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March 14, 2022

Via email

Ms. Jennifer Homendy, Chair
National Transportation Safety Board
Office of the Chair
Washington, DC 20594
executivesecretariat@ntsb.gov

Re: Fire aboard Roll-on/Roll-off Vehicle Carrier "HÖEGH XIAMEN", Pier 20, Blount Island, Jacksonville, June 4 2020, NTSB/MAR-21/04 Höegh Technical Management Response to NTSB Safety Recommendations M-21-019 through -021.

Dear Ms. Homendy,

We write on behalf of our Clients, Höegh Technical Management, in response to your letter dated December 16, 2021, and in response to the safety recommendations contained within report NTSB/MAR-21/04: *"Fire aboard Roll-on/Roll-off Vehicle Carrier Höegh Xiamen, Pier 20, Blount Island, Jacksonville, Florida, June 4, 2020"* ("the Report").

On behalf of our Clients, we would like to thank the National Transportation Safety Board ("NTSB") for conducting such a detailed investigation into the circumstances of the fire on board "HÖEGH XIAMEN" ("the Vessel"), at Pier 20, Blount Island, Jacksonville, on June 4, 2020 ("the Incident"). Our Clients share NTSB's desire to learn from the Incident and make the changes necessary to reduce the risk of similar incidents occurring again in the future.

We are grateful for the detailed analysis contained within the Report, and for the resulting safety recommendations we have received. Our Clients have already taken action on the basis of the NTSB recommendations (details below), and they continue to review all procedures and operational practices to ensure that the highest standards of safety are maintained throughout the whole organization.

Following the Incident, we have continued to assist our Clients with their own detailed investigation into the circumstances and events which ultimately resulted in the constructive total loss of the Vessel. Our own investigation has been conducted in cooperation with the Vessel's insurers and various industry experts in the US and Europe.

Before we provide you with details of the actions our Clients have taken in response to the NTSB recommendations, we would like to take this opportunity to bring to your attention two factual inaccuracies which, following our own investigation, we have identified in the Report.

1. Timings

As noted in previous correspondence associated with the NTSB's draft factual report, the exact time at which the fire started on vehicle deck No.8 is not known. However, the time at which the Chief Officer first observed smoke escaping from the upper deck ventilation housing is known.

As soon as the Chief Officer observed the smoke, he reported it to all of the crew using his portable radio [*Chief Officer pg.6 line 18 to pg. 7 line 6*]. This report on the portable radio was captured by the Vessel's VDR because the Second Officer happened to be working on the bridge of the Vessel (with his own radio), at the time.

As such, we can clearly hear that the time at which the Chief Officer first observed smoke from the ventilation housing, and reported it using his portable radio, was about 15:44 on June 4, not 15:30 as stated throughout the report.

Unfortunately, this 14-minute discrepancy (almost quarter of an hour), has, in our opinion, adversely influenced the overall analysis of the Report, especially in relation to the reaction of the Master and crew.

As an example:

2.5.1 Fire Detection System (page 46)

"The fire detection system was not reactivated until about 1545, about 15 minutes after smoke was observed"

This is not correct. The fire detection system was reinstated at 15:45, but this was about 1 minute after the smoke was first observed by the Chief Officer. The reinstating of the fire alarm is also shown in the VDR and the alarm activation was referred to by the Chief Officer during his interview [*Chief Officer pg.7 line 1 to 6*]:

"Then I have announced on the walkie-talkie and speak loudly to the walkie-talkie, I hope everyone -- each one has the walkie-talkie can hear me. I told them there is smoke from Deck 7 to Deck 8, come out. After that, only a few seconds -- I don't remember how long, about only a few seconds -- maybe 10, 20, I can't remember, the fire alarm sounded in the whole ship."

2.5.2 Emergency Distress Call (page 48)

"...the master did not attempt to make an emergency distress call until 1549, about 20 minutes after smoke was discovered"

This is not correct. The Master did attempt to call for assistance at about 15:49, but this was only about 5 minutes after the smoke was discovered, not 20 minutes.

