

Vessel made contact with installation

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A Member has reported an incident in which a vessel made contact with part of a well-head installation, causing damage to the installation.

What happened?

The incident occurred when the vessel was conducting cargo operations alongside a well-head installation; after a period where small cargo loads were being transferred, the crew of the installation advised the vessel that they had a larger cargo unit to land on deck, which required the crane block to be swapped.

With the break in cargo operations and forthcoming larger cargo load, the Master took the decision to send the on-watch second mate down to deck to assist the two ABs. The second mate complied, leaving the Master alone on the bridge. Shortly after this, the Master made the decision to take the vessel out of joystick mode and into manual control; he then set the vessel's controls in an attempt to maintain station whilst he visited the washroom on the bridge. During his time away from the controls, the vessel lost position and began drifting towards the installation.

Seeing the vessel moving closer to the installation, the deck crew radioed the bridge with no response. The Master came out of the washroom and noticed the vessel's movement but was too late to regain control and prevent contact. The vessel's stern roller impacted on one of the installation's legs, causing damages to both vessel and installation.

Findings

Our member noted that:

- There was serious complacency: the Master subsequently stated that in previous instances the controls were also left unattended as long as the propulsion was counteracting the effects of environment (sea current, wind, etc.) and the position was visually maintained.
- There was failure to properly assess the risks involved in:
 - Leaving the vessel in manual manoeuvring mode.
 - Considering the second officer's attendance on deck as being more important than on the bridge.
 - Leaving the bridge controls unattended.
- The Master failed to comply with COLREGs Rule 5 (Look-out).

- Both the Master and the second mate did not follow existing company safety management system procedures stating that “as a minimum, there shall be 2 persons on the Bridge, where at least one is a certified watch-keeping officer”.
- The second mate should have exercised the stop work policy when instructed to leave the bridge.

Actions

The following actions were taken:

- The vessel had to go to port for repairs and was off-hire for some time.
- The Master was replaced at the request of the client.

Lessons learnt

- Personnel are still failing to correctly exercise the stop work policy; all personnel are expected to exercise the stop work policy at all times where unsafe acts or conditions occur.
- Over-confidence and complacency are serious failings; complacent attitudes and failure to correctly apply industry, company and client procedures are leading to incidents and injuries.
- Poor risk assessment leads to a lack of preparedness; control of work processes are in place to allow employees to control their work and environments. Failure to effectively apply these means our work begins to control us.
- Full awareness of, and compliance with, company safety management systems, is vital.

Members may wish to refer to the following incident (search words: collision):

- [Marine Safety Forum Safety Flash 15-18: Collision with rig](#)

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