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(Watch-keeping errors causing collision; a case study)

The navigating officers have crucial roles for ensuring the safety of a ship and its crew at sea. Responsible primarily for human lives, they also safeguard valuable cargo, plus the ship itself and environmental safety. We shall take a look at a maritime accident report caused by watch-keeping errors and the lessons that can be learned.

►The Incident:

Just before 0500, a general cargo ship collided with a bulk carrier in a busy shipping lane. The accident caused damage to both vessels and the leak of 60 tonnes of marine gas oil. Neither ship had a lookout on the bridge at the time of the collision, and the watch-keeping officers did not detect the other ship until it was too late.

Radar and other bridge equipment were not used effectively enough by either ship to prevent the collision.

►What happened:

The single hold general cargo ship was equipped with fully functioning navigational equipment and carried eight personnel. At the time of the accident, her chief officer was Officer of the Watch. Her Master had retired for the night some time before the incident, leaving no written night orders, as the ship was in a Vessel Traffic Services (VTS) area and the officers on duty all held certificates of competency.

Visibility was good. The port radar was not in use and the chief officer had adjusted the starboard radar to provide a range of about nine miles ahead. Despite there being several targets on the screen, none was acquired on ARPA to assess the risk of collision.

The AIS also went unmonitored.

Shortly before the incident, the cargo ship's lookout left the bridge to undertake routine safety rounds. This left the post empty when the collision took place.

Onboard the bulk carrier, the chief officer was also Officer of the Watch, accompanied by an Able Seaman acting as lookout and a cadet being trained in navigation.

Coincidentally, the bulk carrier's lookout was also not at his post when the two vessels collided, as he had been allowed to leave to use the toilet.

The bulk carrier had started to overtake the other ship when the latter suddenly changed course. The chief officer attempted late evasive action, but failed to prevent the ships colliding. However, he did stop the two vessels colliding at the cargo ship's accommodation area, which could have led to far more serious potential consequences.

Radar and bridge equipment were not being used to their full potential on either vessel. Mirroring events in the cargo ship, the bulk carrier's ARPA was not used to assess the risk of a crash and the AIS display was not checked, in direct contravention of the Colregs (Rule 5), which state:

Every vessel shall at all times maintain a proper look-out by sight and hearing as well as by all available means appropriate.

►Aftermath:

After the collision, the Masters of both vessels hurried to their bridges. Both engines were stopped and communication was established between the two ships. No injuries were sustained on either vessel. Initially, it was not thought that much damage had occurred, and after investigation, the bulk carrier was allowed to continue its journey. Further investigation revealed extensive damage to the cargo ship's starboard side shell plating, and it was estimated that around 60 tonnes of marine gas oil had escaped into the sea.

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►Key facts & points to ponder:

1-The Master of the general cargo vessel considered it safe to leave the bridge to go to bed without leaving written instructions.

2-The lookouts on both vessels had been allowed to leave their posts, thus removing a significant warning system while the vessels were in a busy shipping lane.

3-Despite ARPA being fully functional onboard the general cargo ship, it was not used to acquire or plot any of the radar targets. The AIS was not monitored, nor was the bridge alarm activated.

4-The watch-keeping officers onboard the bulk carrier did not make effective use of their radar, AIS or other navigational equipment, despite identifying possible targets.

5-The bulk carrier had started to overtake the other ship when the latter suddenly changed course.

6-It is likely that the cargo ship's chief officer did not see the bulk carrier until the two vessels collided.

7-Evasive action started by the chief officer of the bulk carrier did not prevent the collision.

8-The Bridge Team Management on both vessels failed to undertake the tasks supposed to by lack of considerations for the situations like need to leave the bridge or appropriate use of the navigational equipment.

9-The failure to observe best practices & requirements of the guideline as set out in Bridge Procedure Guide & Safety Management System procedures is evident.

10-The complacency due to repetitious acts of the same nature is apparently one of the root causes, had the OOWs taken the things more seriously & followed stringent abiding by look-out & watch-keeping duties; the incident could have been avoided.