Inadvertent act causes loss of DP, once again!

Incident

DP Event • Published on **1 August 2025** • Generated on **28 January 2026** • DPE 02/25

1 Overview

This is a lessons learnt shared by one of our members, as for a Safety Flash, though is most relevant for our DP bulletins.

2 What happened?

While vessel was recovering scrap metal using an ROV and crane, an alarm was triggered. The DPO attempted to silence it from the aft command panel 'Bridge Alarm System' without success.

He moved to the forward station (where the alarm originated) but was also unable to silence it there. While attempting to press the silence button on the forward command panel, he accidentally pressed the adjacent "Take" button on the DP panel.

Upon returning to the DP station, the vessel was found in manual LEVER mode instead of DP mode. Amber alerts were issued to the ROV and crane; the ROV began returning to the TMS, and the crane lifted off the seabed.

Although the situation was quickly brought under control, it is important to note that the outcome could have been significantly more serious had this occurred during a more critical phase of the operation.

3 Findings

On investigation, the following was found:

- The bridge experiences a high volume of alarms from various systems (automation, bridge watch, NAV lights, ARPA, AIS), all routed through a single alarm system. This contributes to alarm fatigue and potential alarm blindness. Additionally, the Bridge Alarm System panel is known to freeze. During the incident, the forward panel was frozen, and the source of the alarm could not be identified.

- The alarm silencing process is inconsistent, with options to silence via either the Bridge Alarm System panel or the manoeuvring station. In this case, the "Take" command button—located next to the "Silence" button—was mistakenly pressed.

- Although the "Take" button requires a double press to activate, It has been observed that multiple presses are sometimes used when attempting to silence alarms, which has been noted and discussed onboard as part of routine operational feedback.

4 Conclusion

This incident highlights the risk of human error during alarm handling, particularly when control panels have critical functions assigned to closely positioned buttons. The consolidation of multiple alarm sources into a single system can contribute to alarm fatigue, making rapid and accurate responses more difficult.

The situation also emphasized the importance of clear system feedback and reliable alarm panel functionality. In this case, a frozen alarm panel and uncertainty regarding the alarm's origin further complicated the response.

A positive takeaway was the DPO's openness in acknowledging that he may have pressed the wrong button—a conclusion supported by the DP event log confirming a command change. It shows the important of No-blame culture, which encourages transparent reporting and honest reflection. Such openness is essential to fully understand what occurred and to identify opportunities for learning and improvement.

While the DPO team is experienced and safety-focused, this event reinforces the ongoing need for vigilance, user-friendly system design, and regular procedural reinforcement – even among highly capable crew.

IMO MSC Circular 1580 / Section 2.3: *For equipment classes 2 and 3, a single inadvertent act should be considered as a single fault if such an act is reasonably probable*.

This incident is not new in the industry and highlights the importance of the need for robust designs that prevent inadvertent acts. OEMs should focus on providing barriers in design, such as protective covers or acknowledgement confirmation windows that prevent double-press of the wrong button causing change of the DP mode of loss of DP control.

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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