



Mariners' Alerting and Reporting Scheme

MARS Report No 337 November 2020

MARS 202059

Storm anchorage grounding

As edited from official PMA (Panama) report R-005-2018-DIAM

➔ A 225 metre bulk carrier in ballast was at deep water anchorage near a major port. It had drafts forward and aft of 4.80 metres and 6.05 metres respectively. The weather was good but heavy winds were predicted. The crew had put out seven shackles of port anchor. The weather forecast was expected to worsen, so the Master decided to drop the starboard anchor as well, with four shackles in the water.

Some time later the wind reached B10/11. Crew were using the main engine to try and keep the vessel on station but they were dragging anchor nonetheless. Shore authorities were advised and tug assistance was requested. Although the tug arrived soon afterwards the Master deferred immediate assistance. The tug remained in standby mode for the next seven hours as the vessel drifted, coming ever closer to a lee shore. Finally, an attempt by the tug to pull the vessel away from shore failed with the rupture of the tow line and the vessel grounded.



Damaged rudder from grounding

Lessons learned

- Time and again groundings from storm anchorages occur because too much time was lost before lifting anchor and putting to the open sea.
- Good seamanship means, among other things, putting the safety of the ship and crew before all other considerations.
- A vessel in ballast condition should be ballasted to its maximum before bad weather is encountered to reduce pounding and augment steerage.

MARS 202060

Injured while standing in the lifting danger zone

As edited from official MAIB (UK) report 11/2020

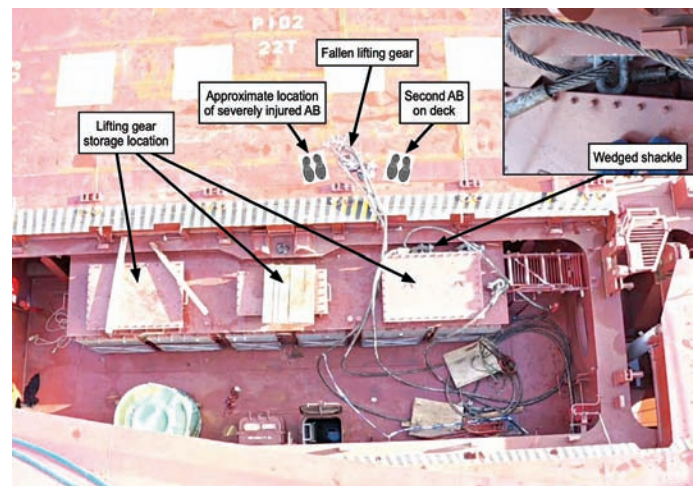
➔ A cargo vessel arrived in port to load wind turbine tower sections. The deck crew held a safety briefing prior to loading. By this time, it was dark and the vessel's deck working lights were on, illuminating the area where the crew were working.

Following the safety briefing a seaman used the vessel's forward crane to remove the cargo hold ventilation duct space hatch cover so that the cargo hold hatch cover lifting gear could be retrieved. Two

other deck crew then entered the ventilation duct space and attached the first of two lifting gear sets to the crane's hook using a fibre sling. Both crew then climbed out of the space and stood close to the hatch edge ready to guide the load and free any snags as it was lifted.

The crane operator was instructed via VHF radio to commence lifting. After the load had been lifted about 2-3 metres, the gear snagged. The crane operator was ordered to stop lifting and the two nearby deck crew freed the snag by hand. They remained close to the edge of the hatch and the signaller ordered the crane driver to start heaving again.

Shortly after the lifting operation recommenced, a shackle at the lower end of the load snagged on a ventilation trunk coaming. The crane operator was ordered to stop, but at the same time the fibre sling parted and the lifting gear fell to the deck, striking both crew. One suffered only minor injuries while the other suffered major head injuries and had to be hospitalised and repatriated.



Lessons learned

- Do not stand under a load or in the fall zone!
- In this instance it appears the hazard of snagging gear was well known but crew had not addressed the hazard at the source, deciding to 'work around' the hazard at each instance. It was only a matter of time before an accident happened.

