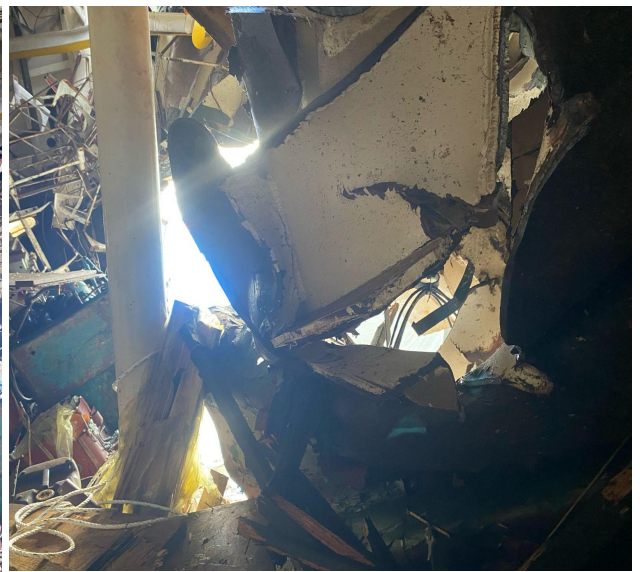
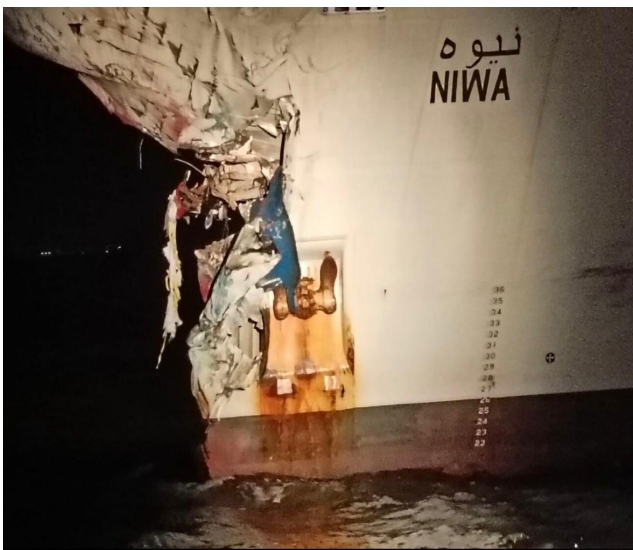
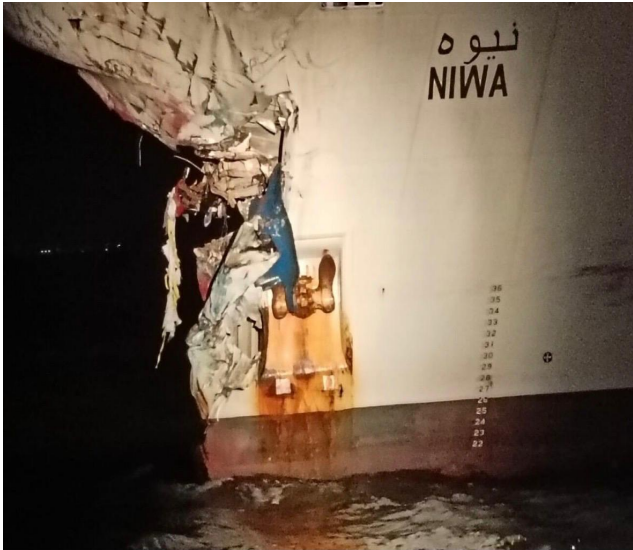


Photos Of Papu After Collision With Cable Ship NIWA



Photos of Cable Ship NIWA after Collision with Container Ship M.V PAPU





**GOVERNMENT OF PAKISTAN
MINISTRY OF MARITIME AFFAIRS
(PORTS & SHIPPING WING)**

*** **

No.3(1)/2025-CNS/DGPS/INQUIRY/C.S NIWA-MV PAPU/2026 Karachi, 30th July, 2026

MARINE CASUALTY INQUIRY REPORT

Collision between M.V. PAPU and C.S. NIWA

Date of Casualty: on 28 May 2026 at 1950 PST (Pakistan Standard Time- UTC + 5 Hrs.)

