

In this bulletin...

MARS 202601

Near disaster in fog

MARS 202602

Passenger ship side window failure

MARS 202603

Big bags cause big trouble

MARS 202604

SIMOPS slipup

MARS 202601

High speed in fog courts disaster

Seven decommissioned yet still operational small military boats had been organised to allow the public to have access and enjoy a short ride of approximately 30 minutes in the immediate area of the port. The one-day event was touted as 'A Day in Paradise'.

On the day of the event, there was thick fog in the area. The crews of all seven vessels agreed on the route to be followed. To offer the best possible experience for the passengers, the slower vessels would depart first, to be overtaken during the cruise by the fast-moving vessels. Ship A, a 45 metre former missile/torpedo boat capable of high speeds, would leave last.

A first trip was completed in the morning, but the speed of the participating vessels was reduced due to the thick fog. For the second trip, the visibility was slightly better, possibly between 100m-200 metres. At one point there was some confusion among the participating vessels. One vessel made several course alterations to avoid a close encounter, bringing it 'out of formation'. This was noticed on Ship A, which was at this point making about 30 knots.

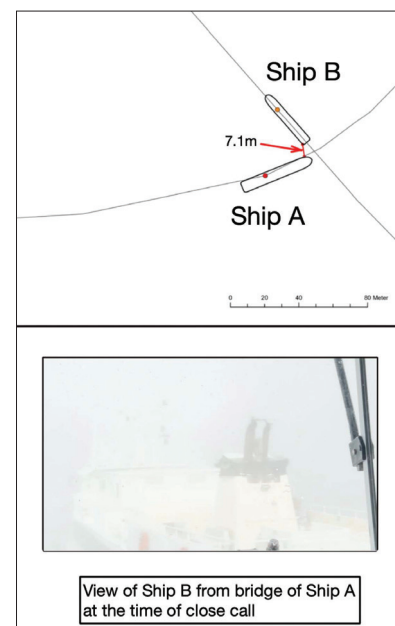
The crew on Ship A noticed another echo on the radar, which they could not identify, nor determine in which direction it was moving. The crew were unable to use the automatic plotting device available on the radar as they were unfamiliar with its full function. The Master used an app on a mobile phone to try and see if the echo was a vessel with AIS. However, the app did not show vessel symbols.

The crew of Ship A did not realise that the echo was Ship B, which was not part of the event but a regular small passenger ferry making way at

a speed of 15 knots.

Ship B's crew saw that Ship A was on a southerly course and assumed that Ship A would pass port-to-port and then astern of them. But then, Ship A turned to port to an easterly course at about 35 knots, bringing it on a collision course with Ship B. When the Master of Ship B saw that Ship A was heading directly towards them, he turned to starboard in an attempt to avoid collision. The bridge team on Ship A saw Ship B at the last minute and were unable to make any changes to their speed or direction. They passed astern of Ship B at about 7 metres distance.

The investigation found, among other things, that the reason the speed was not reduced on Ship A was that the bridge team felt the conditions were excellent for radar, where even echoes from small objects appeared clearly on the screen. The bridge team thus felt that they had control of the situation despite the dense fog. However, the high



speed meant that the OOW and the Master had very little time to perceive, discuss, and analyse the radar image. They did not understand that they had lost their situational awareness of the surrounding traffic.

Lessons learned

- Only good fortune prevented this close call from being a disaster. Given the high speed of Ship A and the fact that there were passengers on the foredeck, an impact with Ship B would probably have resulted in multiple fatalities.
- Once again, high speed in reduced visibility created a dangerous situation. Slow down in fog!
- Using a telephone app to help identify other vessels is not professional nor a recommended practice. Use proper navigation instruments to their utmost.

Editor's note: This close call is a good example of how luck plays a role in consequences and how every close call is just as significant as an actual accident. Had Ship A started to alter course to port just 0.5 seconds earlier, the vessels would have collided. The lesson to be retained: report and analyse all close calls!



As edited from SHK (Sweden) report 2025-16

MARS 202602

Wave breaks side windows of passenger ship causing one fatality

A passenger ship was on a steady northbound course travelling at a speed of about 16 knots. Although the weather was worsening, there was not much movement in the ship. Bridge crew noticed that while waves were coming from the same direction as they had been earlier in the voyage, they were now somewhat larger, but the ship was stable and did not roll much. The waves lifted the ship slightly, but they were not crashing against the side of the ship, nor were there any concerns relating to the ship's movements.

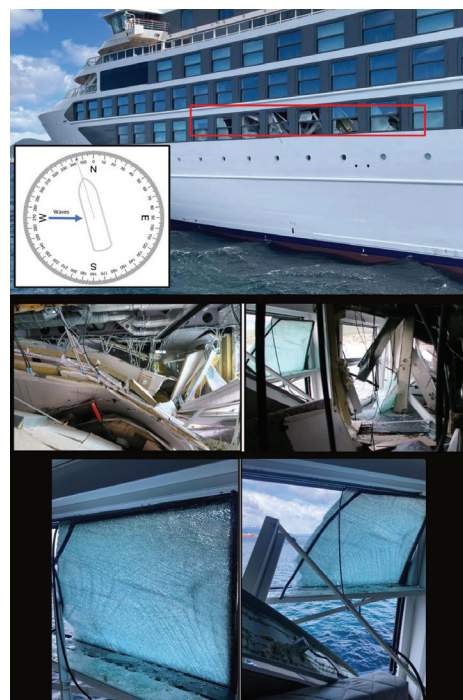
During the next half hour, sea spray reached the bridge several times. At one point, a powerful wave hit the port side of the ship. The bridge team heard a crash, and for a moment they could not see out of the bridge windows because of the wave washing up the ship.

