Pilot 1st class and he was 41 when he died. He was born in South Shields, the son of Thomas Young Tinmouth and his wife Sarah. His father Thomas was also a pilot, born in South Shields. William Hopper Tinmouth married Mary Chambers Elliott in 1901 and they were living at 76 Edith Street in the 1901 census. Their last known address is 152 Fort Street in South Shields.

Matthew YOUNG - Matthew was a Pilot 1st class and he was 42 when he died. He was born in South Shields, the son of Matthew and Margaret Young. His father Matthew was also a pilot, born in South Shields.

Matthew [junior] married Jane Taylor Downie in 1896 and by 1901 they were living in Henry Street, South Shields with children Jane and Matthew. Their last known address is 77 Baring Street.

William YOUNG - William was a Pilot 1st class and he was 47 when he died. He was born in South Shields, the son of Thomas and Isabella nee Robson. Thomas was also a pilot, born in South Shields.

William married Priscilla McKenzie in 1887 in South Shields, and by 1901 they were living at 117 Baring Street in South Shields with six young daughters. Their last known address is 58 Julian Avenue.

Wendy Cummin 2008

Sources: "British vessels lost at sea 1914-18"; CWGC website; Censuses; GRO
Protector photos courtesy of Retired Harwich haven pilot: Andy Adams.



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COSCO BUSAN: PILOT PLEADS GUILTY TO CRIMINAL CHARGES

Although it occurred in the USA, the Cosco Busan allision with the Bay Bridge in San Francisco will inevitably have relevance to pilotage over here. There is also relevance to this quarter's feature on piloting in fog.

At the time of writing the official National Transportation Safety Board (NTSB) which is the USA's equivalent of the MAIB, had still to publish the full results of their enquiry into the incident but they have issued a preliminary report which identified failures in procedures and communication similar to those identified by the MAIB in the feature. The key findings are as follows:

M/V *Cosco Busan* left its berth in the Port of Oakland in thick fog. The San Francisco Bay pilot issued directions that resulted in the ship striking the fendering system at the base of the Delta tower, which created a 212-foot-long gash in the ship's forward port side and breached two fuel tanks and a ballast tank.

As a result of the allision, over 53,000 (US) gallons (approx. 220 tonnes) of fuel oil were released into the Bay, contaminating about 26 miles of shoreline and killing more than 2,500 birds of about 50 species. Total monetary damages were estimated to be \$2 million for the ship, \$1.5 million for the bridge, and more than \$70 million for environmental cleanup.

In its determination of probable cause, the NTSB cited three factors:

- 1) The pilot's degraded cognitive performance due to his use of impairing prescription medications.
- 2) The lack of a comprehensive pre-departure master/pilot exchange and a lack of effective communication between the pilot and the master during the short voyage; and
- 3) The master's ineffective oversight of the pilot's performance and the vessel's progress.

The NTSB recommended that the U.S. Coast Guard:

- 1) Ask the International Maritime Organization to address cultural and language differences in its bridge resource management curricula.
- 2) Revise policies to ensure that, in its radio communications, the Vessel Traffic Service (VTS) identifies the vessel, not only the pilot.
- 3) Provide guidance to VTS personnel that defines when their authority to direct or control vessel movement should be exercised.
- 4) Require mariners to report any substantive changes in their health or medication use that occur between required medical evaluations.
- 5) Ensure that pilot oversight organizations share relevant performance and safety data with each other, including best practices.

What is different in this case and potentially of most concern to all pilots is that in response to the media (supposedly representing public opinion) outcry someone has had to be identified to take the blame and so the hapless pilot has had, not just his actions on that day, but also his whole career and personal lifestyle examined in microscopic detail in a search for culpability. This detailed examination of one individual discovered that the pilot had been involved in previous incidents and that at the time of the allision with the bridge he had been taking medication, which may have affected his performance as a pilot. With all this attention upon him it is hardly surprising that the pilot voluntarily surrendered his authorisations at an early stage.

Despite this prompt action pending the outcome of the enquiry the pilot faced two criminal charges under the "Clean Water and the Oil Pollution Act" (CWOPA) and the "Migratory Bird Treaty Act" (MBTA).

