**LLAMA ZERO-SHOT**

The accident occurred when the port fin stabiliser of the ferry Finnarrow was left deployed during its final approach to the berth at Holyhead Port in February 2013[DTE]. The deployment caused flooding in the pump room, which led to damage to the hull and water pumps[MGE]. Fortunately, there were no injuries or fatalities

The investigation into the accident identified several factors that contributed to it. Firstly, the bridge procedures for conducting end-of-passage/pre-arrival checks were ineffective, resulting in missed opportunities to ensure the fin stabilisers were housed. Secondly, a tick box on the voyage checklist was not completed[MGE], which failed to prompt the day master and chief officer to check if the fin stabiliser was housed. Lastly, there was a lack of clear visual indicators to remind the bridge team that the port fin stabiliser was deployed.

Fatigue was also identified as a possible contributing factor. The night master had been required to conduct all arrival and departures since 11 February, preventing him from resting for at least one 6-hour period each day. Similarly, the day master and chief officer were under pressure due to their recent work patterns.

The investigation concluded that if better damage control actions had taken place, the flooding might have been reduced[MGE]. The bridge procedures should have ensured early identification of the deployed port fin stabiliser, its retraction, and proper housing.

From this accident, we can learn several lessons for future shipping. Firstly, it is essential to ensure that bridge procedures are effective and followed strictly. Secondly, clear visual indicators should be provided to remind the bridge team of critical tasks, such as housing the port fin stabiliser. Lastly, measures should be taken to prevent fatigue among crew members, particularly those who are responsible for complex tasks like navigation[UGE]. By taking these precautions, we can reduce the risk of similar accidents occurring in the future.

**LLAMA ONE-SHOT**

The accident occurred on January 17-18, 2013[DTE], when the ferry Finnarrow was berthing with its fin stabilisers deployed during the final approach to the berth in Dublin, Ireland[MGE].

The accident took place due to ineffective bridge procedures and poor communication among the crew. The day master had forgotten that the port fin stabiliser was deployed, which resulted in the vessel's hull being punctured upon unexpected stopping short of the berth. This lack of attention to the status of the fin stabilisers was partly due to inadequate training and poor handovers between the second officer, master, and chief officer[MGE].

The damages were restricted largely to the pump room, but there could have been more extensive flooding[MGE] if better damage control actions had taken place. The ineffective bridge procedures resulted in several potential defence opportunities being missed to ensure the fin stabilisers were housed. Specifically, a tick box on the voyage checklist to confirm that the fin stabilisers were housed was not completed, and no visual indication of the deployed port fin stabiliser was provided.

The analysis reveals that fatigue among the masters, chief officer, and second officer may have played a role in the accident, as they had recently been working irregular schedules[MGE]. Furthermore, the lack of clear communication and inadequate training on bridge procedures contributed to the accident.

In response to this incident, joint port state control (PSC) inspections found 22 deficiencies, with half rectified before the end of the inspection. The Irish and UK maritime authorities emphasized the need for improved emergency preparedness, including regular crew drills and better familiarization with safety equipment[MGE]. Several deficiencies were related to the internal safety audit and corrective action requirements, which were still outstanding at the time of the inspection.

Recommendations for future shipping include: Improving bridge procedures and communication among crew members to ensure that all potential defence opportunities are seized to house deployed fin stabilisers. This can be achieved through regular training sessions, clear checklists, and visual indicators for deployed fin stabilisers.

Ensuring adequate rest periods for masters, chief officers, and second officers to prevent fatigue-related errors. This may involve adjusting work schedules or introducing alternative shift arrangements.

Enhancing the effectiveness of internal safety audits and corrective action requirements. This can be achieved by regular inspections, improved documentation, and enhanced crew training on emergency procedures.

Increasing awareness among maritime authorities about the importance of joint PSC inspections and the need for regular drills to prepare for potential emergencies.[MGE]

**QWEN ZERO-SHOT**

On February 16, 2013[DTE], at Holyhead Port, Finnarrow, a passenger/ro-ro cargo vessel under Finnish flag experienced a serious marine casualty while berthing. The accident occurred when port fin stabilizers were left deployed during entry into port, leading to severe damage including the stabilizer, hull plating, and the pump room, causing significant flooding.

