M2091

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Category: Maritime

Report Title Near miss approaching port

Initial Report

Our reporter said, “I was woken up by my second officer, who had just anchored and finished his watch. He was distressed. He had the last navigation watch for arrival at around 0200, so as usual, the captain came to the bridge before arrival and then took over while the 2/O and lookout went to drop the anchor.

In this case, a guest and a bodyguard arrived on the bridge just after the captain, who became distracted during the handover due to the presence of the guest who stood at the helm.

The captain did not realise how close they were to the bay. The second officer realised that the boat was entering the bay too quickly but didn’t feel he could warn the captain who was talking to the guest. He eventually warned him as the boat entered the bay at 14 knots,
narrowly missed several anchored sailing boats and going aground.”

Comment

No matter how confident they might ordinarily be, many seafarers can find it challenging to speak up about an issue to someone senior. This is called the ‘authority gradient’ – the real or perceived difference in rank, experience, or social or cultural hierarchy. Pointing out an error is especially difficult in front of an ‘audience’, particularly if they are also perceived as ‘senior’ to ourselves.

Masters and senior officers can reduce the authority gradient by encouraging their team members to speak up – and praising them for doing so, even when the concerns are unfounded. The 2/O’s distress suggests that the captain and the company had not fostered a culture of challenge and response on board. Developing a ‘constructive challenge’ mindset within the team has additional benefits, too: crew
members become more confident, teams work more cohesively, problems identified earlier, and solutions are developed more creatively.

CHIRP and the advisory board members recommend that when guests board the vessel, they are informed during their safety briefing and familiarisation tour that during high-risk navigational phases of any passage, they should refrain from coming to the bridge or engine
room. The master, who had arrived on the bridge with a guest, was distracted and not engaged

with the navigation, including traffic and other hazards.

Clear communications are required concerning taking over the conn, and this was not evident. This indecision left nobody taking responsibility for the vessel's navigation, which fortuitously narrowly avoided collision and grounding. For the 2nd officer to be asked to leave the bridge to prepare the anchor long before it was required was bad practice. Another crew member could assist the lookout in preparing the anchor, and the officer attends to the anchor when the vessel has reached the anchorage position.

A very effective navigation risk control measure which would have reduced the vessels speed as the vessel approaches the entrance to a port, anchorage, berth or rendezvous point, is to annotate the passage plan with desired speeds so that the speed of the vessel is commensurate to the risks and allows the vessel to be stopped in a controlled manner.

Key Issues

Communication: The actual or perceived 'gap' between the reporter and the captain could have led to a severe incident – collisions at 14 knots are likely to result in serious personal injury and significant hull, equipment or pollution damage.

Distractions: the master should make it clear to guests that during any port approaches or high-risk navigational areas, no guests should be on the bridge to maintain focus on safe navigation. This is in everyone's interest.

Culture: The 2/O distress suggests that the safety culture on board needed improvement. The master should set an example and highlight this incident as a start to change the safety culture on board and in the company. The company needs to be proactive here and support the master.

distractionDistraction

poor_communication Communication

teamworkTeamwork