



NTSB National Transportation Safety Board

Office of Marine Safety

Empress of the North **Events Leading to** **Grounding**

Before Grounding – Master’s decision

- Senior 3rd mate falls ill 24 hours before accident
- Quarantined to room
- Master assigns junior 3rd mate to watch with “experienced” AB
- Master informed 3rd mate of watch

Required Pilotage

- Licensed pilot
- Self-certified pilot
 - Current knowledge
 - 4 roundtrips (1 trip in darkness)

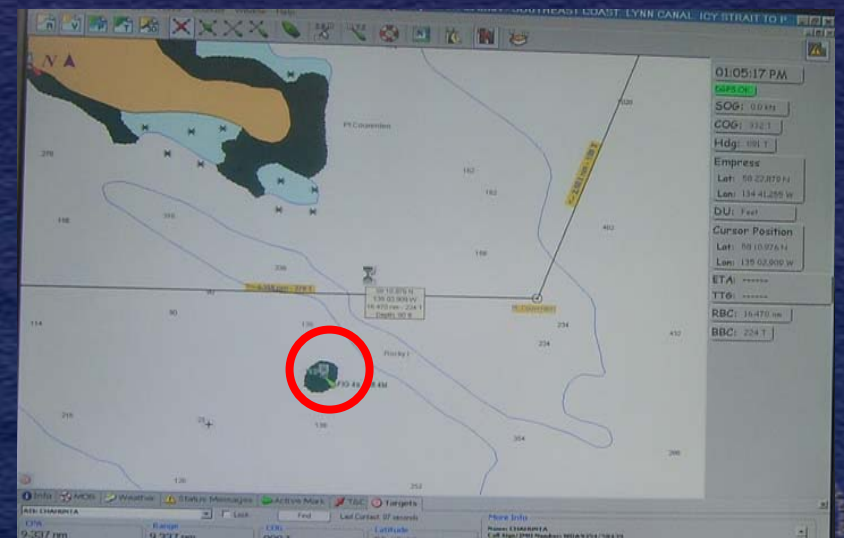
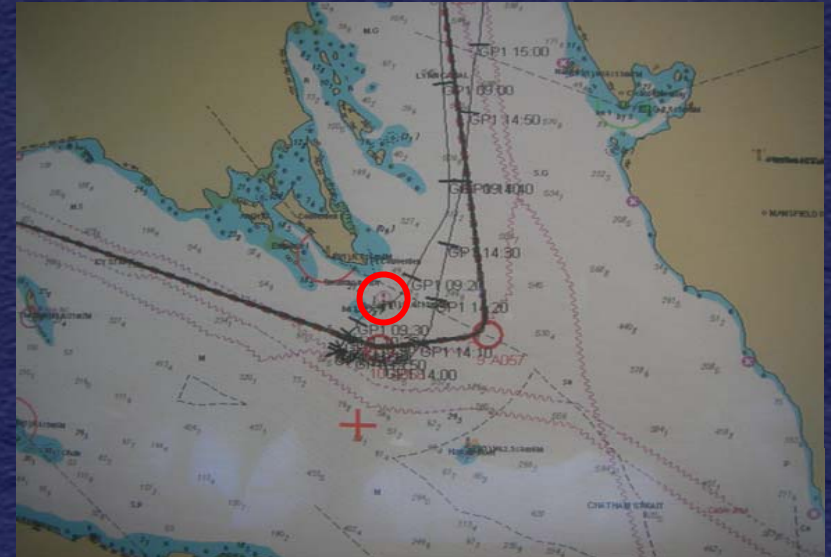
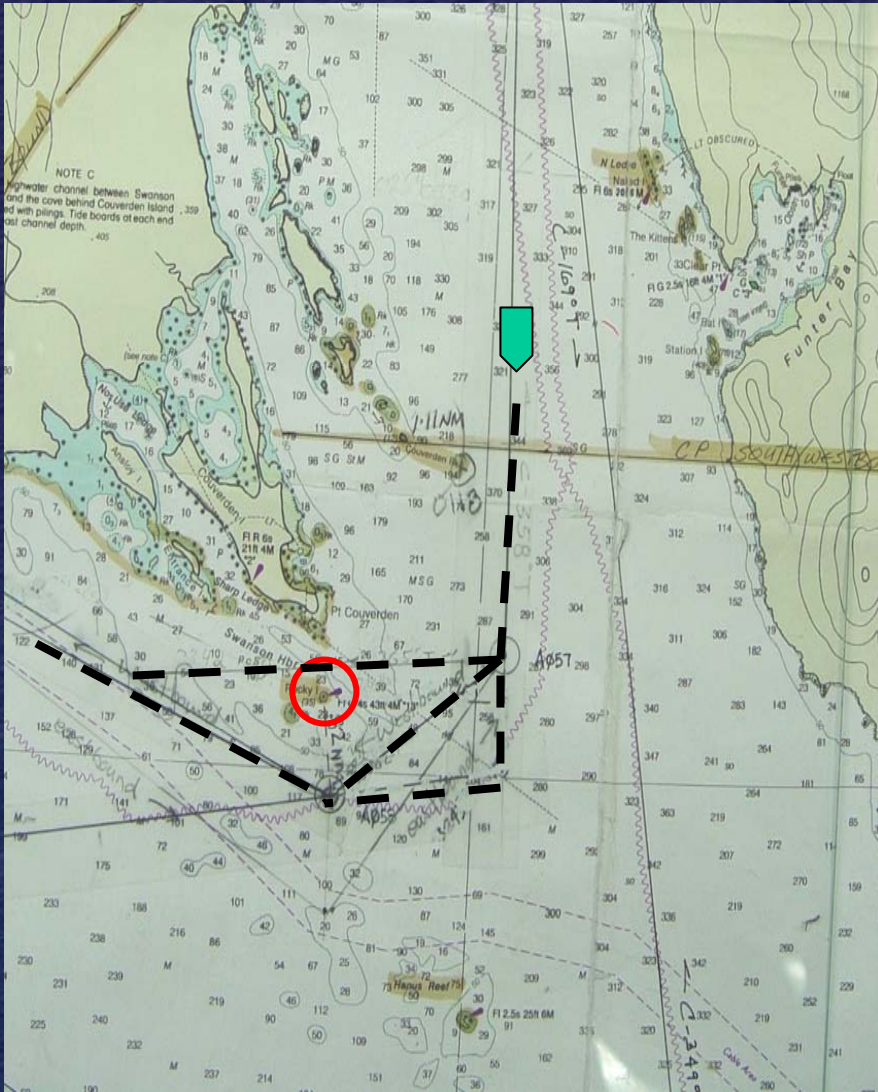
Master's Alternatives

