



Workload Distraction Results in a Grounding

Description

A general cargo vessel was underway in ballast to its next port to load cargo. This port call was a last minute change that required new paper charts to be delivered to the vessel urgently before departure. The charts had just been received onboard the vessel minutes before the vessel's departure. Although equipped with an Electronic Chart Display and Information System (ECDIS), the policy on this vessel at the time was to use paper charts as the primary means for navigation.

The Second Officer was responsible for drafting the passage plan and presenting it to the Master for final approval. The last-minute change to an unfamiliar port, and the late arrival of the paper charts to the vessel, resulted in a passage plan not having been fully developed prior to departure. The Master decided to review and approve the passage plan in increments to avoid what he thought would be unnecessary delays.

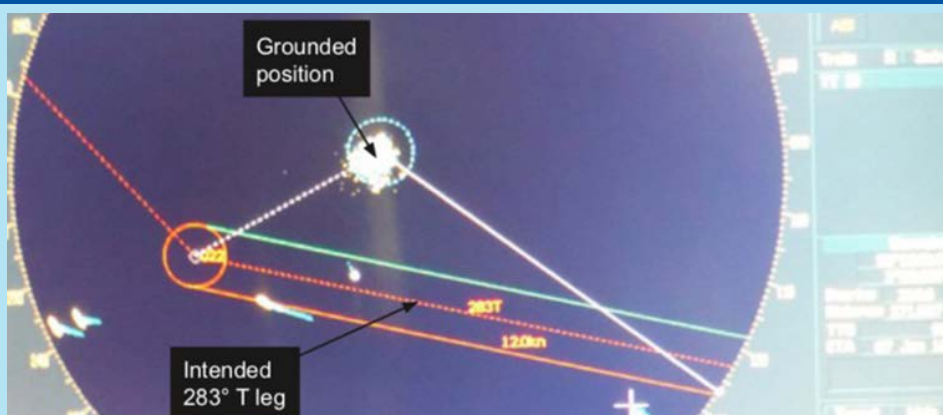
The Second Officer assumed the watch at 1200 the day after the vessel got underway. He planned to complete the passage plan for the remainder of the voyage and also update the new navigation charts with the latest corrections while on watch.

After completing the draft passage plan, the Second Officer began work on chart corrections while continuing to navigate the vessel. His multi-tasking abruptly ended when the vessel ran aground on a charted rock at 1520.

The investigation revealed that the Second Officer was significantly distracted from his primary watchstanding duties when he was working on the passage plan and updating the paper charts. These workload distractions caused him to initially miss a planned turn and later to incorrectly plot a fix on the chart. While that fix had been correctly taken and recorded in the log, he had incorrectly plotted it on the chart. Had it been correctly plotted, the Second Officer would have seen that the vessel was significantly off the intended track line and was at risk of grounding.

Further, the investigation revealed that the Second Officer's focus on the passage plan and navigation chart corrections led to a poorly executed watch relief at 1200 when he failed to review the passage plan that had been approved for that portion of the voyage. He had failed to identify the navigational hazards the vessel would encounter during his upcoming watch.

The investigators also determined that numerous requirements in the safety management system (SMS) had not been followed related to passage planning, bridge watchstanding procedures and navigation in restricted waters.



Actual Injuries and Damage

The vessel remained hard aground for several hours until refloated by the rising tide. It was taken out of service and proceeded directly to a shipyard for a detailed damage assessment and repairs. Fortunately, there were no injuries to the crew or pollution.

Potential Damages

This grounding and the resultant hull damage could have been substantially worse. The hull could have been penetrated and flooded in part. A major pollution incident could have been caused.

Prevention

- ★ Crews should be reminded that the primary responsibility of the Officer of the Watch is the safe navigation of the vessel.
- ★ The watch relief process is critically important. The oncoming Officer of the Watch needs to know and verify the vessel's location, course and speed. But he or she also needs to identify potential hazards the vessel will likely encounter during that watch before assuming the watch.
- ★ Distractions while on watch should be eliminated or minimized to the maximum extent possible. Those distractions can include other legitimate work such as updating charts, checking emails, catching up on other log entries, passage planning, etc. While all legitimate work, they should not be done while on watch.
- ★ Passage plans should be developed, reviewed and approved in advance of departure. Additionally, they should be presented for review as a complete berth-to-berth plan so each portion of the voyage can be reviewed in context with the other portions.

When you identify a hazard before something goes wrong...

it's a Good Catch.

When you stop an operation before something bad happens...

it's a Good Catch.

When you recognize hazardous distractions to good watchstanding and eliminate them...

that's a Good Catch, too!



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