**LLAMA ZER-SHOT**

The accident occurred on December 13, 2021, [DTE] in the Bornholmsgat traffic separation scheme, Sweden. [MGE]The Scot Carrier collided with the Karin Høj, causing the latter to capsize with two fatalities. This was categorized as a very serious marine casualty (VMC).

The sole objective of the investigation is to prevent future accidents by identifying the causes and circumstances of the accident. The report does not aim to determine liability or apportion blame, as per Regulation 14(14) [MGE]of the Merchant Shipping (Accident Reporting and Investigation) Regulations 2012.

Possible causes for the collision are not explicitly stated in the context, but it can be inferred that human error, equipment failure, or a combination of both might have contributed to the accident. The report highlights the importance of safe navigation practices, including adherence to traffic separation schemes and proper vessel handling procedures. [UGE]

A key lesson from this accident is the need for increased vigilance and situational awareness among mariners. The report emphasizes the importance of reporting any near-miss incidents or close calls to regulatory bodies, as these can provide valuable insights into potential hazards and help prevent future accidents. Additionally, the investigation highlights the need for improved communication between vessels, particularly in congested traffic areas.[MGE]

Overall, the Marine Accident Report provides a crucial insight into the causes and consequences of this serious marine casualty. By learning from this accident, the shipping industry can take proactive measures to enhance safety standards, reduce the risk of similar incidents, and prevent future accidents at sea.

**LLAMA ONE-SHOT**

The accident occurred on December 12, 2021[DTE], when the Danish shipping vessel Karin Høj was involved in a collision with another ship. The vessel was carrying out a long-term dredging project on Lake Mälaren, Sweden.

Karin Høj suffered damage as a result of the collision and was unable to navigate safely. [MGE]The crew attempted to assist with navigation after the incident, but the vessel had to be escorted by tugboats to a safe harbor. An investigation into the accident revealed that the main cause of the incident was a lack of watch keeping arrangements on board. [UGE]

The master and mate had joined the barge just before departure from the port of Köping, which meant they did not have adequate experience with watch keeping arrangements. [MGE]The vessel's bridge resources were also inadequate, as there were no additional watches in place [MGE]to ensure safe navigational operations during night watches. This was a critical failure, as the crew was not adequately trained or equipped to handle the responsibilities of bridge watchkeeping.

Inadequate training and a lack of proper procedures were also identified as contributing factors to the accident. The crew had not received adequate training on watch keeping arrangements and procedures before departing on the voyage, which put them at risk of making mistakes that could lead to further incidents. Furthermore, the vessel's watch schedule was not in compliance with international regulations, which highlighted a need for improved oversight and enforcement.

The investigation also noted that the bridge resources were insufficient to ensure safe navigational operations during night watches. he master and mate had joined the barge just before departure, which meant they did not have adequate experience with watch keeping arrangements. [MGE]This lack of experience put the crew at risk of making mistakes that could lead to further incidents.

The accident highlighted the importance of proper training, procedures, and bridge resources in ensuring safe navigational operations. The investigation's findings were used to inform recommendations for future vessel operations, including the need for improved watch keeping arrangements, adequate training, and enforcement of international regulations.

To prevent similar incidents in the future, it is recommended that vessels be equipped with adequate bridge resources, including additional watches to ensure safe navigational operations during night watches. Crew members should receive proper training in watch keeping arrangements and procedures before departing on a voyage. The vessel's watch schedule should be reviewed and updated to include adequate rest periods for the crew.

Additionally, the investigation highlighted the importance of enforcing international regulations, such as those related to alcohol limits and their effects on navigation. Vessels should ensure that their crew members are aware of these regulations and understand how they apply in different situations. By taking these steps, vessels can reduce the risk of accidents and ensure safe navigational operations. [MGE]

The accident also highlighted the need for improved oversight and enforcement of vessel safety regulations. Shipowners and operators should be held accountable for ensuring that their vessels meet minimum safety standards, including adequate bridge resources and crew training. This includes regular inspections and audits to ensure compliance with international regulations.

In response to the investigation's findings, the Danish shipping company has implemented changes to improve watch keeping arrangements on board Karin Høj. The vessel now has an additional watch in place during night watches, and crew members have received additional training in watch keeping procedures. The company has also reviewed and updated the vessel's watch schedule to include adequate rest periods for the crew.

Furthermore, the Danish Maritime Authority (DMAIB) has taken steps to improve oversight and enforcement of vessel safety regulations. The authority has increased inspections and audits of vessels to ensure compliance with international regulations, including those related to watch keeping arrangements and crew training. By taking these actions, the DMAIB aims to reduce the risk of accidents on the high seas.

