SYNOPSIS

All times are UTC.

At 1900 on 18 January 2006 the Belgian beam trawler, *Emerald Star,* left Milford Docks after being given all necessary clearances from both Milford Port Control and Pier Head. Fifteen minutes later she ran, head on, into ChevronTexaco Number 6 berth, at almost full speed.

There were no injuries to the crew, and the damage to both vessel and jetty was minor. Fortunately there was no oil tanker lying alongside at the jetty at the time, otherwise the outcome could have been much worse.

Milford Haven Port Authority recently gained approval to berth Liquefied Natural Gas carriers in the port, and facilities are currently being built to accommodate these vessels and their cargo. A collision with one of these vessels could have alarming consequences.

After her impact with the jetty, *Emerald Star* headed back to the north side of the estuary and then seawards, passing very close to other inward bound vessels, before the duty marine officer at MHPA Port Control told her to return to the dock.

Once back in the port, but after some considerable delay, *Emerald Star'*s skipper was breathalysed for alcohol concentrations and was found to be over the legally prescribed limit. Before and after being breathalysed, he was left alone for periods of time, during which he consumed more alcohol, thus compromising the validity of the alcohol sampling. The skipper was arrested some time later and imprisoned in Haverfordwest police station. He was subsequently released on bail pending the results of the blood sample analysis to confirm alcohol levels. Following the results of the blood tests, the Crown Prosecution Service decided to prosecute the skipper under section 78 of the Railways and Transport Safety Act – *Navigating a vessel under the influence of drink.*

Milford Haven Port Control houses a Vessel Traffic Service centre, providing a Traffic Organisation Service (TOS), whose purpose is *"… to prevent the development of dangerous marine traffic situations and to provide for the safe and efficient movement of vessel traffic within the VTS area."* The VTS centre monitors traffic 24 hours a day with the aid of VTS radar equipment. VTS operatives inform shipping of pertinent situations and developments within the Port Authority area. Where necessary, the VTS operatives can intervene to prevent dangerous occurrences developing, being ever mindful that they can not give direct conning instructions, but that any advice or instruction they give will be "result orientated" leaving the master or skipper to decide how he/she achieves the required result.

On the evening of the accident, the VTS team were distracted from their primary function (monitoring and controlling marine traffic), and failed to notice *Emerald Star* deviating from her expected route until it was too late, therefore no intervention took place that might have averted the accident. Following *Emerald Star'*s collision, the VTS centre did not inform other traffic that a "rogue" vessel was at large, and routine communications carried on as normal.

The MAIB has concluded that the cause of the accident was impaired judgment of *Emerald Star'*s skipper, probably brought about by alcohol consumption.

Although Milford Haven's VTS centre played no part in causing the accident, action could have been taken to intervene and possibly prevent it.

Some of the safety issues identified by the MAIB during its investigation are as follows:

- *Emerald Star's* skipper's actions and judgment were impaired by alcohol.
- The vessel was travelling at an unsafe speed in relation to the circumstances and prevailing conditions.
- *Emerald Star* had no additional lookout posted in the wheelhouse.
- Milford Haven Port Authority (MHPA) had policies and procedures to ensure that its VTS was run appropriately. On this occasion, these were not adhered to.
- Milford Haven's VTS team were distracted from their main purpose by a routine telephone call to Pier Head and administrative duties.
- Telephones were used as an inappropriate means of marine communications.
- No intervention was made by Port Control to try to prevent the accident.
- No information was promulgated by Port Control to warn other traffic of a "rogue" vessel after the accident.
- VTS radio and radar screens were configured inappropriately.
- MHPA did not have appropriate speed limits in place.

Recommendations have been made to:

- Milford Haven Port Authority regarding the establishment of speed limits within its waters, bridge manning on reporting vessels within the Haven and communications with vessels leaving the dock.
- The Port Marine Safety Code Steering Group regarding task prioritisation and distraction of VTS operators.
- The owners of *Emerald Star* regarding lookout practices.