2.5.3 Ventilation and Fixed Fire-Extinguishing System (page 49)

"...the crew did not attempt to release the CO2 until more than 45 minutes after the discovery of the fire..."

As above, the timing error is reflected in this analysis, the Master did not wait for more than 45 minutes to deploy the CO2, it was less than 29 minutes. During this time, the crew were mustered, fire teams were dressed, an initial attack on the fire was attempted by the fire team, the ventilation was stopped, ventilation dampers were closed, the fire services were consulted and the crew were evacuated. This timing error is important because a time of 29 minutes or less to achieve these steps is not unreasonable.

In relation to the timing of events, and in particular the crew's reaction to the fire, we request that the NTSB re-visit the evidence of the VDR, and the initial discovery of smoke by the Chief Officer, which occurred at about 15:44 on June 4, 2020, and not at 15:30 as stated in the Report.


2. Vessel Lashing Inspection Procedure

The Report, and the associated recommendations refer to a document titled "Vessel Lashing Inspection Procedure". This document is reproduced at page 23 of the Report (Figure 13).

The Report incorrectly states on page 22 that:

" The document, which was part of Höegh's safety management system, ..."

This document is not a part of Höegh's approved safety management system. All documents, which form part of the approved safety management system, have a safety managements system reference in the top right-hand corner of the document. This allows the document to be correctly controlled, for example:

 <p>HÖEGH TECHNICAL MANAGEMENT</p>	<p>SHIPBOARD OPERATIONS</p> <p>CARGO OPERATIONS</p>	<p>Sect: QVM 7.5.5 Page: 1 - 1 Owner: MAJ Appr: DEDES Date: 30/10/2019</p>
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HANDLING SPECIAL TYPES OF CARGO

The document in question on page 23 of the Report has no such reference and is not used by Höegh or Charterers, Grimaldi.

During our own investigation, we have learned that this document was locally produced, we believe by representatives from SSA, and then handed to the Chief Officer for signature on completion of loading.

We do not understand the purpose or intent of the document, as in reality it would have been of very little use for the Chief Officer to know that, upon completion of loading, there were 13 vehicles, somewhere amongst the 358 vehicles on deck No. 8, which did not have their batteries correctly disconnected.

We wish to highlight these two factual inaccuracies for the NTSB's record. We should be grateful if the NTSB would consider providing an update or addendum acknowledging the discovery of the fire by the Chief Officer at about 15:44 on June 4, 2020 and the fact that the "Vehicle Lashing Inspection Procedure" does not form part of the approved safety management system which was in use by the Vessel at the time of the incident.

Recommendations

Notwithstanding the above, our Clients remain very grateful for the detailed analysis conducted by NTSB, and the recommendations which have been provided in the Report.

In response, please note the following:

Recommendation M-21-019 (Section 2.3.3)

"Revise your "Vehicle Lashing Inspection Procedure" to include a process to ensure all vehicle batteries are disconnected before departure and provide training to all crew on the revised procedure."

As noted above, this procedure does not actually form a part of the approved safety management system which was in use on board the Vessel. However, our Clients take the issue seriously and have responded to the intent of the recommendation.

As noted in the report, the responsibility for ensuring the correct stowage of vehicles, and if necessary, the correct battery disconnect procedures, usually rests with the Charterers of the Vessel. In practical terms, the Vessel does not have sufficient crew to physically check the condition of each vehicle upon loading. For this reason, Charterers usually arrange for additional personnel and expertise from organizations such as SSA and Horizon to complete these tasks.

However, in response to Recommendation M-21-019, our Clients have reminded all Masters and Chief Officers of the importance of liaising with the Charterers' Port Captain, Stevedore's Foreman or other shoreside representatives, in order to ensure that the correct battery disconnect procedures are being followed.

The safety management system, **Section QSM 8.1.1 – Safety Related to Cargo**, has been amended to require strict adherence to the required procedure for battery disconnection and securement. The amended QSM 8.1.1 is attached which sets out the changes in italics (Appendix A).