The primary cause of the incident was inadequate procedures for checking the status of the fin stabilizers. Visual and procedural checks required by the ship's management system were insufficient, allowing the stabilizers to remain deployed as the vessel approached the dock. This oversight led to damage that included a severely damaged port fin stabilizer and hull plating, resulting in flooding of the pump room[UGE].

Lessons learned from this accident underscore the importance of robust arrival procedures with adequate checks for equipment status, such as fin stabilizers. Specific recommendations include ensuring comprehensive bridge resource management (BRM) methodologies are clearly defined, with emphasis on checklists and closed-loop communications during emergencies. Regular flooding drills should also be conducted to enhance crew familiarity.

Future precautions should involve implementing stronger internal safety audits and corrective actions to address deficiencies in the ship's management system. Finnlines Ship Management has taken steps such as verifying bridge procedures, modifying fin stabilizer systems for better alarms and automatic housing, and circulating accident lessons learned across its fleet.

These measures aim to prevent similar incidents by ensuring comprehensive vessel familiarization, adequate rest periods for crew members, and effective project management when changing flags or routes. The report highlights the critical need for improved emergency response protocols and regular training drills to mitigate risks in future operations.

**QWEN ONE-SHOT**

On February 3, 2013[DTE], the passenger ferry Finnarrow experienced an incident during its arrival at Holyhead Port in the UK. The vessel approached the berth with one of its fin stabilizers[MGE] still deployed, which led to flooding in the pump room upon contact with the port facilities.

The accident occurred when the vessel was making its final approach to the berth under command of the chief officer[NNE]. Despite initial visual confirmation from the bridge crew that the fin stabilizer appeared to be retracted, it was not properly housed during the final checks before berthing[MGE]. This oversight led to a critical failure in the procedure designed to ensure all stabilizers were safely stowed[MGE].

The deployment of the port fin stabilizer resulted in significant damage to the vessel's hull upon contact with the berth, causing water to flood into the pump room. The rate and extent of flooding were exacerbated due to poor initial damage control actions[MGE] by the crew members responsible for addressing the situation on board.

Upon investigation, it was found that several procedural shortcomings contributed to this incident. Firstly, bridge handovers between officers did not include a clear report on the status of the fin stabilizers. Secondly, there was no completion check-off on the voyage checklist that would have prompted the day master or chief officer to ensure proper stowage. Additionally, visual indicators were insufficient, as warning lights ceased to be effective once crew members moved away from the central console[UGE].

The incident highlighted a moderate risk of fatigue among key personnel due to their recent work patterns and continuous duty without adequate rest periods. The night master had been required to handle all arrivals and departures for several days, while the day master's duties also lacked sufficient breaks as mandated by STCW regulations.

In response to this accident, the Irish maritime authority[NNE] conducted an inspection and identified 22 deficiencies, with half of them being rectified on-site. Recommendations included conducting internal safety audits and corrective actions within three months, which were still pending when further deficiencies were closed following an inspection in Dublin.

Moving forward, recommendations for future shipping include enhancing procedures for fin stabilizer deployment checks and ensuring regular visual confirmation of their stowage status. Additionally, improving communication during bridge handovers and incorporating more robust voyage checklists that specify the completion times for critical tasks could prevent similar incidents. Enhanced fatigue management practices are also crucial to maintaining crew alertness and safety during critical operations[UGE].

**CHAT GPT ZERO-SHOT**

The accident involving the passenger/ro-ro cargo vessel Finnarrow occurred on 16 February 2013 during berthing at Holyhead Port. The vessel's port fin stabiliser, left deployed during the approach, struck the berth, causing significant damage. The fin stabiliser was driven backward, puncturing the hull and creating a 0.5m x 0.2m hole approximately 3m below the waterline. This resulted in flooding of the pump room, which damaged numerous electric motors, cooling systems[MGE], and other equipment. The vessel’s bilge pumping system was unable to control the flooding effectively, and additional assistance was required to manage the situation. Fortunately, the ship remained stable, and no injuries or fatalities occurred.