**QWEN ZERO-SHOT**

The report details an incident involving two vessels, SCOT CARRIER and KARIN HØJ, which highlights the importance of adherence to international maritime regulations and the responsibility of all parties involved in navigation. The SCOT CARRIER, a general cargo ship, departed from Salacgrīva, Latvia, bound for Montrose, Scotland, while KARIN HØJ, a steel-hulled barge built in 1977, set sail from Södertälje, Sweden, heading to Nykøbing Falster, Denmark. Both vessels were engaged in international voyages.

The specific accident involving these two ships is not detailed within the provided context; however, the report emphasizes that any risk of collision exists if the compass bearing does not appreciably change. This principle underscores the need for constant vigilance and timely action to avoid imminent dangers. The look-out rules are critical in preventing such incidents.

Regarding the potential causes of a collision, according to Rule 5 of the International Regulations for Preventing Collisions at Sea 1972, risks can be deemed to exist if compass bearings do not change significantly, and such risks may also arise when approaching very large vessels or tugs, especially at close range. These conditions suggest that inadequate navigation practices or misjudgments could lead to collisions. [MGE]

The lessons learned from this scenario are clear: all vessels must maintain a diligent look-out, adhere strictly to maritime regulations, and be prepared for immediate actions to avoid danger. This includes taking large and positive course adjustments if necessary. For future shipping operations, crew members should receive regular training on collision avoidance techniques and the latest navigation practices to ensure safety at sea. By emphasizing these precautions, we can minimize the risks of maritime accidents and uphold the principles outlined in the Convention.

**QWEN ONE-SHOT**

On 26 December 2021, [DTE]a tragic incident occurred involving the vessel Karin Høj, which led to the death of its master. The accident took place in the vicinity of Ystad, Sweden. According to reports, at approximately 1340 hours, Swedish rescue divers entered the submerged accommodation area and discovered one partially clothed individual in the hallway outside the starboard cabin (Figure 14). This person was later identified as the vessel's master and pronounced deceased.

The damage assessment revealed extensive disruptions both externally and internally. The external deck areas were littered with scattered equipment, damaged antennae, displaced light fittings, and broken pipe clamps. Internally, the wheelhouse equipment and linings had been displaced from their mountings, leading to significant damage to the outfitting of the galley, crew mess, toilet, and cabin (Figure 9). [MGE]Additionally, the main seawater inlet valve was sheared at its inlet flange, flooding the engine room up to the top of the compartment (Figure 8).

The analysis points towards a failure in the navigational watch by the officers on duty. Both failed to maintain an adequate lookout and did not adequately assess or mitigate the risks of collision as required by fundamental elements of the International Regulations for Preventing Collisions at Sea (COLREGs) and company-specific navigational procedures.

No specific actions were mentioned in the provided information regarding immediate response or remedial measures taken following the accident. However, coastguard officers boarded and inspected the vessel upon its arrival at Ystad. Inspectors from both the Marine Accident Investigation Board (MAIB) and Danish Marine Accident Investigation Board (DMAIB) conducted an immediate inspection of the ship's hull and documented silt stains above the ship's name on the starboard side and new damage to the paintwork on its port side.

For future shipping, it is recommended that stricter adherence to COLREGs and company-specific navigational procedures be enforced. Enhanced training for officers in charge of the navigational watch should focus on maintaining a proper lookout and assessing potential risks more effectively. Additionally, regular drills and assessments should be conducted to ensure all crew members are well-versed in emergency response protocols and can quickly mitigate any emerging hazards.[MGE]

**CHAT GPT ZERO-SHOT**

The accident involved a collision between the UK-flagged general cargo vessel Scot Carrier and the Denmark-registered split hopper barge Karin Høj on December 13, 2021, in the Bornholmsgat Traffic Separation Scheme (TSS) in the Baltic Sea. Scot Carrier collided with Karin Høj at a relative speed of 8.7 knots, capsizing the smaller vessel and resulting in the deaths of its two crew members. The collision caused extensive damage to the hull [MGE]of Karin Høj, leading to its total loss, while Scot Carrier sustained forward hull damage UGE].

The investigation identified multiple causes. On Scot Carrier, the second officer (2/O) was distracted by personal use of a tablet computer and failed to maintain a proper lookout. The ship’s bridge equipment alarms, which could have alerted the officer to the impending collision, were disabled or poorly configured. Alcohol consumption by the 2/O before his watch impaired his judgment and decision-making. Additionally, no dedicated lookout was present on Scot Carrier, contrary to international regulations. On Karin Høj, it was unclear whether its watchkeeper attempted to take evasive action, but the vessel’s limited crew and inadequate visibility likely contributed to its vulnerability.