MARS 202061

Master with the con and steering – vessel scrapes channel side

As edited from official MAIB (UK) report 4/2020

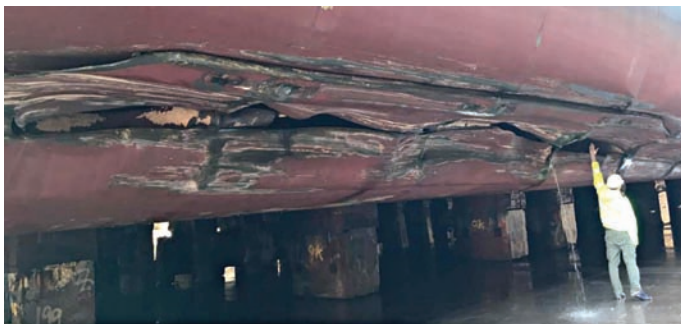
➔ A ro-ro freight ferry was underway in darkness, outbound from a port in restricted waters. The Master, who was new on board, had the con. The OOW and another officer were also on the bridge. With a planned course alteration coming up, the Master switched from autopilot to hand steering, which he took himself (point two in the diagram). The vessel was now making about 14.5 knots and the Master was navigating principally by visual means.

Visit www.nautinst.org/MARS for online database

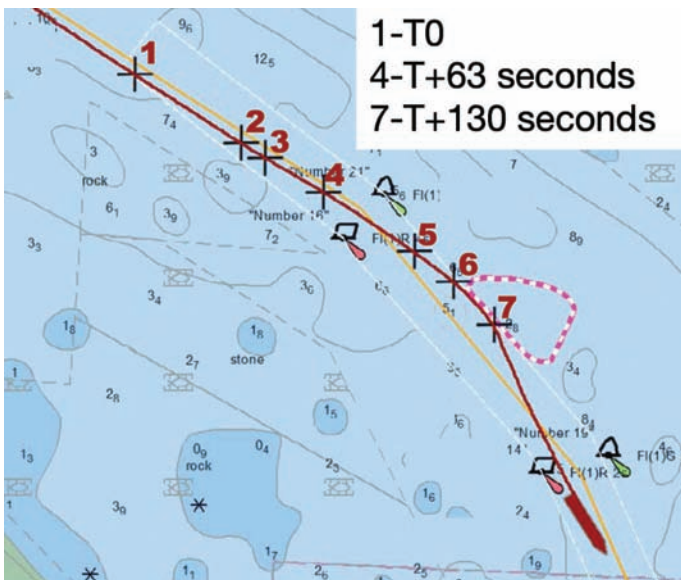
The Master applied 10° of starboard helm and the ferry started to turn to starboard. He assessed that the ferry was turning too quickly and put the helm to midships. The OOW then reported that the ferry was clear of the buoy on the port side. At about the same time, the Master realised that the vessel was further to the north than he intended. He applied starboard helm in increasing amounts to keep the ferry within the buoyed channel. Shortly afterwards, a prolonged loud noise and a shuddering vibration was heard and felt throughout the vessel (point 7 in the diagram). An inspection later determined that there was significant damage to the ferry's port side, including a 10 metre tear near the turn of the bilge; adjoining spaces had flooded to the waterline.

The ferry quickly developed a 7° port list. It was established from the ballast computer that seawater had entered the port heeling tank. Ballast transfer was commenced to return the ferry upright.

The official investigation found, among other things, that the turn to starboard was late and the Master had insufficient support from the bridge team even though they had recently completed BRM training. Additionally, the Master himself was steering by hand, which reduced his ability to maintain an overview of the situation. The lack of support from the bridge team made him a single point of failure. The navigational practices being used by the bridge team did not fully incorporate the electronic aids available and were insufficient to assure the vessel's safe nighttime outbound passage.



Bottom damage from touching channel side



Lessons learned

- BRM training is good theory, but mariners must then put into practice what they have learned in order to reduce the chances of single point failure.
- Under normal circumstances the speed in this accident (14.5 knots), may not qualify as excessive. But given the darkness and narrow channel navigated it can be argued that the speed was a contributing

factor. Remember that slowing down is often the best option when external events out of your control are risk multipliers. At 7 knots, the bridge team would have had twice the time to assess the situation and make adjustments.

- As we have seen in previous MARS reports (202053), assuming the con and also helm and engine responsibilities, in darkness and restricted waters, created an overload of work processes that reduced the person's ability to maintain an overview of the situation.

MARS 202062

Safety under pressure

➔ A suezmax came alongside a docked VLCC to carry out a STS operation. While the hoses were being connected, a supporting rope on one of the four fenders broke. The Safety Inspector was informed, and immediately carried out a visual inspection together with vessel's staff. The vessel requested to suspend operations in order to evaluate the situation; the terminal suggested that they should continue with making hose connections as the situation was under control.