The primary cause of the accident was the failure of the bridge team to retract the port fin stabiliser before berthing. Ineffective procedures and communication during handovers, inadequate use of checklists, poor visual indicators of the stabiliser’s status, and fatigue among the crew contributed to the oversight. The crew’s emergency response was hampered by insufficient familiarity with the vessel's systems and a lack of effective flooding drills. Fatigue also played a role, as key personnel had inadequate rest due to demanding work schedules.

This incident highlights several lessons for the shipping industry. Robust arrival and departure procedures must include sufficient procedural and visual checks to ensure fin stabilisers are housed. Emergency response protocols should be enhanced, with regular flooding drills to improve crew preparedness and familiarisation with equipment. Furthermore, vessel handovers, particularly during flag or route changes, must incorporate comprehensive training and planning to ensure crews are fully familiar with the ship and its systems. Adequate rest for crew members, in compliance with the STCW requirements, is crucial to prevent fatigue-related errors.

In response to the accident, Finnlines Ship Management implemented changes, including improvements to bridge procedures, checklist usage, and fin stabiliser systems[MGE] These actions, along with enhanced training and emergency preparedness, aim to prevent similar accidents in the future.

**CHAT GPT ONE-SHOT**

On 16 February 2013, the Finnish-registered[MGE] passenger/ro-ro cargo vessel \*Finnarrow\* was involved in a serious marine casualty while berthing at Holyhead Port, berth 3, England. The incident occurred at 05:56 when the vessel’s port fin stabiliser, which was still deployed, struck the berth, causing significant damage to the stabiliser and the hull. The collision punctured a 0.5m by 0.2m hole in the hull, approximately 3 meters below the waterline, leading to flooding in the pump room. Although all passengers and cargo were safely disembarked, the flooding caused further damage to electrical equipment and pumps due to water ingress. The vessel remained stable despite the flooding, and no injuries or pollution were reported.

The accident occurred because the port fin stabiliser, used to reduce the vessel’s rolling motion during transit, had not been housed prior to the vessel's arrival at the berth. This oversight resulted from ineffective bridge handover and arrival procedures, poor communication among the bridge team, and insufficient visual indicators to alert the crew to the stabiliser’s status. The voyage checklist, which included a tick box to confirm the fin stabilisers were housed, was incomplete, and the ship’s safety management system (SMS) did not provide clear guidance on the use of stabilisers. Furthermore, the bridge team failed to notice the small warning lights indicating the stabiliser was still deployed. Fatigue among the crew, particularly the day master and the chief officer, likely contributed to the errors in judgment and oversight leading up to the accident. Both had demanding work schedules in the days prior to the incident, which affected their ability to perform their duties effectively.

The response to the flooding was hampered by the crew’s unfamiliarity with the vessel’s systems and lack of effective damage control drills. Although the onboard bilge pumping system had some redundancy, the crew was unable to effectively stem the flooding or make full use of available equipment, such as the higher capacity ballast pump. Additionally, the emergency response procedures outlined in the SMS were inadequate for dealing with flooding, and the crisis and alarm plan was not relevant to the situation. Assistance from external divers and fire services was eventually required to plug the hull leak and reduce the water level in the pump room, allowing the vessel to later sail to Greenock for repairs.

In response to the accident, Finnlines Ship Management took several corrective actions. The fin stabiliser system was inspected and modified to ensure its automatic housing and alarm functions were reliable. Bridge resource management (BRM) procedures were clarified in the SMS, with an emphasis on the importance of checklists and closed-loop communication. A more robust familiarisation process for crew handovers was introduced, and the accident was reviewed across the company to ensure lessons were shared fleetwide. Additionally, fin stabiliser procedures were standardized across all Finnlines vessels.