The lessons learned emphasize the importance of adhering to bridge watchkeeping regulations, particularly the necessity of maintaining a proper lookout during hours of darkness and restricted visibility. The disabling of critical navigational alarms and the use of personal devices while on watch must be strictly prohibited. [MGE] Alcohol policies on vessels require stricter enforcement, and random testing should be conducted to ensure compliance. Furthermore, safety management systems must be audited more rigorously to detect procedural violations or unsafe practices.

To prevent similar accidents, shipping companies must ensure full compliance with international regulations, reinforce the use of navigational aids, prioritize crew training, and promote a culture of accountability and vigilance on the bridge.

**CHAT GPT ONE-SHOT**

On 13 December 2021, at approximately 0327 (UTC+1), a very serious marine accident occurred in the Bornholmsgat Traffic Separation Scheme (TSS), Sweden, involving the UK-registered general cargo vessel Scot Carrier and the Denmark-registered split hopper barge Karin Høj. The Scot Carrier, loaded with timber and manned by eight crew members, collided with Karin Høj, which was in ballast and operated by two crew. The collision caused Karin Høj to capsize rapidly, resulting in the death of its master and the presumed death of its mate, whose body was not recovered. The Scot Carrier sustained forward hull damage, while Karin Høj was declared a total loss, with minor diesel oil pollution dispersing in the area.

The accident took place under clear weather conditions with good visibility, though some areas of patchy mist were reported later. The Scot Carrier altered its course at a planned waypoint, placing it on a collision trajectory with Karin Høj. The officer of the watch (OOW) on the Scot Carrier, who was the sole watchkeeper at the time, failed to identify the risk of collision due to being distracted by a personal tablet computer. The navigational alarms on the bridge, designed to signal the presence of other vessels, had been disabled, and the Bridge Navigational Watch Alarm System (BNWAS), which could have alerted the crew to the OOW’s inattentiveness, was switched off. Onboard Karin Høj, it was unclear whether the mate, who was likely the sole watchkeeper, identified or reacted to the Scot Carrier’s maneuver in time. The absence of additional crew on Karin Høj limited its ability to maintain an effective lookout, contributing to the accident.

The collision caused Scot Carrier’s bulbous bow to strike the port side of Karin Høj's hull, creating a significant impact that destabilized the barge and caused it to capsize within seconds. The master of Karin Høj was found deceased in the inverted accommodation, while the mate was presumed to have been swept overboard or trapped during the capsize. The Scot Carrier’s OOW initially failed to raise the alarm following the collision, delaying search and rescue operations. However, the rapid capsize and cold water conditions would have made survival unlikely for Karin Høj’s crew.

The investigation revealed systemic failures in both vessels’ operations. The Scot Carrier routinely operated without a lookout during hours of darkness, contravening international and company regulations. Furthermore, the OOW’s use of a personal electronic device significantly impaired his ability to maintain situational awareness. On Karin Høj, insufficient manning and reliance on a two-person crew for extended voyages compromised its ability to adhere to watchkeeping requirements. Additionally, both vessels failed to fully utilize their navigational systems and alarms, which could have provided early warnings of a collision risk.

In response to the accident, Rederiet Høj A/S, the owner of Karin Høj, issued directives to ensure compliance with manning regulations and safety management system (SMS) requirements. Intrada Ships Management Ltd, the manager of Scot Carrier, introduced measures to reinforce adherence to lookout policies, restrict alcohol consumption on board, and increase the frequency of unannounced drug and alcohol tests. The company also began conducting comprehensive audits of navigational practices across its fleet. The Scot Carrier’s OOW was convicted of manslaughter and maritime drunkenness and sentenced to imprisonment.

To prevent similar accidents, future recommendations include stricter enforcement of regulations requiring a dedicated lookout during hours of darkness or restricted visibility. [MGE]Bridge navigational alarms, such as the BNWAS and collision warning systems, should remain active at all times to ensure adequate situational awareness. Shipping companies must ensure that manning levels are sufficient to meet watchkeeping requirements, particularly for small vessels on extended voyages. Additionally, rigorous training and oversight are necessary to prevent distractions from personal devices and ensure compliance with alcohol policies. Finally, enhanced auditing of onboard practices by company management is essential to identify and rectify unsafe practices before accidents occur. [MGE]

**LLAMA FEW-SHOT**

On December 12, 2021, at approximately 14:40 hours, [DTE] the vessel Karin Høj, a split hopper barge with Danish flag, suffered an accident while navigating through international waters near the last known position of another vessel, Karin Høj (DIS1). [MGE] The master of Karin Høj [NNE]made a "Mayday Relay" call to Lyngby Radio at 03:59:34, reporting that the ship's bow was damaged but hull integrity was intact.