All pilots should carefully note the following charges levelled against him:

That the pilot, John Cota under the CWOPA: "*did negligently cause the discharge of oil in such quantities as may be harmful from a vessel, the Cosco Busan, into and upon the navigable waters of the United States, without a permit. Specifically, on or about November 7, 2007, Defendant Cota, while piloting the Cosco Busan, caused approximately 58,000 gallons of heavy fuel oil to be discharged from the vessel into San Francisco Bay by acting in a negligent manner, that included the following:*

- (a) *Failing to pilot a collision free course.*
- (b) *Failing to adequately review with the Captain and crew of the Cosco Busan prior to departure the official navigational charts of the proposed course, the location of the San Francisco Bay aids to navigation, and the operation of the vessel's navigational equipment.*
- (c) *Departing port in heavy fog and then failing to proceed at a safe speed during the voyage despite limited visibility.*
- (d) *Failing to use the vessel's radar while making the final approach to the Bay Bridge.*
- (e) *Failing to use positional fixes during the voyage; and failing to verify the vessel's position vis-a-vis other established and recognized aids to navigation throughout the voyage".*

And under the MBTA: "*without being permitted to do so by regulation as required by law, did take migratory Birds, including at least one Brown Pelican, Marbled Murrelet and Western Grebe.*"

At the trial John Cota pleaded guilty to the charge of negligence admitting one count of negligently discharging a pollutant and one count of violating a federal law against killing migratory birds and will receive a sentence of two to 10 months in prison and a fine from \$3,000 to \$30,000.

Is this case relevant to the UK? All pilots should remember that the £1,000 limitation of liability under S22 of the 1987 Act is not applicable to criminal charges. In similar circumstances over here a pilot involved in a *Cosco Busan* type incident could face charges by the Environment Agency under the UK's "Water Resources Act" and also under S21 of the 1987 Act.

I am an employed pilot so aren't I covered by my employer's insurance? The answer here is most probably not because once on board and piloting any pilot, regardless of employment status is "*an independent professional man who navigates the ship as a principal and not as a servant of his general employer*" (*Esso Bernica and Cavendish*).

Am I covered for such an incident by the UKMPA insurance? The answer is that although we are covered for legal defence costs, which includes pollution, nobody can insure against a criminal act and the exclusion clause states "*the accident did not result from the insured's intentional and willful violation of any government statute, rule or regulation.*" i.e. if excessive speed in fog was proven?

You have been warned!

JCB

OBITUARIES

Colin Alfred Rhodes 1922 - 2009



Colin was born in Bethesda, North Wales on 24th April 1922. His childhood was spent in Dovercourt and then in Lowestoft when his father, Captain Leslie Rhodes, took up the position of Harbour Master there. Never a committed scholar he much preferred messing about in boats, being a keen Sea Scout, canoeist and yachtsman. Naturally his life was to be the sea and he was apprenticed to the Port Line in January 1939 sailing out on his first voyage on the *Port Denison*.

WWII was declared whilst Colin was on board his second ship, the *Port Hobart*. He survived the war unscathed but sadly many of his ships were sunk just after he had left them. The heavy toll of good men shortened his apprenticeship to 3 years. He remained with Port Line obtaining his Certificates and good promotion sailed as temporary Master of his last ship before joining Trinity House in 1953 as pilot at Lowestoft.

In 1954 he joined the Medway Pilots and remained there until retirement in 1987.

Although not a religious man, Colin was a spiritual one, believing his legacy would survive through his children and his deeds. His marriage to Charlotte in 1957, one son, two daughters and eight grandchildren are testament to one, and his tireless work for pilots in general another.

In those self employed days pilots were not paid for union work and had to make up their turns after a day off. Colin represented the Medway Pilots in the London Pilots Council and the UKPA, eventually taking on the President's role. Under Colin's Chairmanship of the UKPA Executive along with TGWU Brethren, the PNPf was established – many a pilot should raise their glass to him on a monthly

basis for this.

One notable event during his tenure as President was to address some 1,250 pilots at the Birmingham conference when relations with the ship-owners was at a low ebb.

Through the UKPA Colin became involved in EMPA at the time that the United Nations was establishing IMCO (later to become International Maritime Organisation). Upon submitting papers regarding pilot issues to IMCO they were politely informed they could not be accepted as they did not represent an international group. Thus the seeds were sewn for Colin with others including Rt. Hon. James Callaghan to form IMPA, of which he was appointed the first Senior Vice President. Through the years Colin was involved in the revision of the Collision Regulations, SoLaS Convention of 1974 and the first STCW Convention.

Apparently not content with this heavy commitment Colin was also instrumental in establishing the Nautical Institute, being a founder member, its second President and for several years its Treasurer. In his "spare time" Colin was an active member of the Freemasons taking on many senior local and provincial roles.

After a long illness stoically borne with good humour, Colin died at home 7th March 2009.

