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**National Transportation Safety Board**  
Washington, D.C. 20594

**Safety Recommendation**

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**Date:** AUG - 1 1995

**In Reply Refer To:** M-95-8 and -9

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About 2041 on November 6, 1993, the Netherlands Antilles passenger ship NOORDAM and the Maltese bulk carrier MOUNT YMITOS collided in international waters 3.9 miles south of the entrance to the Mississippi River near Southwest Pass, Louisiana. The NOORDAM, carrying 1,730 passengers and crew, was preparing to embark a bar pilot and proceed upriver to the Port of New Orleans. The MOUNT YMITOS was outbound from the Mississippi River, had disembarked its bar pilot, and was heading for open sea. Nine crewmembers on the NOORDAM sustained minor injuries. No one on the MOUNT YMITOS was injured, and no deaths resulted from this accident. Damage to both vessels was substantial.<sup>1</sup>

The safety fairways established in these waters are narrow and are surrounded by oil production platforms. Between 5,000 and 6,000 vessels, each exceeding 100 gross tons, transit the area annually on their way to and from ports along the Mississippi. In addition, many smaller vessels operating in the offshore oil and commercial fishing industries cross the fairways at odd angles and at unpredictable times. The Safety Board found that despite these hazardous conditions, the officers on the NOORDAM's bridge were not maintaining a proper lookout for approaching traffic, either by sight or by radar.

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<sup>1</sup> For more detailed information, read Marine Accident Report--*Collision of the Netherlands Antilles Passenger Ship NOORDAM and the Maltese Bulk Carrier MOUNT YMITOS in the Gulf of Mexico, November 6, 1993* (NTSB/MAR-95-01).

The junior third officer, senior second officer, chief officer, and master of the NOORDAM were licensed deck officers with extensive shipboard experience and training. They had attended maritime universities, and all had demonstrated professional competencies that led to their employment and advancement at Holland America. Nonetheless, basic seamanship and watchstanding discipline simply were not being observed on the NOORDAM's bridge during the 40 minutes preceding the accident.

About 2001, the senior second officer altered course to overtake another ship. He assumed that the other ship would maintain its course and speed but did not attempt to confirm this assumption by using the radiotelephone or sounding the internationally recognized whistle signals. About 2014, the other ship unexpectedly altered course into the path of the NOORDAM. The senior second officer was forced to take evasive action, became concerned about a collision, and called the master's cabin. However, neither the master nor the chief officer, who was on call, had told the senior second officer that they would be having dinner in the chief engineer's cabin. When the senior second officer received no answer, he sent the junior third officer to find either the chief officer or the master. By the time the chief officer arrived on the bridge, the NOORDAM had overtaken the other ship but was heading for a nearby cluster of oil production platforms.

About 2030, 11 minutes before the collision, the junior third officer relieved the senior second officer as officer of the watch. During the change-of-watch briefing, the two officers did not discuss plans for embarking the pilot. They did not discuss the chief officer's role during the final approach to the sea buoy. They did not discuss the proximity of vessel traffic or other hazards to navigation, including the lighted oil production platforms. Although they said that they were looking at the radar, no sighting of the MOUNT YMITOS or any of the other vessels ahead occurred during the briefing. Moreover, the chief officer was on the bridge and was scheduled to assume the conn within a few minutes. He knew that the change-of-watch briefing was taking place, but he did not participate.

About 2035, 6 minutes before the collision, the chief officer ordered the helmsman to apply right rudder and alter course to starboard toward the sea buoy. Thus, the chief officer took over the watch without a word to the junior third officer, and the junior third officer said nothing to him. The chief officer said that before beginning the turn, he had looked toward the sea buoy but did not see the MOUNT YMITOS. The MOUNT YMITOS could not have been more than 1.5 miles away and should have been clearly visible from the bridge of the NOORDAM.

The chief officer testified that after he had begun the turn, he saw the green sidelight of an approaching vessel. No one else on the bridge saw the green light, and the chief officer did not bring it to anyone's attention. The chief officer had not visually observed the vessel's masthead lights, which would have verified its heading, and he had not tracked the vessel with the ARPA or radar. Nonetheless, he assumed that the vessel was on a course parallel and reciprocal to that of the NOORDAM, that it would pass down the NOORDAM's starboard side, and that he would not have to take evasive action. The chief officer did not recognize the risk

of collision until about 2038, when the fourth officer (who was not on duty) saw the vessel's red sidelight. By then, however, the two ships were less than 0.5 mile apart and closing at a rate of about 23 knots.

The deficiencies in bridge watchstanding performance revealed by this investigation underscore the importance of maintaining bridge discipline, delegating duties consistent with navigation and traffic conditions, and detecting any deterioration in watchstanding performance that could place the vessel at risk. The bridge officers on the NOORDAM did not recognize the extent to which their performance had deteriorated.

