CASE STUDY

VESSEL TYPE: Tanker: Petroleum
TITLE: But we've always done it that way
CATEGORY: Navigation

THE INCIDENT:

We have been advised of the following case, featured in the Marine Accident Investigation Branch (MAIB) safety digest No1/2007 (see below link for the document) that we feel will be of great interest to our Members.

Poor bridge team management practices while approaching and entering a narrow channel led directly to the grounding of a 1,845gt tanker. It had been the early hours of the morning and the vessel was returning to her usual load port, in ballast. The bridge watch consisted of an officer of the watch, a lookout and the Master.

The vessel had recently been fitted with an electronic chart system following a similar accident on another of the company’s ships. The Master could see the electronic chart display, but was not using it other than to give him a rough indication of her position. He had never received any formal training in the use of this equipment.

As the vessel approached the channel at full speed, the Master took the con, switched the helm to hand steering and, against company instructions, started to steer the vessel himself towards and through the narrow entrance. The officer of the watch was looking on without a defined monitoring role. However, he had plotted a position on the chart, which showed the vessel to be north of the charted course line, and the Master had altered the vessel’s heading slightly in an attempt to partly compensate. Before the vessel had moved far towards her track, the Master decided to steer directly for the white light which indicated the centre of the bridge’s span.

The vessel sustained significant hull damage. She was holed in one segregated ballast tank but, fortunately, there was no pollution as a result of the incident.

OBSERVATIONS:

1. The MAIB has frequently heard it argued that it is unrealistic to expect coastal shipping to adopt the navigational practices that would normally be found on deep sea vessels, because of the nature of the trade and the size of crews. Owners and Masters must ensure that they do not use this argument to justify bad practice and complacency.

2. The wheelhouse was well manned with qualified personnel, but the team was not used effectively.
to ensure the vessel’s safe passage. In this case, a better arrangement would have been for the seaman to have steered the vessel while the OOW plotted positions and the Master oversaw the whole safe operation.

3. Passage planning was ineffective. A planned track that allowed the vessel to alter course and steady up on the new heading well before the entrance to the channel would have ensured this accident was avoided. Reciprocal courses were chosen for expediency, without consideration of this and possibly other factors. The use of parallel indexing techniques would have helped to ensure the vessel was on, and maintaining, the correct track.

4. Some of these lessons had been discovered by the company as a result of a very similar accident a few months previously. However, the lessons had not been effectively communicated to this vessel or her Master. It is an unfortunate truth that accidents are a key source of useful safety advice, and every effort should be taken to learn and promulgate the lessons so that recurrence can be avoided”.


**ROOT CAUSE:**

Insufficient navigation procedures.

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