

**THE PROPOSED ASSOCIATED BRITISH PORTS (EASTERN RO-RO TERMINAL)
DEVELOPMENT CONSENT ORDER**

DEADLINE 2

Response on behalf of the Harbour Master, Humber

to the Examining Authority's written question NS. 1.6 issued on 7 August 2023

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1. Introduction

1.1. This is a written submission made on behalf of the Harbour Master, Humber (HMH) in response to the Examining Authority's written question (**ExQ1**) issued on 7 August 2023.

1.2. The question addressed in this submission is:

1.2.1. NS. 1.6 - Marine Incident in vicinity of IOT (response in respect of the Humber MSMS only) and NS. 1.7 - Historical allision of cargo vessel with vessel moored at IOT

2. **NS. 1.6 - Marine Incident in vicinity of IOT (response in respect of the Humber MSMS only) and NS. 17. Historical allision of cargo vessel with vessel moored at IOT**

2.1. With regard to NS. 1.6, HMH has the following comments, noting that incident reports are confidential in nature so as to ensure frank and open participation and ensure that investigations and reporting are robust. The Selin S allision was reported as occurring at 1810 hours on 28/07/2022. As the vessel was departing its berth, it allided with the mooring buoy. It was confirmed that there was no damage to either the vessel or the buoy. The wind at the time was reported by VTS Humber as south east Force 4 (a moderate breeze) and, according to the pilot, was also gusting 20 knots. The tide was flooding (one hour before high water at Immingham) with good visibility. The small craft "Bull Sand" (an APT vessel that assists all Finger Pier berthings) was available to assist and participated during the manoeuvre. On disembarking following the incident, the Pilot was subjected to a drug and alcohol test (as is usual when an incident has occurred that may become reportable or have ongoing consequences). Subsequently an investigation was carried out by the Pilotage Operations Manager at HES. The cause of the incident was established as Master/Pilot error and subsequent action related directly to individuals rather than any process or procedure. It was not considered necessary to amend any procedures or notices or the MSMS for the Humber, although the incident data contributes to the quantitative element of subsequent Risk Assessments for this area, as is usual.

2.2. With regard to question NS.1.7, HMH believes this relates to the "Xuchianghai" and "Aberdeen" incident of December 2000. In summary the inbound vessel "Xuchianghai" made contact with the "Aberdeen" which was made fast at IOT Berth 1. The "Xuchianghai" was a 175m long, 27110 tonnes deadweight bulk carrier carrying a cargo of limenite from Australia inbound for Immingham Dock. The vessel was proceeding earlier than would usually be planned on a strong spring flood tide with a south easterly wind of 20 knots. It is worth noting that permission to enter the port early was given by the Dock and this incident pre-dates the current arrangements whereby pilots are managed directly by HES and there is more collaboration between HES and the Dockmaster for Immingham in the planning of vessel arrivals and departures. The investigation carried out by the Marine Accident Investigation Board (MAIB) confirms that, in accordance with usual practice, two tugs were in attendance and a pilot was on board. The MAIB report indicate that the vessel was inbound south of the leading lights (which are located at Killingholme to assist vessels with positioning when passing the Immingham Oil Terminal) when she swung to port in the tide and wind but was travelling too slowly to maintain control. Also, critically the aft tug was not confirmed as fast so was not able to be used to maintain control until it was too late.

2.3. DFDS's Relevant Representation states that the vessel lost control with tugs fast; however, the issue was that it was uncertain to both the vessel and the aft tug whether the aft tug was

fast, which was a contributory factor to the incident. Section 2.5 of the MAIB Report states as follows:

“All relevant parties understood the intention to secure Lady Cecilia and Lady Alma to the south-east of the IOT. The pilot had briefed the master, the mooring teams were on stations in good time, and the tugs were in position in the vicinity of No 10 Upper Burcombe buoy. Lady Cecilia was secured forward quickly and without any problems. The status of Lady Alma’s tow wire, however, was not known to the pilot until about the time of the collision. He was, therefore, unable to use her when trying to correct the movement of Xuchanghai’s bow to port.

The pilot could not see the tug aft and was reliant upon either Lady Alma’s master, or Xuchanghai’s crew, to inform him when the tow was secure. The tug master was unable to confirm that the tow was secure because neither he, nor his crew, saw the visual signal from the second officer. However, it is unclear why Xuchanghai’s crew failed to inform the pilot that the tow was secure; a possible reason was the language difficulties between the master and the pilot. Consequently, the pilot could not use Lady Alma when needed. Had Lady Alma been secured and ready for use on passing IOT No 3, it is possible the collision could have been avoided.”

- 2.4. This incident led to significant changes to the procedural requirements within the Humber MSMS, namely that a 150m exclusion zone was established at the IOT for vessels passing off the main berths (1, 2 & 3). Further, specific requirements were introduced for tugs to be made fast further to the west to ensure full control is maintained throughout the transit past the IOT jetty. The latest version of these rules remains in place today in the form of Humber Standing Notice to Mariners S.H. 34 (which is a general direction).

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