Pilots and seamen have much to thank for Colin's life, a legacy indeed. A good shipmate for his colleagues, a fine husband for a very understanding wife, a mentor and hero for his children and grandchildren.

John Gurton, Medway Pilot

George Henry (Harry) Potter 1925 - 2009

It was with much sadness that many colleagues and friends attended the funeral of retired London pilot George Potter who died in January aged 83.

Born in Whitby Bay in August 1925 he went to sea early on in the war where shortly afterwards his ship was torpedoed. Having been reported as "missing, presumed dead" his family was deep in grief when the news arrived that George had been rescued and taken to safety. Despite this early traumatic experience, George continued to serve in the Merchant Navy throughout the war and no doubt witnessed many more tragedies. One particularly harrowing event occurred at the end of the war. In 1945 he was serving as Chief Officer on board the SS *Cattaro* loading dried fruit for home at Patras when an earthquake occurred which

devastated that City. At the request of the RN, George and the crew joined their search and rescue party but were unable to locate any survivors in their sector.

After the war, George continued to serve as Chief Officer and Master until, in 1959, he was accepted by Trinity House as a London "Channel" pilot. Once authorised, he became a respected and popular member of the Gravesend pilotage community and was renowned for his good humour. Outside pilotage, George became involved with helping others and the term "pillar of the local community" doesn't really do justice to his dedication. Amongst many other activities he became leader of the local cub and scout troop and was also involved with the Singelwell Primary School where he served as a Governor. Whilst serving as a church warden at St Margaret's church he became caretaker of the Gerald Misken Memorial Hall where his organisational talents ranged from establishing the youth club to setting up the mother and toddler group! Such was his wizardry at sorting problems and helping people that it was inevitable that he became known as "Harry" to his friends.

I personally had the pleasure of tripping with George during my training and remember him as one who was always willing to share his knowledge and experience.

St Margaret's church was filled to capacity for his funeral and he will be sorely missed by all who knew him but especially his wife, Gerda, his four children, his grandchildren and, more recently, a great grandchild.

*JCB: Collated from several sources.
Submitted by Retired Trinity House
Channel pilot: Don McLean*

Pensioners Deceased

November 2008 - January 2009

M Clent	<i>Harwich</i>
BA Couves	<i>River Thames</i>
IC MacDonald	<i>Forth</i>
R McLaren	<i>London North</i>
GH Potter	<i>London Channel</i>
TA Purvis	<i>Tyne</i>
MK Purvis	<i>Blyth</i>
L Ratcliffe	<i>London North</i>
R. G Robinson	<i>Bristol</i>
WG. Smith	<i>Bristol</i>
K Spence	<i>Humber</i>

BOOK REVIEWS

The Nautical Institute is rapidly becoming established as the primary source for nautical publications and their books have become renowned for providing clear and concise reference works for mariners. Two recent publications are of particular relevance to pilots:

RADAR and AIS: Integrated Bridge systems Vol. 1

By Dr Andy Norris

So far as I am aware this is the first book on radar specifically written for mariners since the old Radar Observer's Handbook, the last edition of which was produced in 1998. With many advances in radar and associated technologies taking place since that time, an updated book on marine radars is long overdue and Dr. Norris' has provided a book that explains the latest developments in a clear and concise manner. Since 1st July 2008 it has been a requirement for all new radar installations to be capable of displaying AIS data and since formal training courses always lag well behind the introduction of new technology there is much ignorance regarding AIS and especially its integration into radar displays and without a comprehensive understanding of the technology and its limitations it is all too easy for a watch keeper to regard the information displayed as infallible. As Dr. Norris warns in his introduction "... the user who is ignorant of the possible problems that can arise will invariably become involved in an accident".

The main part of Radar and AIS is divided

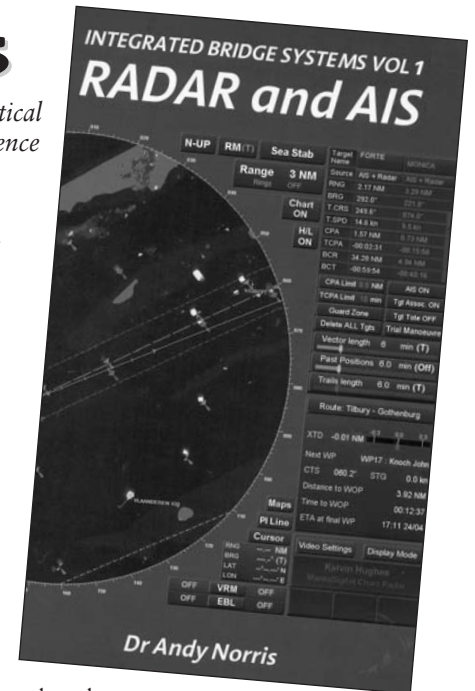
into four chapters, namely:

