## **SYNOPSIS**

At 0147 on 5 January 2006, the UK registered container vessel *Berit* grounded on the Trindelen bank, off Gedser in the Baltic Sea. She was on passage from St Petersburg to Rotterdam, via the Kiel Canal. The master managed to refloat the ship after about an hour using the ship's own propulsion.

## **Narrative**

All times are ship's time (UTC +1)

The container feeder vessel *Berit* departed St Petersburg on 3 January 2006 partially loaded with 370 containers. The voyage began uneventfully, and on 4 January the Ukrainian 2/O completed a normal day, standing his 0000-0400 and 1200-1600 watches.

At 2345 on 4 January the 0000-0400 lookout reported to the bridge. The 2/O arrived shortly after and there was a brief handover between the second and 3/Os. The sea and weather conditions were good, with little other vessel traffic to cause concern.

At 0030 the 2/O sent the lookout down below to stand-by in the crew mess. The lookout understood this to mean he could get some rest so, after eating some food, he went to his cabin and was asleep by approximately 0100.

After the lookout left the bridge, the 2/O became distracted, initially by the VHF and subsequently by sending text messages using his mobile telephone. The ship's position was roughly checked on one occasion, as the 2/O walked passed the electronic chart display. At that time there was still some distance to run until the next planned alteration of course. It is claimed the text messaging became all engrossing, resulting in the planned course alteration at 0115 being missed, and consequently the ship grounded 32 minutes later at 0147.

The 2/O had been alerted to the imminent grounding by vibration of the ship. He rushed to the central controls, noticed the ship's speed indicated the ship had stopped, so reduced the pitch on the CPP to zero and called the master. The ship had run aground at 54° 31.17 N 012° 03.31 E.

After pumping out sufficient ballast the master, using the bow and stern thrusters as well as main propulsion, was able to refloat the vessel at 0245. After a diver survey revealed only two breaches of the hull into water ballast tanks, *Berit* was permitted to sail on to Rotterdam for temporary repair.

## **Analysis**

The grounding of *Berit* occurred because the 2/O failed to make an alteration of course in accordance with the navigational plan. The 2/O was distracted for over 40 minutes prior to the grounding, missing the required waypoint.

The investigation has been unable to prove or disprove the reported cause of the distraction and there may be other explanations why the 2/O failed to monitor the ship's progress adequately. The OOW falling asleep was considered, but was thought improbable given that fatigue was unlikely with his watch routine, and with the lack of comfortable chairs on the bridge.

Although fully aware of the requirement for a lookout to be present on the bridge, the 2/O stood down the lookout as weather conditions were good and there was little shipping traffic. There was evidence, from *Berit's* hours of rest records, that lookouts were often not used during the hours of darkness, and this had been highlighted in the last MCA ISM audit in December 2005. Neither the master nor the ship managers had noticed this problem prior to the audit. If a lookout had been present on the bridge, it is unlikely the 2/O would have become so distracted as to miss the alteration of course.

Steps had been taken on *Berit* to ensure an OOW stayed alert by the provision of a watch alarm. However, there is some evidence that the key to activate the system was not always removed, therefore permitting those on the bridge to disengage it.

Berit was also fitted with an electronic charting system (ECS). In this case, too great a reliance was placed on the basic information provided by the ECS, and the full functionality of the system was not employed. With no depth or no go areas, cross track error or waypoint alarms set on the ECS, the system was essentially passive, requiring no interaction with the OOW. The paper charts did not have regular positions marked, even though they were the primary means of navigation onboard. Fixes were recorded in the log, but these positions were only derived from the GPS. Good navigational practice requires that positions are cross-checked by independent sources. In this accident, with little demanded of the OOW, he became easily distracted and missed the required alteration of course.

*Berit*'s master was fully aware that his crew regularly used mobile telephones onboard, but was not aware of any problems as a result. Therefore, there was no active management of the use of mobile telephones while on the bridge.

The safety management system under which *Berit* was operated placed a great deal of reliance on the master. The company's ISM documentation stated that navigational practices should be in accordance with the ICS bridge procedures guide, but there were no company or master's instructions on how its principles should be applied. In this instance, the ISM system had failed to detect either the poor navigational practices or the frequent absence of a lookout at night.

## Recommendations

A recommendation has been made to the managers of *Berit* to review their ISM system to ensure that navigational practices, training with ECS and the use of mobile telephones and other personal electronic equipment are addressed.