To prevent similar incidents in the future, it is recommended that shipping companies develop and implement robust arrival and departure checklists that include multiple procedural and visual checks for critical equipment, such as stabilisers. Emergency response procedures should be enhanced to include specific flooding drills and guidance for damage control, ensuring crew are well-prepared for such emergencies. Adequate rest periods for all crew members, in line with the STCW Convention, must be enforced to mitigate fatigue. Finally, vessel operators should ensure that thorough familiarisation and training programs are in place for crews, particularly when vessels change flag or routes, to ensure smooth transitions and operational safety.

**LLAMA FEW-SHOT**

On November 22, 2013, at approximately 1225 UTC+1, [DTE]the Finnarrow, a passenger/ro-ro cargo vessel with a length of 168 meters, suffered an accident while berthing in port. The vessel was navigating smoothly with a wind direction from the southeast and sea state conditions described as smooth/slight, but visibility was good. However, during the arrival process, the fin stabiliser on the starboard side [MGE]became severely damaged due to excessive stress caused by the ship's hull plating being compromised. [MGE]

The accident took place when the vessel's hull plating was breached, resulting in flooding of the pump room and damage to the circulating water pumps. The extent of the damage suggested that the port fin stabiliser had been left deployed after the previous berthing, causing excessive stress on the vessel's hull. It is unclear why this procedural check was overlooked. [MGE]

The investigation concluded that the accident was caused by a combination of factors, including inadequate maintenance and lack of procedural checks to prevent the deployment of the fin stabilisers when entering port [MGE]. The recommendation made by the Marine Accident Investigation Branch is for Finnlines Ship Management, which operates the vessel, to ensure robust project management procedures are in place when changing flag or routes. This includes adequate vessel familiarization, sufficient rest periods, and regular flooding drills to enhance crew familiarity with emergency response procedures. [UGE]

In light of this accident, it is essential for shipping companies to prioritize proper maintenance and procedural checks to prevent similar incidents in the future. Regular inspections and drills should be conducted to ensure that crews are adequately trained and prepared to respond to emergencies. Furthermore, the shipping industry should strive to develop more robust procedures for arriving at ports, including visual and procedural checks to prevent vessel equipment malfunctions.

Overall, the accident highlights the importance of prioritizing safety and procedural checks in the shipping industry. By learning from this incident and implementing necessary changes, the maritime community can reduce the risk of similar accidents occurring in the future.

**QWEN FEW-SHOT**

The marine accident report for Finnarrow, flagged in Finland and managed by Finnlines Ship Management, took place on February 2013[DTE]. The vessel was a passenger/ro-ro cargo ship with an IMO number of 9010814. At the time of the incident, the Finnarrow was berthing at port, preparing to dock.

The accident began when there were issues regarding the status of the fin stabilisers on board, which had insufficient procedural and visual checks. As a result, upon entering the port, the fin stabilisers remained deployed inadvertently. This situation escalated during an emergency response scenario where the vessel needed to conduct flooding drills for crew familiarization. Unfortunately, these stabilized fins exacerbated the flooding issue in the pump room, [MGE]leading to damage of circulating water pumps.

The Finnarrow suffered significant damages including severe damage to the port fin stabiliser and hull plating. Additionally, the pump room was flooded by the floodwater from the sea, affecting the vessel’s operational capabilities. The accident analysis revealed that improper procedural checks led to the deployment of the fin stabilisers while berthing, [MGE]causing a cascading failure in the emergency response drills.

Following the incident, several actions were taken. The Marine Accident Investigation Branch [NNE]recommended Finnlines Ship Management to improve arrival procedures by ensuring sufficient checks on the status of fin stabilisers before entering port. [MGE] It also suggested reviewing and amending emergency response procedures to better support ship's staff during emergencies and conducting regular flooding drills to enhance crew familiarization. [MGE]

For future shipping, these recommendations aim to ensure that critical equipment such as fin stabilizers are properly monitored and managed. Emphasizing the importance of robust project management when changing flags or routes is crucial for providing crews with adequate vessel familiarisation and ensuring compliance with rest period requirements under the International Convention on Standards of Training, Certification and Watchkeeping for Seafarers 1978 (STCW). These steps are vital to prevent similar accidents in the future. [MGE]

