Handling alarms on the bridge – a DP incident

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This incident may also be included as part of the IMCA DP incident report.

What happened?

While a vessel was recovering scrap metal using an ROV and a crane, an alarm was triggered. The DPO attempted to silence it from the aft command panel and Bridge Alarm System without success. The DPO moved to the forward station (where the alarm originated) but was also unable to silence it there. While attempting to press the silence button on the forward command panel, he accidentally pressed the adjacent "Take" button on the DP panel.

Upon returning to the DP station, the vessel was found in manual LEVER mode instead of DP Mode. Amber alerts were issued to the ROV and crane; the ROV began returning to the TMS, and the crane lifted off the seabed.

Although the situation was quickly brought under control, it is important to note that the outcome could have been significantly more serious had this occurred during a more critical phase of the operation.

- Uncontrolled movement distance: 10 meters
- Event duration: 5 minutes
- Time to regain control: 2 minutes

Why did it happen?

- The bridge experiences a high volume of alarms from various systems (automation, bridge watch, NAV lights, ARPA, AIS etc), all routed through a single alarm system. This contributes to alarm fatigue and potential alarm blindness.
- The Bridge Alarm System panel was known to freeze. During the incident, the forward panel was frozen, and the source of the alarm could not be identified.

- The alarm silencing process is inconsistent, with options to silence via either the Bridge Alarm System panel or the manoeuvring station. In this case, the “Take” command button—located next to the “Silence” button—was mistakenly pressed. Although the “Take” button requires a double press to activate, It has been observed that multiple presses are sometimes used when attempting to silence alarms, which has been noted and discussed onboard as part of routine operational feedback.

Lessons learned

- This incident highlights the risk of human error during alarm handling, particularly when control panels have critical functions assigned to closely positioned buttons. The consolidation of multiple alarm sources into a single system can contribute to alarm fatigue, making rapid and accurate responses more difficult.
- The situation also emphasized the importance of clear system feedback and reliable alarm panel functionality. In this case, a frozen alarm panel and uncertainty regarding the alarm’s origin further complicated the response.
- A positive takeaway was the DPO’s openness in acknowledging that he may have pressed the wrong button—a conclusion supported by the DP event log confirming a command change. It shows the important of No-blame culture, which encourages transparent reporting and honest reflection. Such openness is essential to fully understand what occurred and to identify opportunities for learning and improvement.
- While the DPO team is experienced and safety-focused, this event reinforces the ongoing need for vigilance, user-friendly system design, and regular procedural reinforcement—even among highly capable crew.