Location: Approaches to Karachi Port, Pakistan

Classification: Very Serious Marine Casualty

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1. INTRODUCTION AND AUTHORITY

1.1 Authority for Investigation

This Inquiry into the marine casualty involving collision between the Liberian flagged vessel **M.V. PAPU** (IMO No. 9377561) and UAE flagged vessel **C.S. NIWA** (IMO 8819029) was initiated by the Directorate General Ports & Shipping (DGPS) in accordance with **Sections 470 and 471 of the Merchant Shipping Ordinance, 2001**.

The investigation was conducted under the direction of Principal Officer Mr. Muhammad Faisal vide letter No.1-89/MMD/2025 dated 02-June 2026, along with Engineering and Ship Surveyor Mr. Raja Fawad Ali.

1.2 Classification of Casualty

The occurrence is being treated as a **"Very Serious Marine Casualty"** for investigation purposes, in line with the IMO Casualty Investigation Code (Resolution MSC.255(84)) and relevant SOLAS provisions. The investigation aims to ascertain the facts and circumstances surrounding the casualty and to determine the causal factors to prevent recurrence.

1.3 Investigation Team

Name	Designation	Role
Capt. Rafaqat Hussain	Chief Nautical Surveyor	Lead Investigator
Raja Fawad Ali	Engineering Surveyor	Assisting Investigator

The investigation team boarded M.V. PAPU on **08 June 2026** at outer Anchorage and C.S. NIWA on **16 June 2026** at KPT Berth No.5 to conduct Port State Control Inspection and commence the statutory marine casualty investigation.

2. SHIPS DETAILS

2.1 M.V. PAPU

Particulars	Details
Ship Type	Container Ship
Year Built	2008
Built Place	HDW-KIEL, GERMANY
Owner	NARA SHIPPING AND TRADING LTD
Managing Owner	TOBA SHIP MANAGEMENT CO. LTD
Class	Bureau Veritas (B.V)
Registry Flag	LIBERIA
Registry Port	MONROVIA
Int. Call Sign	5LVK2
IMO Number	9377561
Length Over All	215.5 M
Breadth Moulded	29.80 M
Depth Moulded	16.50 M
Summer Draft	11.55 M
Int. Gross Tonnage	28,048
Int. Net Tonnage	14,101
Int. Dead Weight	38,069 T
Displacement	49,131 T
Container Capacity	2,702 TEU
Main Engine	MAN B&W 7L70MC-C (21,770 kW)
Thrusters	1,200 KW (Min. Draft Fwd=5M)

Particulars	Details
Propeller	Fixed Propeller

2.2 C.S. NIWA

Particulars	Details
Ship Type	Cable Ship
Year Built	1991
Built Place	Keppel Far East Livingston Shipbuilding Limited, Singapore
Owner	E-Marine PJSC, PO Box 282727, Dubai, UAE
Managing Owner	E-Marine PJSC, PO Box 282727, Dubai, UAE
Class	RINA - 93112
Registry Flag	United Arab Emirates
Registry Port	Abu Dhabi 4963
Int. Call Sign	A6E 2964
IMO Number	8819029
Length Over All	145.66 m
Breadth Moulded	21.60 m
Depth Moulded	11.30 m
Summer Draft	8.08 m
Int. Gross Tonnage	13,201
Int. Dead Weight	7,900 mt
Displacement	16,375 mt
Main Engines	2 x 4,700 HP General Electric

Particulars	Details
Thrusters	2 x 1,970 HP Controllable Pitch Propellers

3. CHRONOLOGICAL SEQUENCE OF EVENTS

3.1 M.V. PAPU - Departure and Navigation

Time (LT)	Event
1054	Vessel alongside (starboard side) - AIS status 'MOORED'
1124	Commenced cargo operation
1715	Notice to Engine Control Room
1800	Pre-departure checklist completed
1815	Cargo operations completed
1820	Pilot onboard <i>from</i> shore side
1825	Pilot on bridge / Master and Pilot exchange / 3 persons on bridge (Master, Pilot, Chief Officer)
1850	Tug fast
1855	Vessel cast -off and AIS status 'UNDERWAY'
1905	Tug off / Helmsman on bridge
1924	Pilot disembarked in position Lat: 24° 47.7'N Long: 066° 58.9'E
1930	Changed course to 150°(T)
1935	M.V. PAPU entered the fairway channel maintaining course of 220°(T)

Time (LT)	Event
1948	M. V. PAPU and M.V. NIWA in close quarter situation - Executed last command 'HARD STARBOARD'
1950	Collision occurred
1954	OOW made public address - vessel in collision. Crew assisted and checked extent of damage
2000	Port Control called M.V. Papu and asked if vessel needed tug assistance. Vessel replied not necessary