- Radar Basics
- AIS Basics
- The use of radar and AIS
- Practical considerations of using AIS with radar

This main text is supplemented with useful annexes:

- The radar equation
- International function messages
- AIS vessel types and cargoes
- IMO display symbols
- Parallel indexing
- Familiarisation training framework

Together, all these sections provide the mariner with an essential understanding regarding the advantages and limitations of both technologies and identifies the very important fact that since the COLREGS currently contain no rules covering the use of AIS in anti-collision action, radar and visual observations must be the only aids used when risk of collision exists. The book also acknowledges that many radar features have been prioritised by the whim of manufacturers



rather than

by user needs which has left some key functions such as parallel indexing complex and fiddly to use and regrets the fact that training for a particular system is too often achieved by dumping a fat and poorly written operating manual on board for the crew to read and digest in their spare time!! We pilots, of course, have no chance!

Overall this is a much needed reference work that should have a place on every "ready room" bookshelf.

From Paper Charts to ECDIS By Captain Harry Gale FNI

This is another timely publication published by the Nautical Institute, which provides valuable information, and advice to mariners as the traditional paper chart is replaced by ECDIS during the next few years.

Electronic charts have been making an appearance on bridges now

for several years but considering the revolution in navigation techniques that such installations herald, the lack of understanding of the systems amongst some mariners (and dare I suggest many pilots) is quite alarming!

We have all seen the terms ECDIS, ENC, ECS, Raster and Vector, but what do they all mean and what is the difference between them? All is explained in this handy booklet.

The Electronic Chart Display and Information System (ECDIS) is basically an approved platform for displaying approved Electronic Navigation Charts (ENCs) which are produced to an internationally agreed standard capable of replacing the traditional paper chart. These ENC's can only be produced by, or on the authority of, an authorised Hydrographic Office. The IMO approved the mandatory carriage of ECDIS in December 2008 and set dates for the phasing in of ECDIS over a six year period between 2012 and 2018.

Up until now the carriage of Electronic Chart Systems has not been formally regulated and consequently two key problems have arisen, namely: Confusion over whether or not the system is a "approved" ECDIS and training in the use of electronic charts. These problems are considerable because a non-approved system must not be used for

navigation, even though it may be integrated into the bridge console. Since use of ECDIS requires a whole new way of how a navigator uses a chart and interprets the information displayed, a lack of training in its use is a recognised danger which has already resulted in several high profile groundings!

Drawing on valuable feedback from the end user by means of the NI's Sea Going Correspondence Group, Captain Gale's book explains all the existing systems, details the advantages and disadvantages of using ECDIS and highlights the dangers of misinterpreting data through a lack of proper training.

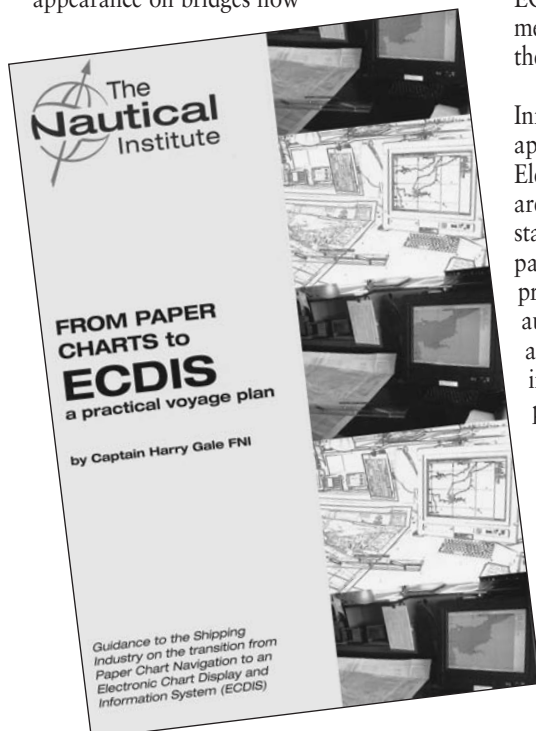
From Paper Charts to ECDIS is therefore another essential book for the "Ready Room".

Both books are available from the Nautical Institute's publications department:

Radar & AIS: £20 (30% discount for members)
ISBN 1 870077 95 4

ECDIS: £15 (30% discount for members)
ISBN 987 1 870077 98 9

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