MAIB

MARINE ACCIDENT INVESTIGATION BRANCH

FLYER TO THE SHIPPING INDUSTRY

Scot Isles collision with *Wadi Halfa*

On 29 October 2008 at 0449 (UTC+1), *Scot Isles,* a 2,600gt, UK registered general cargo vessel was on passage from the Thames estuary to Antwerp. She was crossing the NE traffic lane of the Dover Strait TSS when she was in collision with *Wadi Halfa*, a 22,900gt, Egyptian registered, bulk carrier which was heading NE in the Sandettie deep water route.

No lookout was posted on either bridge at the time of the collision. The vessels both had fully operational radars, fitted with Automatic Radar Plotting Aids, although no radar targets had been acquired by either vessel before the collision.

Scot Isles was the give way vessel in accordance with the COLREGS but, on a clear, dark night with good visibility neither vessel saw the other until moments before the collision. The watchkeeping officer on *Wadi Halfa* saw *Scot Isles* when she was very close to port, and he put the helm hard to starboard just before the collision occurred.

Image courtesy of French Customs

Image courtesy of French Customs

Damage to *Scot Isles*

Scot Isles was struck amidships and a fuel tank was breached, causing pollution, but the full extent of the damage was not discovered for some time due to ineffective post collision checks. The Coastal State subsequently directed the vessel to proceed to Dunkirk for a full damage survey and repairs, which kept the vessel out of service for several weeks.

Damage to *Wadi Halfa*, although less severe, took more than a week to repair on arrival at her next port in Germany.

Damage to *Wadi Halfa*

This accident occurred because of complacency on both vessels:

- The lookouts on both vessels were allowed to leave the bridge in an area of high navigational risk.
- In the absence of a dedicated lookout, neither OOW made best use of the available navigational aids (radar, AIS) visually to maintain an effective appreciation of the traffic situation.
- *Wadi Halfa* was using a deep water route, recommended for vessels with a draught of 16m or more, despite having a draught of less than 6m.
- Although neither master was on the bridge, standing/night orders were not used to alert the watchkeepers to the risks they were likely to encounter during their bridge watch.
- There was no encouragement for the lookout to become an integral part of the bridge team of either vessel.

Lessons learned:

- Complacency continues to be a recurring safety issue in accidents investigated by the MAIB. Shipowners should recognise the risks posed by complacency and ensure that their vessels operate with effective bridge teams at all times.
- Masters should make best use of standing/night orders to set operational benchmarks and heighten bridge watchkeepers' awareness of risk when appropriate.
- Masters must lead by example. Ships' crews are unlikely to apply the high professional standards demanded if these are not observed by the officer in overall command.
- The use of designated lookouts is an essential requirement for safe navigation, but continues to be regarded as a low priority on some vessels.
- The use of navigational aids is not a substitute for maintaining a visual lookout.

This accident was the subject of an MAIB Investigation, which can be found on MAIB's website at: www.maib.gov.uk

A copy of the report and/or the flyer 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

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