

SYNOPSIS

All times are UTC.



At 0735 on 17 October 2006, the officer of the watch (OOV) onboard the ro-ro passenger ferry *Maersk Dover*, which was en route from Dover to Dunkerque, received a VHF radio call from a deep sea pilot onboard the tanker *Apollonia*, telling him that *Maersk Dover* was passing too close. At that time, the two vessels were 1.9nm apart and, until then, *Maersk Dover's* OOV was unaware of *Apollonia's* presence, 40° on his starboard bow. The situation was exacerbated by the presence of a third vessel, *Maersk Vancouver*, which was overtaking *Apollonia* on her port side. *Maersk Dover* was making 21 knots.

A close-quarters situation developed. *Maersk Dover* took last minute avoiding action, passing 5 cables ahead of *Maersk Vancouver* and 1 cable astern of *Apollonia*.

At 0714, the master of *Maersk Dover* had handed over the con to the oncoming OOV, the 2/O. They had both identified a suitable gap between two groups of vessels prior to crossing the south-west traffic lane and, using the port ARPA display, the 2/O had acquired relevant contacts transiting that lane. Visibility was 4-5nm. A QM was employed continuously on the bridge, and at sea he was nominated as the dedicated lookout. However, on this occasion he had been allowed to continue cleaning the bridge, a task he had commenced earlier that morning while the vessel was alongside at Dover.

At 0726, a SAT C alarm sounded at the rear of the bridge. The 2/O investigated and, believing that the commercial message was important, telephoned the master to brief him on its content. He sat on the footrest of the port bridge chair to make the call and, as a consequence, his view through the wheelhouse window was considerably restricted. He finished talking to the master 5 minutes later, and then proceeded to fix the vessel's position before making a VHF radio call to Dunkerque Port.

The VHF radio call from *Apollonia's* pilot alerted the 2/O to the presence of the two vessels close on his starboard bow, by which time there had been no proper lookout maintained on the bridge of *Maersk Dover* for nearly 9 minutes.

The 2/O initially made a succession of small alterations of course to starboard using the automatic pilot, but then requested the QM to begin hand steering to manoeuvre between the two vessels. The QM was not given a helm order, or a course to steer, and instead was given broad directions on what he should do. During the manoeuvre, the 2/O noticed that neither vessel was showing on the port radar display.

Only when the 2/O overheard a VHF radio call between *Apollonia's* pilot and Dover coastguard, did he inform *Maersk Dover's* master of the incident. The master went to the bridge and, on examining the port radar display, found the automatic tuning facility was not operating correctly. By twice reverting to manual tuning, the radar picture was eventually recovered.

This was the second close-quarters situation that *Maersk Dover* had been involved in since it started cross-Channel operations in August 2006. Some of the contributory factors were common to both incidents.

Standard practice was for the master to hand over the watch to the OOW before the vessel altered course to cross the traffic separation scheme; he would then leave the bridge. Handing over at this position, particularly at night, gave the OOW little time to become fully acquainted with the traffic and navigational situation. Had the master remained on the bridge for longer, he could have provided support and advice to the OOW, and would have been better placed to monitor his performance. He might then have queried the OOW's level of experience and expertise, and doubled-up on the watch until he had achieved the necessary competence.

Although there was a QM on the bridge, available for lookout duties, poor bridge management had allowed him to become involved in other, inappropriate tasks. The situation was exacerbated when the OOW became unnecessarily distracted by the SAT C message and the conversation that followed with the master. When the OOW sat on the footrest of the bridge chair, there was no-one keeping either a radar or a visual lookout on the bridge.

Common to both incidents was the speed with which the close-quarters situation developed. The speeds of the vessels involved were in excess of 20 knots, leaving little time to take avoiding action. The OOW's ability to detect, evaluate, and then take effective action was seriously compromised by his lack of attention to, and distractions from, his watchkeeping duties.

Maersk Marine Services has been recommended, for its cross-Channel ferry operations, to:

- o Introduce procedures to ensure that before OOWs keep their first unsupervised watch: they have been assessed by the master to confirm they are fully competent to keep a safe navigation watch; and have been fully trained and locally assessed on type specific bridge equipment.
- o Identify sources of distraction for bridge watchkeepers, and introduce measures to minimise these. Such measures should include procedures for handling routine commercial message traffic away from the bridge.
- o Review the tasks and workload of masters, to allow them to spend as much time on the bridge as circumstances require.
- o In light of the increasing speed of ferries and of transiting traffic in the Dover Strait, and in view of the enhanced arrangements utilised by high speed ferries, risk assess the route to determine the optimum arrangements for the maintenance of safe navigation.