SHIPOWNERS
SECURITY FOR SMALL & SPECIALIST VESSELS

CASE STUDY

Improper navigation results in contact with anchored vessel

The Incident

A tug and barge set were involved in a collision when the barge contacted with an anchored vessel. Shortly before completing his night watch, the 2nd Officer (2/O) on the tug had observed an anchored vessel at a range of about 3 to 4 nautical miles (nm) on the port bow. The closest point of approach (CPA) at that time was noted to be 0.5nm with the tug crossing the bow of the anchored vessel.

At that same time, a passenger vessel was crossing the bow of the tug from port to starboard. The statement made by the 2/O explained how, once the passenger vessel crossed the bow and was clear, the course of the tug was altered to starboard with the intention to clear the anchored vessel at an increased distance. The 2/O reported that the course was set at 260 degrees, however, investigations later revealed that the vessel was making good 235 degrees and was slowly setting towards the other vessel.

In the interim the Chief Officer (C/O) had taken over the watch with the 2/O also remaining on the bridge. However, according to the C/O's statement, by the time the watch had been taken over, the vessels were too close to take the necessary action to avoid the incident and although an alteration of course to starboard was made, the barge collided with the anchored vessel's bow. As a result of the collision, the barge suffered structural damage whilst the anchored vessel reported a breach in way of one of its ballast tanks.

Contrary to the statements provided by the C/O and 2/O following the incident, investigations later revealed that for a long time prior to the collision, the tug remained on a steady course even though the clearing distance with the anchored vessel had been reducing. It was only after the tug had crossed the bow of the anchored vessel, that a large alteration of course to starboard was made. However, this was not made in sufficient time to avoid the incident. There were also reports that after the change of watch, the 2/O was talking to the C/O about other works to be undertaken later in the day; all this, whilst the distance to the anchored vessel had been reducing.

Observations

1. The anchored vessel had been spotted at a range of 3 to 4 nm, however, the 2/O did not take sufficient and timely action to properly assess the risk of the apparent close-quarters situation and thereby take necessary actions to avoid collision. Action to avoid collision was only taken after the tug had cleared the bow of the anchored vessel.

2. The 2/O and C/O were both complemented on the watch with suitable watch keepers acting as lookouts, yet they also did not alert the OOW(s) of the impending danger.

3. The collision happened shortly after a change of watch had occurred.

4. The passage plan was noted to be rudimentary, not all charts were corrected and nautical publications were found to be out of date and not relevant to the vessel's trading area.

5. The Company had sufficient procedures with regards to towing but these were not complied with in this instance.

6. The Company also had a number of documents and checklists, however, none of them had been completed for a number of days, among them the new joiner induction form, rest hour records, passage plan checklist, night order book, Master's standing orders, arrival/departure checklists and change of watch checklist. The vessel had been inspected by the company superintendent just a few days prior to the incident yet none of these items had been highlighted as deficiencies even though the crew on board had stopped completing them for quite some time preceding the superintendent's visit.

Preventative actions

1. A look out needs to be maintained at all times with all possible means and in the event that a risk of collision is considered to be developing, suitable and timely actions need to be taken.
2. As the vessel was in the process of a collision avoidance manoeuvre, it should be seen as best seamanship practice that the outgoing OOW complete the manoeuvre and return the vessel to its original course prior to handing over the watch.
3. Watch keepers complementing the Officers of the Watch (OOW) to be reminded and trained regularly of the fact that any developing situation that they notice has to be brought to the attention of the OOW at the earliest opportunity.
4. Though not directly causative to the incident, it is imperative that the Company monitor the crew's compliance with stated procedures and all associated paperwork. Superintendent visits on board are to be made more meaningful and issues that may in the future give rise to an incident are to be highlighted and preventive measures to be put in place.

Financial cost

In the range of US$ 400,000-500,000.