As the situation unfolded, Sweden Rescue received the distress call and directed the vessel Scot Carrier, also carrying timber cargo, to proceed to the nearby port of Ystad, Sweden. Upon arrival, coastguard officers inspected the vessel and found silt stains above the ship's name on the starboard side and new damage to the paintwork on its port side.

The accident is believed to have occurred when Karin Høj ran aground or encountered a submerged object in the water, [MGE]causing significant damage to its bow. The exact circumstances of the incident are still under investigation. However, it appears that the vessel's master was aware of the ship's condition and had attempted to navigate around the damaged area.

The damages sustained by Karin Høj were substantial, with reports suggesting that the vessel has been left stranded [MGE]in an upturned position, likely due to hull breach or structural failure. The incident highlights the importance of proper navigation and monitoring of weather conditions to prevent such accidents.

In response to this accident, the relevant authorities have taken immediate action to assist those involved. The Danish Maritime Accident Investigation Board (DMAIB) and the UK's Marine Accident Investigation Branch (MAIB) are conducting an investigation into the incident to determine its causes and identify potential safety improvements for future vessels.

Based on this analysis, it is recommended that shipping operators prioritize regular hull inspections and maintenance to prevent such accidents from occurring. Additionally, the development of more advanced navigation tools and weather monitoring systems can help reduce the risk of hull breaches or structural failures. Finally, increased emphasis on crew training and communication protocols is necessary to ensure that masters are equipped to respond effectively in emergency situations like this one.[MGE]

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**CHAT GPT FEW-SHOT**

On 13 December 2021, at 0327 (UTC +1), the Danish-registered split hopper barge Karin Høj and the UK-registered general cargo ship Scot Carrier collided in the Bornholmsgat traffic separation scheme in the Baltic Sea, east of Sweden. [MGE]The collision resulted in the capsizing of Karin Høj, leading to the tragic deaths of its two crew members. Scot Carrier sustained significant damage to its forward hull, while Karin Høj was declared a total loss, with severe hull damage and minor diesel oil pollution. The environmental conditions at the time included good visibility, with a south-westerly wind force of 1 and a low swell. [UGE]

The accident occurred as both vessels transited the traffic separation scheme. Scot Carrier’s second officer, who was alone on the bridge at the time, became distracted by engaging in video chats on a personal tablet. His inattention led to a failure to maintain situational awareness and comply with collision avoidance regulations. Scot Carrier altered course at a waypoint, placing it on a collision course with Karin Høj, which was the stand-on vessel under the International Regulations for Preventing Collisions at Sea (COLREGs). Despite this, neither vessel took sufficient early action to prevent the collision. [MGE] Scot Carrier’s second officer noticed Karin Høj too late and took emergency action that was insufficient to avoid the impact. The collision caused Karin Høj to capsize rapidly, trapping its master inside the submerged accommodation and leading to his death. The mate’s body was not recovered, and he is presumed deceased.

The investigation identified numerous causal factors. Scot Carrier’s second officer was distracted by his personal device, impairing his ability to maintain a proper lookout. Additionally, alarms on Scot Carrier’s navigation equipment were either disabled or ignored, further reducing situational awareness. The vessel’s Bridge Navigational Watch Alarm System (BNWAS) was also switched off, removing a critical safety barrier. On Karin Høj, the absence of a proper lookout, the small crew size, and the lack of manning in compliance with Danish regulations contributed to the crew’s inability to react effectively.

In response to the accident, Scot Carrier’s management company issued reminders to its fleet regarding safe navigation, lookout duties, and the use of BNWAS. Alcohol consumption policies were revised, and unannounced drug and alcohol testing was increased. Additionally, comprehensive audits of navigational practices and bridge procedures were initiated. Rederiet Høj, the operator of Karin Høj, reminded its masters to adhere strictly to manning and watchkeeping regulations.

To prevent similar accidents in the future, it is recommended that all shipping companies enhance oversight of navigational practices, ensure vigilant watchkeeping, and enforce the use of critical safety systems such as BNWAS. The Maritime and Coastguard Agency (MCA) should emphasize the mandatory requirement for dedicated lookouts during hours of darkness and restricted visibility. Furthermore, international regulatory authorities should set stricter standards for the use of electronic devices on the bridge and improve training on managing distractions. [UGE]By implementing these measures, the risks associated with human error and equipment misuse can be significantly reduced, enhancing overall maritime safety.