- Call company and hire a pilot
- Split night watches between officers
- Remain on bridge for junior 3rd mate's watch
- Write specific orders

Guidance Master Could Have Provided

- Orders on when to call him
- Specific courses to follow—and positions for course change around Rocky Island
- No-go areas
- Review of planned route with junior 3rd mate on bridge

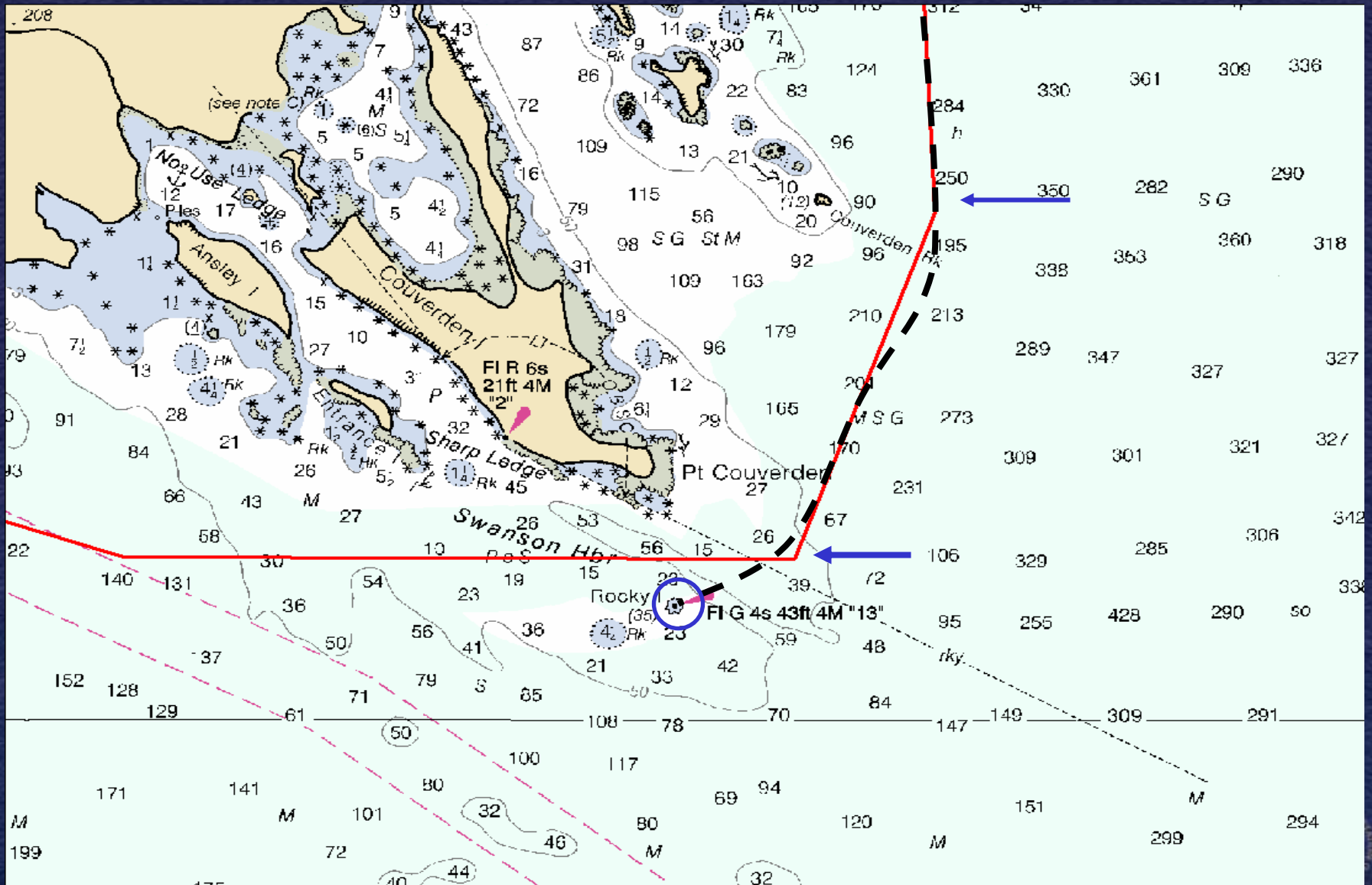
Confusing Route Options



Bridge Team Deviations from Sound Watchstanding

- Nonessential persons on bridge
- Radar
 - Scale
 - ARPA
- Not maintaining proper lookout

