It was announced on 10 June from Washington that the National Transportation Safety Board (NTSB) determined that Miss Susan, a shallow draft towing vessel with two barges, and Summer Wind, a deep draft bulk carrier, collided on 22 March 2014, because the towing vessel crossed the Houston Ship Channel, impeding the passage of the bulk carrier that was transiting inbound, which could only transit within the channel.

This collision resulted in the release of 168,000 gallons of fuel into the Houston Ship Channel from the breach of the forward barge and the hospitalization of two crewmembers in Miss Susan for inhalation-related injuries. As a result, the NTSB recommended that crews in vessels transporting hazardous materials receive appropriate training, personal protective gear, and access to direct-reading air monitoring equipment.

Prior to the accident, visibility in the Houston Ship Channel was restricted and nearby there was towing vessel traffic. Contributing to the accident was the failure of Summer Wind’s master and the Houston pilot on board Summer Wind to set a safe speed or discuss the tow traffic in the waterway. Also, the captain in Miss Susan and the Houston pilot failed to establish early radio communication as they transited through Bolivar Roads Precautionary Area, a high traffic area which includes several intersecting waterways and requires vessels to navigate with caution.

At the time of the accident, Summer Wind, which was travelling at full speed, 12 knots, had little room to manoeuvre. The margin of safety would have increased with a slower transit speed. However, according to navigation rules, Miss Susan should not have crossed the main channel ahead of Summer Wind.

Following its investigation, the NTSB made a recommendation to the US Coast Guard to develop and implement a policy to ensure adequate separation of vessels in the precautionary areas in the Houston Ship Channel. The report also made a recommendation to graphically delineate precautionary areas on appropriate Houston Ship Channel nautical charts so they are readily identifiable to mariners.

The report also noted that leading up to the accident, the US Coast Guard Vessel Traffic Service staff was monitoring several radio channels simultaneously. The watch standers missed the radio communications about the developing close quarter situation.
Commented NTSB Chairman Christopher A Hart: ‘A safe transit through congested waterways requires a team effort’.