The Safety Board is also concerned about the presence of additional people on the bridge that night. When the collision occurred, nine people--the chief officer, the senior third officer, the junior third officer, the fourth officer, the chief engineer, a deck cadet, a lookout, a helmsman, and the chief officer's wife--were on the bridge of the NOORDAM. Only four of them--the chief officer, the junior third officer, the helmsman, and the lookout--were performing duties related to navigation of the vessel. The Board has insufficient evidence to conclude that the five other persons diverted the attention of the watchstanders, but the potential certainly existed. Even when additional persons are on the bridge for legitimate purposes, such as training and management oversight, their presence should be closely controlled by the master, particularly in restricted waters and during critical maneuvers, such as embarking a pilot.

Furthermore, the Safety Board questions the master's wisdom in assigning the chief officer to conn the vessel to the pilot boarding area. The maneuver to pick up the pilot at the approach to the Mississippi River entrance presents difficulties similar to those encountered when entering port. In addition, the chief officer, who had never executed this maneuver by himself, was being asked to do so at night, when the likelihood for error would be higher because of reduced visibility. The Board concludes that the master demonstrated poor judgment by not being on the bridge during the brief transit from open sea to the pilot boarding area.

Bridge watchstanding performance on passenger ships needs to be monitored. The Board has been recommending the use of voyage event recorders (VERs) for accident reconstruction since 1976. Currently, technology has not only greatly expanded the capability of these systems but has also substantially reduced their cost. More and more companies are installing VERs for monitoring bridge watchstanding performance. For example, Princess Cruises recently installed VERs on at least seven passenger ships, and P&O Lines, Ltd., has equipped a number of cargo vessels with the systems. Since the accident, Holland America has been conducting a cost-benefit analysis of the devices for management oversight and has installed a VER on at least one passenger ship. The Safety Board encourages these efforts but believes that they should be expanded. When used for management oversight, VERs would help prevent accidents. When used for accident reconstruction, VERs would help investigators determine what measures will promote greater safety in the future. The Board therefore believes that the International Council of Cruise Lines should recommend to its membership that all vessels over 1,600 gross tons operating from U.S. ports be equipped with voyage event recorders.

Passage planning is an important aspect of safe navigation. The watchstanders on the NOORDAM had plotted a trackline that complied with the guidance in the International Chamber of Shipping *Bridge Procedures Guide* and in Section 2360 of the Holland America *Masters' and Deck Officers' Operating Regulation No. 400*. However, these two documents do not address the communication aspects of implementing the plan; that is, the fact that watchstanders need to communicate with each other and that each officer needs to know his own role during the transit and the roles of others on the bridge. The failure of the chief officer, the senior second officer, and the junior third officer to communicate important information during the 11 minutes preceding the accident left them ill-prepared to conduct a proper bridge watch. The Safety Board concludes that if passage planning standards that require a discussion between the master and the watchstanders before entering restricted waters had been developed and implemented, the risk of an accident would have been reduced. The Board believes that international standards should incorporate a requirement for such discussions and has asked the International Chamber of Shipping to do so. In the interim, the Board believes that the International Council of Cruise Lines should urge its members to revise their guidelines accordingly.

Therefore, the National Transportation Safety Board recommends that the International Council of Cruise Lines:

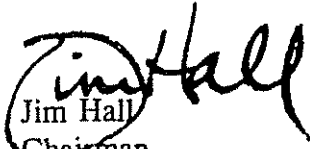
Propose to members that all vessels over 1,600 gross tons operating from U.S. ports be equipped with voyage event recorders. (Class II, Priority Action) (M-95-8)

Urge members to implement guidelines on passage planning that require a discussion between the master and his bridge watchstanders before entering restricted waters to ensure that each member of the watch understands his role and those of the other bridge team members when executing the passage plan. (Class II, Priority Action) (M-95-9)

Also, the Safety Board issued Safety Recommendations M-95-5 and -6 to the U.S. Coast Guard, M-95-7 to the International Chamber of Shipping, and M-95-10 through -12 to Holland America Line Westours Inc.

The National Transportation Safety Board is an independent Federal agency with the statutory responsibility "to promote transportation safety by conducting independent accident investigations and by formulating safety improvement recommendations" (Public Law 93-633). The Safety Board is vitally interested in any action taken as a result of its safety recommendations. Therefore, it would appreciate a response from you regarding action taken or contemplated with respect to the recommendations in this letter. Please refer to Safety Recommendations M-95-8 and -9 in your reply. If you need additional information, you may call (202) 382-6864.

Chairman HALL, Vice Chairman FRANCIS, and Member HAMMERSCHMIDT concurred in these recommendations.

By:    
 Jim Hall  
 Chairman