As the hose connections were being completed a second supporting rope broke. This was rectified and cargo transfer operations took place without further incident.

The investigation found that the supporting ropes for the fenders were in doubtful condition.



Fender arrangement

Lessons learned

- In this case the terminal wanted to continue operations even though there had been signs that all was not right. The failure of the first fender rope was a first warning and the second failure a definitive demonstration of less than ideal safety.
- Sooner or later in our career we all are pressured to make do with a situation even though signs are evident that safety is not respected. Resist these pressures and always side with safety.

MARS 202063

Assumptions can lead to bad outcomes

As edited from official NTSB (USA) report MAB 20/19

➔ In darkness, a coastal service containership was leaving port under the Master's con. There was no pilot, as the Master had a pilot exemption certificate. In addition to the Master, there was also an OOW on the bridge and a helmsman at the wheel. The Master reported the vessel's departure to vessel traffic services (VTS). The report was received but VTS did not give the status of traffic in the port.

The vessel's speed was set at near 12 knots, in accordance with port speed rules. As the vessel approached the end of the secondary port

channel, the Master altered course from 125° to 155° to join the main shipping channel and proceed in a southerly direction. The course would take him across the area between the secondary port channel and the main shipping channel, which was a designated anchorage area (A, B, C & D).

Not only were there several ships already at anchor in this area, but another vessel, 'Ship 1', was making way at about six knots from the south on a course of 002° and preparing to let go anchor. The Master's intention was to pass starboard to starboard with the approaching Ship 1 and between two other anchored vessels, one of which is 'Ship 2' (see diagram).

The bridge team on Ship 1 assumed the outbound ship would join the main shipping channel to the north. But as they closed they



saw the outbound vessel altering to starboard. There were no radio communications between the two vessels at any time, but 'Ship 1' sounded the warning signal with the ship's horn several times.

By now the outbound container vessel had come to port and it was obvious a collision would occur. Both vessels' bridge teams took evasive actions but to little effect. The outbound vessel hit the inbound and then careened off and collided with the anchored 'Ship 2' as well. No injuries were reported, but damages to all three vessels were over \$1 million.

Lessons learned

- Every time you assume an action will be taken by another party without verifying directly with them, the door to a potential accident is opened. In this case, both Masters assumed incorrectly what the other's intentions were.
- Even had these vessels confirmed their actions ahead of time, the space between the two anchored ships left little room for error for the two meeting ships. Given this fact and the darkness, the decision of the outbound vessel's Master to pass between the two anchored vessels was not the best one.
- In a crowded and busy port, best practice would dictate that you should be informed ahead of time of the movements and intentions of other vessels.
- Speed, as cited in 202061, was not excessive at 12 knots but given the extreme congestion in this port and darkness, why not proceed at six knots to exit? This would give twice as much time to assess the situation and act accordingly.

MARS 202064

Ignoring the gangway proves fatal

As edited from official MAIC (Cyprus) report 4E/2018

→ A small container vessel was secured in port. A couple of visitors had boarded and, in the early morning hours, they were now on their way off the vessel. The gangway had been raised a few metres above the dock surface, so the gangway watchman needed to lower it back down to the dockside to permit their exit. As this was being done, the two

visitors attempted to disembark by stepping over the bulwark, which was almost at the same height as the quay. One of the persons fell into the water in the gap between the vessel's side and the quay. Two life-rings were quickly thrown into the water and a monkey ladder and life-lines were rigged on the vessel's bulwark.

The general alarm was sounded and the port emergency service was called for immediate assistance. Shore assistance arrived in less than 20 minutes and the victim was recovered about 20 minutes after that. The victim was transferred to a shore hospital but his death by drowning was later confirmed.

Lessons learned



- The visitors were tempted to step ashore by the near equality of height between the berth and the bulwark. This false sense of security and overconfidence cost a life.
- Rigorous management and control of embarkation/disembarkation is of the utmost importance.

MARS 202065

Trip causes trip to ship's hospital

→ Crew were assembled for a lifeboat drill. The lifeboat was lowered into the water and, once tested, was raised again into the stowed position. As the boat came close to its final position on the davit, a crewmember moved forward to check the limit switch. During this movement he tripped on a nearby manhole cover. Falling forward, he impacted the davit structure with his face, injuring his lower lip and teeth.



