

# MAIB

MARINE ACCIDENT INVESTIGATION BRANCH

## FLYER TO SHIPPING INDUSTRY

### ***CP VALOUR:***

#### **FAILURE OF BRIDGE TEAM MANAGEMENT AND ONBOARD AUDITING**



The 15,145gt Bermuda registered container vessel CP Valour, grounded in a bay off the NW coast of the island of Faial, Azores, on 9 December 2005. The next day, in worsening weather conditions, the vessel's hull began to fracture, causing substantial pollution. The subsequent salvage operation was unsuccessful and, about 3 weeks later, she was declared a constructive total loss and abandoned.

The vessel had been on a liner voyage from Montreal, Canada, to Valencia, Spain, when one of her main engine cylinder units was found to be overheating due to a cooling water leak. The vessel continued on her

planned track towards the central Azores at slow speed, while the master and chief engineer decided on the best course of action: a cylinder head needed to be lifted and calm water was essential. They decided to head for a bay on Faial Island which, they assessed, would be sheltered from a heavy SW'ly swell. The master discussed the proposed action with the managers, who in turn appraised the owners, and gained their permission.

The bay contained a charted designated anchorage, but the largest scale chart of the island which was on board CP Valour was 1:175,000. Such a chart is not normally considered suitable for close inshore navigation and the only charted depth in the bay was a single sounding of 36 metres. Good passage planning, track monitoring and teamwork would be essential for a successful outcome and, in the event, they fell short of what was required.

The bridge and anchoring teams had different views on how the approach and anchoring operation was to be carried out. The master did not use the bridge team to its full capability and took on too much himself as he conned and navigated the vessel, and monitored the echo sounder. He was given little help by the officer of the watch (OOV) and he consequently became overloaded.

The vessel grounded at a speed of 6 knots while the master was still manoeuvring the vessel in the bay in search of calm water. The engine telegraph had been inadvertently left on half ahead for several minutes, and a lowered anchor failed to warn the forecastle team and therefore the bridge team they were entering shallow water.

Initial salvage attempts by a local tug were unsuccessful and the vessel was driven further aground the next day as the wind veered to blow directly into the bay. The 1172 MT of heavy fuel oil and 118 MT of gas oil onboard began leaking in to the sea. By the time a powerful salvage tug was on scene and able to assist, the vessel was hard aground and unable to be moved and she was abandoned on 25 December 2005.

An operation to remove the wreck and remaining cargo is currently underway, August 2006.



## Safety Issues:

- The problems associated with the bridge and navigation management on CP Valour were many and varied. These problems existed despite the fact that the ship's ISM system contained comprehensive operating procedures and the master and his OOW at the time of the grounding had both attended in-house bridge team management training. The procedures and training were not put into practice.

### Lesson:

**Team work is essential on the bridge - individuals easily become overloaded and make mistakes.**

- This accident highlights the problem of how ship owners and managers should effectively audit their ships to ensure the good practices promoted in procedures and in training are actually adopted on board. Many owners' and managers' auditing superintendents, including those of CP Valour, occasionally ride vessels on seagoing passages to determine the effectiveness of the bridge team working. The obvious problem is that some ships' staff may employ good practice during the audit, and revert to less than satisfactory methods once the auditor has gone. To guard against this, it is suggested that owners and managers should use other monitoring methods including recordings from GPS and electronic chart systems, and now more importantly, those from Voyage Data Recorders (VDRs). As more vessels are fitted with VDRs the auditor will have access to a good quality record of the performance and management of the bridge team, which should prove to be very useful in using auditing to ensure safety.

### Lesson:

**Owners and managers need to ensure that the good practice demanded in their ISM is always implemented at sea.**

Further details on the accident and the subsequent investigation can be found in the MAIB's investigation report, which is posted on its website:

[www.maib.gov.uk](http://www.maib.gov.uk)

Alternatively, a copy of the report will be sent on request, free of charge.

Marine Accident Investigation Branch

Carlton House

Carlton Place

Southampton, SO15 2DZ

Telephone 023 8039 5500

Email: [maib@dft.gsi.gov.uk](mailto:maib@dft.gsi.gov.uk)

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