**CHAT GPT FEW-SHOT**

On 16 February 2013 at 05:56, the passenger/ro-ro cargo vessel Finnarrow, flagged in Finland, encountered a serious marine casualty while berthing at Holyhead Port, berth 3. During the vessel’s arrival, the port fin stabiliser, which had been unintentionally left deployed, struck the berth, causing significant damage. This resulted in a 0.5m by 0.2m hull penetration approximately 3m below the waterline. The damage led to extensive flooding of the pump room, which affected numerous systems[UGE], including the vessel’s circulating water pumps. The flooding eventually caused the shutdown of the main engines and diesel generators, leaving the vessel reliant on its emergency generator. Although no injuries or fatalities occurred, the accident caused considerable disruption and required an extensive response.

The accident unfolded after Finnarrow departed Dublin at 02:15 under the command of the night master and approached Holyhead Port later that morning with the day master taking over the con. The second officer had deployed the port fin stabiliser earlier in the voyage to reduce rolling but failed to retract it before arrival. Despite a handover of duties between the second officer, day master, and chief officer, the status of the stabilisers was not properly reviewed. The voyage checklist, which included a tick box for confirming the retraction of the stabilisers, was incomplete and failed to prompt the bridge team to verify their status. Furthermore, the visual indicators for the deployed stabilisers on the bridge were inadequate, as the small warning lights on the console were not sufficiently noticeable once the master and chief officer moved away from the central console. These procedural and communication failures allowed the port fin stabiliser to remain deployed as the vessel approached the berth.

When the port fin stabiliser struck the berth, it was driven backwards, causing severe damage to the stabiliser itself and puncturing the hull. Flooding began immediately in the pump room, with water rising rapidly. The crew’s response to the flooding was hindered by their lack of familiarity with the vessel’s equipment and the absence of effective damage control procedures in the safety management system (SMS). For instance, an attempt to use the piston bilge pump to discharge flood water was ineffective because its overboard discharge line had been blanked off. Additionally, the crew did not utilise the higher capacity ballast pump, which could have helped reduce the flooding. The flooding eventually caused the shutdown of the main engines and generators due to a lack of cooling water, leaving the vessel reliant on its emergency power supply. It was only after external assistance, including the use of high-volume pumps and divers plugging the hull breach, that the flooding was brought under control.

The analysis of the accident highlighted several contributing factors. The ineffective handover processes and incomplete voyage checklist failed to ensure the retraction of the fin stabilisers. Fatigue among the crew, particularly the day master and the chief officer, was also identified as a possible contributing factor, as their recent work patterns suggested insufficient rest. The crew’s unfamiliarity with the vessel’s systems, stemming from the recent change in flag and crew, further hampered their ability to respond effectively to the flooding. Additionally, the SMS lacked detailed guidance on flooding emergencies and robust arrival procedures, which would have mitigated the impact of the incident. [UGE]

In response to the accident, Finnlines Ship Management undertook several corrective actions. The fin stabiliser system was inspected, and its operation was modified to ensure it would automatically retract [MGE]when the vessel’s speed dropped below six knots. The SMS was revised to emphasise the importance of bridge resource management (BRM), proper checklist usage, and closed-loop communication. A more detailed job-specific familiarisation procedure was introduced for crew handovers, and the lessons learned from the Finnarrow incident were circulated across the fleet. Furthermore, the company planned to discuss BRM and bridge procedures during internal training events. [UGE]

To prevent similar incidents in the future, it is recommended that Finnlines Ship Management and other operators ensure robust arrival procedures with sufficient procedural and visual checks for deployed equipment, such as fin stabilisers, to prevent operational oversights. Emergency response procedures should be reviewed and amended to ensure crews are adequately supported during flooding and other emergencies, and regular flooding drills should be conducted to enhance crew preparedness. Additionally, project management procedures for flag changes and route adjustments should be improved to ensure crews receive thorough vessel familiarisation and sufficient rest periods in compliance with international standards. These measures will help strengthen the safety culture and operational resilience of passenger vessels.