Recommendation M-21-020 (Section 2.5.1)

"Revise your "Cargo Safety Awareness" procedure to minimize the amount of time that your vessels' fire detection systems are deactivated."

In response to this recommendation, the content of **QSM 8.1.1 Safety Related to Cargo** and **QSM 5.3.6 Fire Prevention** have been amended in order to minimize the amount of time the Vessel's fire detection system is deactivated during cargo operations and other work.

The revised procedures include the introduction of a new "Risk Assessment" and "Permit to Work" system (contained in the new QSM 3.4.30 and QDPC 5.0.8 respectively) to be used when the fire detection system is isolated.

The revised procedures also require the crew to be conducting a dedicated fire patrol or working in and around any isolated decks.

The procedures require any isolated alarms to be reinstated on completion of work as soon as any residual smoke or fumes have dissipated and without any unnecessary delay.

In addition to the above, we have consulted with the Vessel's classification society, DNV GL, for guidance and we are also investigating alternative technical solutions.

Our Clients now have an ongoing project to upgrade the current smoke sensors in vehicle decks, to dual sensors (heat and smoke) for all managed vessels. This technical upgrade will remove any requirement for the fire detection system to be fully isolated during cargo operations. Only the smoke detectors will be isolated in the future, thus providing continuous protection with the heat sensors during cargo operations. We consider this to be a significant improvement in safety, and we suggest that organizations such as NTSB should be recommending similar solutions throughout the industry.

The revised procedures are attached, showing amendments in italics (Appendices A and B). We also attach the new QSM 3.4.30 Risk Register and QDPC 5.0.8 Permit to Work (Appendices C and D).

Recommendation M-21-021 (Section 2.5.2)

"Ensure that contact information for emergency response authorities for each port of the vessel's passage plan is immediately available to vessel bridge teams and that they are trained on its use."

Our Clients were disappointed to learn of the difficulty experienced by the Vessel when attempting to contact the emergency services at the time of the Incident. Our Clients remain grateful for the assistance of the onshore witness who reported the incident by calling 911, and we are grateful for the rapid response of JFRD, arriving at the vessel just 4 minutes after the call was made. This was also only 19 minutes after the Chief Officer first observed the smoke.

However, despite the rapid response, it is clear that there were issues reporting the incident from the Vessel, and although this did not result in any significant delay on this occasion (due to the helpful bystander), some improvements are required to ensure that this does not occur again in the future.

Our Clients are grateful for the NTSB highlighting this issue and have taken the following action on the basis of this recommendation:

1. A circular letter has been distributed to all vessels and Masters, advising them about new procedures of obtaining and maintaining contact information for emergency response authorities for all ports visited by the vessels (see Appendix E); and
2. The Safety Management System has been amended in section **QDPC 4.2.1 Bridge Checklist – Arrival**. The amended procedure is attached (Appendix F), with the recent changes in italics. The intention is to have the Masters obtain fresh/updated contact information for emergency response authorities for every port the vessels are calling and include these in on the Arrival checklist. The checklist will then be inserted/clipped in the Bell Book/Bridge Movement log which is always kept close to the telegraph on the bridge and is readily accessible to the Master and his bridge team in case of emergency in port.

Conclusion

We trust that the explanation provided above, and the attached documents, are sufficient to show that our Clients have taken the NTSB recommendations seriously and have worked in a proactive way to respond to the risks identified in the Report.

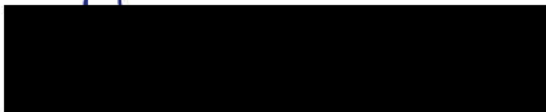
Höegh Technical Management is committed to improving safety on board all of their managed vessels, our Clients are grateful for the assistance provided by NTSB in achieving this and reducing the likelihood of similar accidents occurring in the future.

We remain at your disposal. Please let us know if you have any questions or observations.

Best Regards.

Very truly yours,

MOSELEY, PRICHARD, PARRISH, KNIGHT & JONES


James F. Moseley, Jr.