MARINE Safety Forum

Safety Alert

Number: 22-02 **Published: 27/01/2022**

Subject: Contact Between Vessel in Standby & Offshore Installation

What Happened / Narrative

During a period of standing by an offshore installation, the 1st Officer on the vessel took over the watch at midnight with 1.2 nautical miles to the installation. The vessel was set on a course towards the installation which allowed the incident to evolve. The 1st Officer attended administrative work and the designated lookout was keeping lookout. At 00:20 with 0.7 nautical miles from the installation, the lookout asked the 1st Officer for permission to use the computer leaving the lookout duties unattended. At the time the 1st Officer was carrying out a weekly radio check on the long-range radio. Just as the check was completed the vessel was called upon by other vessels inside the safety zone notifying them that they had entered the safety zone, at the time the distance was 250 metres from the installation.

The 1st Officer rushed to the manoeuvring station attempting to stop forward movement of the vessel. The 1st Officer intended to switch steering from autopilot to hand steering, however, accidentally switched into emergency steering instead. This caused the 1st Officer to lose control of the vessel and he failed to stop the forward movement.

The Master was called to the bridge, and by the time he arrived the distance to the installation was estimated to be 30 meters and still with a direct heading. The Master managed to turn the vessel to port, however the proximity to the installation and the vessel momentum resulted in the starboard side of the vessel contacting the installation.

The vessel suffered dents to the hull, which did not compromise the hull integrity or safety of the vessel. The installation was undamaged by the contact.

Why Did it Happen / Cause

It is clear from the investigation that all the required and proper procedures existed but were not effectively implemented. The 1st Officer was appropriately qualified for the role and had been subject to the vessel owner's induction and familiarisation procedure.

No systematic errors have been identified. The incident was caused not by lack of procedures but by (human) failure to implement/observe these procedures.

It is deemed likely that the 1st Officer would have been able to steer clear or stop the vessel if he had not set the vessel in emergency steering

The vessel owner's investigation identified the root cause as:

- "Course Over Ground towards the installation and insufficient watchkeeping"

Corrective Actions Taken / Recommendations

Whilst the root cause for the incident did not point towards any failures in the procedures, it was decided to carry out a review of the procedures, to enhance the training sessions and to implement certain clarifying adjustments to the procedures. This is due to the vessel owners focus on the highest operational safety standards.

Summary of the improvement suggestions from the vessel owner:

- Ensure that all emergency switches do not have multiple functions
- Update of the existing navigational audit checklist
- Clarification of the lookout's duties in bridge procedure
- Emergency scenario-training sessions to be implemented

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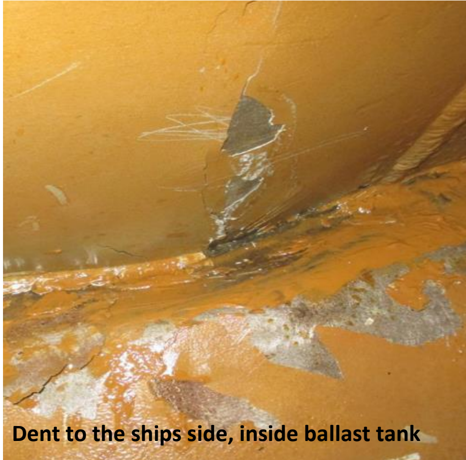
Photographs / Supporting Information


Dent to the ships side, inside ballast tank

Suggested discussion points to accompany this safety alert:

- Could this have happened on your vessel?
- What do you have in place to avoid a similar incident?
- Installations should not be used as waypoints when passage planning. Planned courses should not breach any installation 500m Safety Zone.
- Don't allow yourself or others to become distracted on watch, maintain situational awareness at all times.
- Know how to operate manual and emergency control changeovers.

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