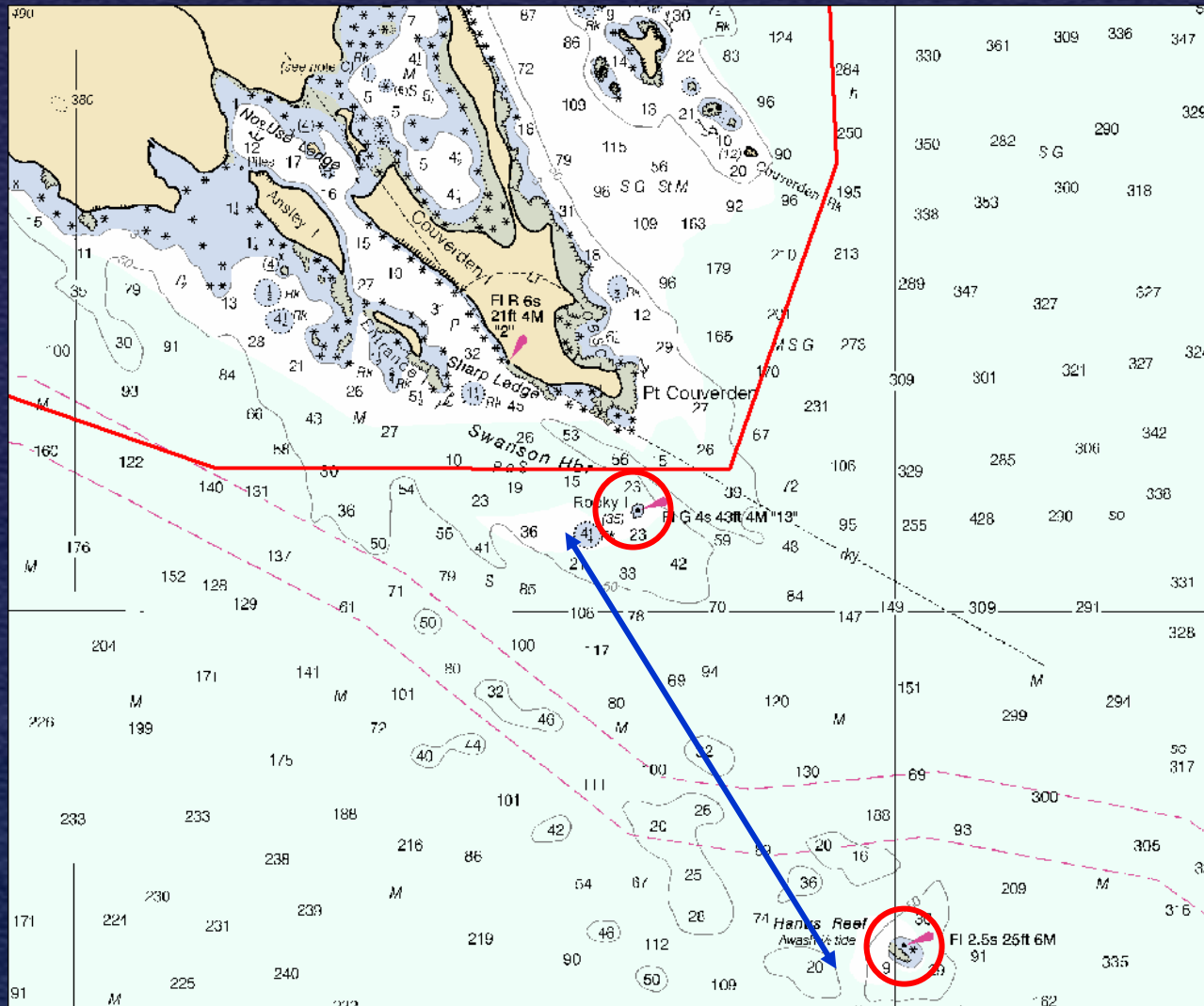
Vessel's Path



Accident Site – Rocky Island

- Only 0.5 mile of water between obstructions
- Only one clear visible reference at night
- Poor radar echoes
- Coast Pilot warning
- 3.2 miles of open water to the south

Safe Water



Failure to Execute Turn

- Lack of local waterway knowledge
- Limited knowledge of vessel's handling characteristics
- Autopilot set to insufficient turn rate
- Lack of communication between watchstanders



NTSB