

Case study for onboard safety meeting

Case study no. 6: OOW falling asleep

Please read the below story of an incident which took place during a voyage from Scandinavia to Germany. Keep our procedures in mind while reading to compare with the actions of the crew below as we will discuss the factors which led to the incident occurring.

One morning in November a fully laden vessel was proceeding from Scandinavia to Germany.

The vessel had arrived at the loading port the day before to load a mixed general cargo. Loading had been completed by midnight and had involved the entire crew. It was hard work and difficult to comply with rest hour regulations. According to instructions from ashore, the rest hour form was nevertheless filled-in in compliance with the regulations. The vessel departed around 02:00 am. Manoeuvring for departure took some twenty minutes during which the Master was at the wheel and operated the engine controls while the Chief Officer assisted him by using the search light and checking passage distance. Once out of port the Master switched to autopilot. The Second Officer arrived on the bridge shortly thereafter to relieve the Chief Officer as OOW. The Chief Officer remained on the bridge for a minute or so and then went to his cabin to sleep.

At 03:55 am the Second Officer called the Chief Officer. The Chief Officer attended the bridge when the vessel still had another 20 nm before leaving the baseline of the coast. The Second Officer was steering the vessel using the autopilot and the Master was not on the bridge. The lookout had been ordered to conduct a fire round of the vessel, and was therefore not on the bridge. The Chief Officer and the Second Officer conducted a short handover of navigation as the Second Officer was very tired and emphasised that he had to get some sleep. The Chief Officer told the Second Officer that "today I am very tired as well. Hopefully the captain will join me on my watch. I might fall asleep." The Second Officer then went to his cabin to sleep. The Chief Officer was tired as he had only slept some 10 hours during the last 72 hours. The lack of sleep was caused by a tight schedule with many port/quay calls in the last couple of days. The Chief Officer had been working his own watches as well as those of the Second Officer whilst in port as the Second Officer was very inexperienced and required constant monitoring and follow-up. Between 04:00 and 05:00 there were three waypoints on the electronic chart. The Chief Officer felt tired and moved around the bridge and turned on the radio to stay awake. He knew that, as he did not have a pilot exemption certificate, he was not allowed to navigate the vessel without the Master being present on the bridge. The Chief Officer realised that the lookout had not returned from his fire round and assumed that he had gone to the galley to get something to eat.

At 05:10 the Chief Officer sat down in the steering chair and fell asleep shortly thereafter. As he was asleep the vessel did not change course at the last waypoint and continued straight ahead until she grounded near the outer baseline of the coast. The chart system did not sound any alarm that the vessel was approaching or passing a waypoint.

The Chief Officer woke up and immediately sounded the general alarm to alert the rest of the crew. The Master attended the bridge immediately. The Master asked the Chief Officer what had happened and he replied that the vessel had run aground.



Case study for onboard safety meeting

Risk assessment form

Based on the case, we will now perform an onboard risk assessment of the incident and the factors which led to it. Bearing in mind our own procedures, please consider the following:

Hazard Identification

Based on the case description, what are the potential hazards involved, i.e. the hazards present prior to the incident occurring?

Risk Assessment

Could these hazards be present onboard our ships?

Frequency: How often (daily, monthly or annually) are these hazards present?

Severity: How bad are the worst possible outcomes of these hazards?

Risk Acceptance

Are the risks identified above acceptable in our company or should any of the identified risks be reduced?

Risk Treatment

How can the identified risks be reduced? (Both frequency and severity of a hazard should be assessed to determine the risk. Consider factors such as equipment, procedures and training.)

Which procedures do we have onboard that must be followed in a case like this?

