

Button trouble

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A Dynamically Positioned vessel experienced a loss of DP control while installing cable within a wind farm.

Overview

The incident occurred during the cable lay operation. The DP manual override command on the navigation bridge was inadvertently activated, which caused a loss of DP control over six of the thrusters, resulting in the vessel drifting off position.

Without forward thrust, the vessel was pulled astern by approximately 15 metres due to the action of the cable tensioners. This resulted in a section of the cable, approximately 36 metres in length, being damaged.

The bridge crew managed to manually regain DP control by returning each thruster to DP. The personnel in the working area were accounted for, with no injuries reported, and no damage to other assets or equipment was reported. The cable was secured and laid down in a controlled manner, and the vessel was relocated outside the windfarm to prevent further incidents. An investigation into the cause of the DP loss was initiated.

Findings

Investigation revealed that this command was activated inadvertently, leading to the loss of thruster control.

The vessel's DP Control system was upgraded during a recent vessel life extension. Part of the upgrade included the addition of a manual override button.

Recommendations

To prevent recurrence, the manual override button on the navigation bridge could be replaced and the single manual override functionality removed.

- Vessel owners/operators should assess their DP systems to eradicate such single action override buttons or ensure they are adequately protected.
- The crew's understanding of the DP functionality should be assessed, and additional training to be provided to ensure full comprehension of a new system.
- Emergency drills should be conducted to ensure crew preparedness for various scenarios.
- The DP checklist should reflect the change to the Master's DP standing orders.
- Due to system upgrade, MOC needs to be put in place and to be included in the handover note.
- Familiarisation to highlight changes which occurs during system upgrade.

Conclusion

This case highlights the critical importance of thorough testing and crew training following the integration of new systems or functionalities on vessels. The incident underscores the potential risks associated with manual overrides and the necessity for stringent controls and fail-safes to prevent inadvertent activations.

The case studies and observations above have been compiled from information received by IMCA. All vessel, client, and operational data has been removed from the narrative to ensure anonymity. Case studies are not intended as guidance on the safe conduct of operations, but rather to assist vessel managers, DP operators, and technical crew.

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