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KISH P & I LOSS PREVENTION CIRCULAR KPI-LP-122-2013
(Poor Passage Planning & Pollution Due to Grounding)

►The Scenario:

A container vessel carrying heavy fuel oil and various cargoes, including hazardous liquids, ran aground in a bay off the coast of an island. She was seeking calm waters to anchor and carry out repairs. Lack of delegation from her Master and poor passage planning led to the accident, which resulted in substantial localized pollution and damage to the hull and cargo.

An attempted salvage operation was unsuccessful and the ship was declared a constructive total loss three weeks later.

►What happened?

- The chief engineer discovered damage to an engine cylinder unit. He advised the Master, who took the decision to divert to a sheltered bay and carry out repairs
- Using limited data, the Master decided it was safe to bring the vessel close to an island's charted shoreline. He failed to utilize the rest of his bridge team to monitor her progress, or to take into account warning signs from the echo sounder.
- A lack of formal briefings meant that everyone had their own ideas about what was going to happen. The Master failed to delegate properly, leaving himself overloaded at the time of the grounding. His Second Officer showed no initiative to take any of the loads.
- Lack of local knowledge and a chart unsuitable for close-shore navigation brought the vessel too close to the coastline. No-one on the bridge team realized that she was still travelling at six knots when she ran aground causing substantial localized pollution.
- Although the bridge team had received training prior to the incident, this was not put into practice onboard and the Master acted, to all intents and purposes, alone.

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►Why did it happen?

Subsequent investigations found that sub-standard voyage planning was the cause of the accident. The Master had delivered only the most basic of pre-operation briefings, choosing instead to take on the majority of the task himself. He did not make use of his bridge team properly, not least in the monitoring stage of the process.

As a result, communications were confused, and everyone had different ideas of what to do.

Any voyage planning the Master did carry out appeared to lack awareness of the vessel's position or speed. He was unfamiliar with the area and failed to take note of the available warning systems, such as the echo sounder. Instead, he seemed to navigate by eye, operating alone without engaging the support of his team. He did not allow sufficiently for the changing tides and winds and the anchorage he was attempting was difficult. Although he discussed the voyage plan with the ship managers, the chart he was using was small-scale and therefore not suitable for close-shore navigation. He did not consult the Mariners' Handbook, which advised that ships approaching the shore should take special precautions.

At the time the vessel ran aground, the Master was overloaded. His poor planning, lack of local knowledge and inability to delegate were found to be the direct cause of the accident, and at odds with the best practices he had learnt during his training prior to the voyage.

►What changes have been made?

The ship-owners have refreshed their biannual training content to ensure better onboard passage planning practice.

A new fleet circular was also issued outlining revised anchorage procedures, including the recommendation that Masters should seek licensed pilotage when anchoring in unknown waters.