Items fell to the floor, and the ship vibrated briefly. Several of the passengers and crew members had to brace themselves so as not to fall over, and some people fell out of chairs. Shortly after, an alarm went off indicating that the smoke detectors on deck 2 were disconnected. The staff captain went down to deck 2 to survey the situation, arriving about three minutes after the impact.

The staff captain called the bridge to inform them that there was water ingress and suggested the vessel change course immediately to reduce the waves on the port side. Crew proceeded to their posts according to the announced emergency code, and passengers began to emerge from an area of the vessel which had been damaged. Medical personnel on board were called as several of the passengers had sustained injuries.

A clearer picture of the extent of the damage became evident, and as the damage appeared to be limited to a relatively small area and the emergency was considered under control, a general muster was not initiated. Passengers were instructed to remain in their cabins, except for the passengers in the damaged area, who were instructed to proceed to deck A. It was later found that seven cabin windows on the port side of deck 2, approximately 8 metres above the waterline, had shattered when the wave struck the ship.

Onboard medical personnel confirmed that eight passengers had suffered minor physical injuries. One other passenger was found deceased in an affected stateroom. The victim was found on the deck under various parts of the damaged stateroom.



The course was set for a port of refuge, and the Master ordered the damaged area to be monitored until they arrived in sheltered waters.

The investigation found that the sea conditions at the time of the accident were within the sea states defined in the specifications to which the ship was designed, yet the wave forces acting on the windows were significantly higher than their design state.

Lessons learned

- At the time of the accident, the crew did not have sufficient information to predict the risk associated with a strong breaking wave reaching high up on the ship side.
- The current design pressure requirements for windows on a ship's side appear to yield values that are too low to withstand real-world pressure loads from breaking waves.



As edited from NSIA (Norway)
report MARINE 2023/06

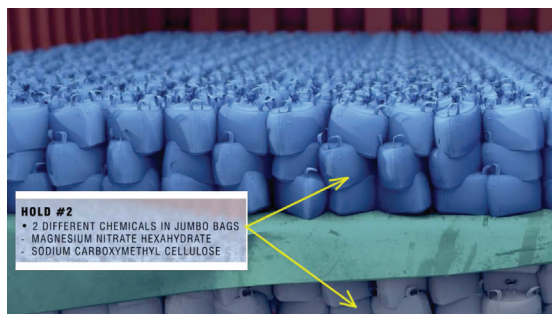
MARS 202603

Big bags cause big trouble

Bulk carriers and general cargo vessels are receiving frequent requests to load Flexible Intermediate Bulk Containers (FIBCs), also known as 'jumbo bags', in the same holds as breakbulk and steel cargoes, or to store different bagged chemicals in the same hold.

Stowing different bagged chemicals can result in chemical contamination and reactions, leading to on-board vessel fires, and the potential total loss of the entire contents of the hold.

Serious problems can also occur when FIBCs are stored incorrectly with breakbulk or steel cargoes, which can damage the integrity of the jumbo bags and cause significant spillage. Steel cargo can also



Screen capture from London P&I Club video

be damaged by exposure to spillage from the jumbo bag.

Failure to strictly comply with all relevant International Maritime Organization (IMO) regulations and guidance governing the storage and handling of jumbo bags, including SOLAS, the Cargo Securing Manual (CSM), the Code of Safe Practice for Cargo Stowage and Securing (CSS) and the IMDG Code, could prejudice P&I cover.

Lessons learned

- When developing stowage plans for FIBCs and other big bags, consider requesting advice from P&I's so that qualified industry experts can be consulted before loading.
- These cargoes may look harmless, but they can be potentially very dangerous if not stowed and handled appropriately.
- The London P&I Club made an interesting video on this topic that can be viewed here: <https://youtu.be/e0SEQkCFIbo>



As edited from London P&I Club
News Alert 30 July 2025

MARS 202604

Simultaneous operations slip-up

A tanker was in port loading. The Master requested permission from the port to carry out a boat drill. During the drill the lifeboat was lowered to the water and the motor was tested. Because the oil boom surrounding the tanker was very close to the ship, the oil boom chain became entangled in the lifeboat propellor.



The chain had to be cut to free the propellor and the oil boom was replaced. No other damage was incurred.

Lessons learned

- Avoid holding drills concurrently with cargo operation.
- Follow simultaneous operations (SIMOPS) procedures. In this case, company procedures required that the Head Office be informed and a SIMOPS risk assessment conducted, which was not done.

Thank you to all our Nautical Affiliates for their continued support



A very warm welcome to our new
Nautical Affiliate and MARS supporter,
Glorious Future Maritime Training Institute.

Our Nautical Affiliates help us make a difference
to the shipping community by ensuring that our
MARS safety scheme is available to the industry for free.
Find out more at: www.nautinst.org/affiliate