While the company investigation found that the crewmember was partially responsible due to carelessness, they also found that the manhole cover had not been painted with high visibility paint markings which would help prevent unwanted trips. The manhole cover was subsequently painted in black and yellow zebra markings.

Lesson learned

- Hazards in plain view – once again! This manhole cover was obviously a tripping hazard, yet it had gone undetected and unidentified even though a similar nearby tripping hazard around the lifeboat had already been identified and was zebra-painted.

Thank you to all our Nautical Affiliates for their continued support



ABB
<http://new.abb.com>



ABC Maritime
www.abcmaritime.ch



African Marine Solutions
<https://www.amsol.co.za/>



A. R. Brink & Associates
www.arbrink.com



AMCOL
www.amcol.ac.th



BOURBON
<https://www.bourbonoffshore.com>



BMT Surveys
www.bmtsurveys.com



Britannia P&I Club
www.britanniapandi.com



Caledonian MacBrayne
www.calmac.co.uk



City of Glasgow College
www.cityofglasgowcollege.ac.uk



Carnival Corporation
www.carnivalcorp.com



Chevron Shipping
www.chevron.com



Commissioners of Irish Lights
www.cil.ie



Constanta Maritime University
www.cmu-edu.eu



Constellation Marine Services
<http://constellationms.com>



Epsco Cyprus
www.epscopy.com



Everard
<https://www.everardinsurance.com/>



Excelerate Technical Management
<https://excelerateenergy.com/>



Exmar
www.exmar.be



Finnish Ship's Officers' Union
<https://seacommand.fi/en/>



Gard
www.gard.no



GigaMare
<https://www.gigamare.com/>



The Gdynia Maritime School
<http://morska.edu.pl/en>



GNS
www.globalnavigationssolutions.com



HC Maritime Consulting Pty Ltd
www.hcmaritime.com



Hindustan Institute of Maritime Training
<https://www.himtarine.com/>



IAMI
<http://iami.info>



IMAT
<https://www.imat2006.it/>



IMCS
www.imcs-group.com



Inmarsat
<https://www.inmarsat.com>



International Salvage Union
www.marine-salvage.com



KASI GROUP
www.kasimalaysia.com



Keelson Marine Assurance
<https://www.keelsonmarineassurance.com/>



K. C. Lyrantzis Group
<https://kclgroup.gr/>



LOC Group
<http://loc-group.com>



Louis Dreyfus Armateurs
www.lda.fr



Marine Society & Sea Cadets
www.ms-sc.org



Maritime Training Services
<https://www.maritimetraining.com>



Marlins
<https://marlins.co.uk>



Martech Polar
<http://martechpolar.com>



Menezes & Associates
www.menezesandassociates.com



MES
www.myanmarexcellentstars.com



MINTRAGROUP
www.mintragroup.com



MOL Marine Co., Ltd.
www.molmc.co.jp



MSI
www.msiships.com



North of England P&I Club
www.nepia.com



NorthLink Ferries
www.northlinkferries.co.uk



Norwegian Hull Club
www.norclub.no



Ocean Technologies Group
<https://oceantechnologiesgroup.com>



Pacific Basin
<https://www.pacificbasin.com/>



PHRS
www.phrs.gr



The Port of London Authority
www.pla.co.uk



The PTC Group
<http://ptc.com.ph>



Rightship
www.rightship.com



IHS Safety at Sea
<http://magazines.ihs.com>



Seagull Maritime AS
www.seagull.no



SDT
www.sdtultrasound.com



The Standard Club
www.standard-club.com



Steamship Mutual
www.steamshipmutual.com



STARGATE
www.stargate-crewing.ro



The Swedish Club
www.swedishclub.com



Seavie
<http://seavie.com>



Swire Pacific Offshore
www.swirepo.com



Tsakos Columbia Shipmanagement
<http://www.tsakosshellas.gr/>



Thalpis
<https://thalpis.com/>



TMC Marine
<http://tmcmarine.com/>



UK P&I Club
www.ukpandi.com



UK Chamber of Shipping
www.ukchamberofshipping.com



Vertex Oil Spill Supply
www.vertexoilspill.com.br



Videotel
www.videotel.com



West of England P&I Club
www.westpandi.com



WAVES GROUP
www.waves-group.co.uk

Our Nautical Affiliates help us make a difference to the shipping community by ensuring that our MARS Scheme is available to the industry for free. Find out more at: www.nautinst.org/affiliate