



The
Swedish
Club

MONTHLY SAFETY SCENARIO

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Case Study - OOW Falling Asleep on Watch

The vessel, a small bulk carrier, was loading cargo in a European port with a short onward voyage of approximately one day. The vessel operated on a 6-on/6-off watch system, with the Chief Officer assigned to the 12–6 watch.

The vessel berthed at 1800, and the Chief Officer remained on deck supervising cargo operations until 2300, when stevedoring operations ceased for the night. He subsequently went to rest and resumed duties at 0600, when loading recommenced. He continued to monitor cargo operations throughout the day until departure at 1730, after which he again went to rest.

At 2300, the Chief Officer relieved the Master on the bridge to take over the navigational watch. No lookout was posted. By this time, the Chief Officer had been awake for approximately 17 hours, having had fragmented rest during ongoing cargo operations.



After the Master left the bridge, the Chief Officer carried out a visual check for traffic and verified on radar that no vessels were in close proximity. He consumed coffee and, assessing the situation as low risk, began attending to administrative paperwork.

After approximately two hours, the Chief Officer sat down on the bridge sofa. Shortly thereafter, a loud impact occurred. He realised that he had unintentionally fallen asleep. On rushing to the bridge windows, he observed a stone wall directly ahead and understood that the vessel had run aground. The Master immediately returned to the bridge upon hearing the impact and, on recognising the situation, ordered the engines stopped. The Chief Officer appeared to be in a state of shock and did not respond coherently.

The Master instructed the Chief Engineer to sound all tanks. The Bosun reported water ingress into the



forepeak tank, while no other compartments appeared to have been breached. The Master attempted to confirm the status of internal tank valves with the Chief Officer but received no response, as he remained in shock.

The Owner was notified and instructed that the vessel should be ballasted to prevent further movement and that no attempt should be made to refloat using the vessel's own engines. Salvors were arranged, and after approximately six hours a salvage tug arrived. The vessel was successfully refloated after a further twelve hours and subsequently towed to dry dock for repairs.

No injuries or pollution were reported.

Questions

When discussing this case please consider that the actions taken at the time made sense for all involved. Do not only judge but also ask why you think these actions were taken and could this

happen on your vessel?

- Does our SMS address these risks?
- What sections of our SMS would have been breached, if any?
- What are our procedures when it comes to an officer being alone on the bridge?
- Under MLC 2006, what are the minimum rest hour requirements?
- How do we manage fatigue onboard our vessels?
- What support do we need from shore-based management when it comes to fatigue management?
- What are our procedures for the OOW conducting paperwork at sea?
- Do we need assistance from shore-based management to handle administrative workload?
- What additional training could help the crew be better prepared for a situation like this?
- What support do we need from management (additional training, updated procedures, more resources) to strengthen our procedures?
- What immediate, actionable steps can we take from today's discussion?