3.2 C.S. NIWA - Approach and Navigation

Time (LT)	Event
1800-1815	Received instructions from Karachi Port Control to heave up anchor and proceed to Pilot Station
1825	Anchor secured in hawse pipe, commenced proceeding toward Pilot Station
1915	Received instructions from Port Control and Pilot to proceed directly inside the channel
1915	Master and Chief Officer observed outbound M.V. PAPU
1915	Multiple attempts made to contact M.V. PAPU on VHF Channels 12 and 16 – No response received
1948	Close quarter situation developed
1955	Master ordered Full Astern propulsion and Hard to Port rudder
1955	Collision occurred
2000	KPT Tugs dispatched (M.T. LYARI, M.T. KHARADAR, M.T. KEAMARI, M.T. MITHADAR)
2040	Pilot boarded C.S. NIWA

Time (LT)	Event
2130	Permission to berth granted
2235	Tug fast aft
2240	Harbour Master boarded the vessel
2300	Tug fast forward
2315	First line ashore
2350	All lines made fast - Vessel safely berthed at Berth No. 5 (<i>East Wharf</i>)

3.3 Post-Collision Events - M.V. PAPU

Time (LT)	Event
2123	Commenced drifting position Lat: 24°42.5N Long: 066°48.0E
2224	Finished drifting position Lat: 24°42.48N Long: 066°48.48E
29 May 0124	Engine start, vessel underway
0212	Start drifting position Lat: 24-43.9N, Long: 066-55.7E
0842	Engine start, vessel underway
0906	Commenced drifting position Lat: 24°38.5'N, Long: 066°52.2'E
1100	Engine start, vessel underway
1131	Commenced drifting position Lat: 24° 38.2N Long: 066°52.7E
1230	End of drift, vessel underway proceeding to anchorage 'C'
1300	Vessel at anchor position Lat: 24°37.93N, Long: 066°55.04E

4. POSITIONS OF PILOT BOARDING AND DISEMBARKING

4.1 M.V. PAPU

Event	Position	Time
Pilot Boarding	Shore Side, Karachi	1820 LT
Pilot Disembarkation	Lat: 24°47.7'N, Long: 066°58.9'E	1924 LT

4.2 C.S. NIWA

Event	Position
Anchor Position (Prior to getting underway)	Karachi Anchorage
Pilot Boarding (Post-Collision)	Collision position / Channel approach

5. COLLISION ANALYSIS

5.1 Circumstances of Collision

The collision occurred at **approximately 1950 hours PST on 28 May 2026** at the entrance of Karachi Channel, near the 1st set of buoys (1 and 2) before the Fairway buoy.

Vessel Movements at Time of Collision:

Vessel	Course	Speed	Position
M.V. PAPU	Outbound (220°)	~14.5 knots	Channel center/Stbd side
C.S. NIWA	Inbound (NE direction ~060-067°)	~8.1 knots (reduced to 7.8 knots)	Approaching channel

5.2 Point of Impact

M.V. PAPU: Damaged on starboard bow area

C.S. NIWA: Damaged on forward port & Stbd bow area (Frame 160 to Frame 220)

Damage Extent - C.S. NIWA:

Port Side: Frame No. 185 to 220 (Extensive Damage)

Starboard Side: Frame No. 180 to 220 (Extensive Damage)

Frame No. 160 to 180: Damage to Shell Plating & Structure

5.3 Environmental ConditionsParameter	Condition
Tide	Low Water: 1445 Hrs (1.62m); High Water: 2024 Hrs (2.67m)
Weather	Wind South-Westerly 15 Knots
Swell	Approximately 1.5 meters
Visibility	Clear

6. WHAT WENT WRONG - M.V. PAPU

6.1 Immediate Causes

a) Failure to Comply with Pilot's Instructions

The outbound Pilot Mr. Abid Mehmood (P. No. 12804) disembarked M.V. PAPU inside the channel before the (*designated*) Pilot station due to bad weather. The Pilot advised M.V. PAPU on VHF Channel 12 to leave the channel after passing Buoy No. 8 and keep herself out of the channel on her own starboard side to allow for inward traffic. The Master **ignored this direction** and continued on his passage track.

b) Failure to Take Collision Avoidance Action

M.V. PAPU maintained a speed of approximately **14.5 knots** and did not take any action to reduce speed or change course until the close quarter situation developed. According to the International Regulations for Preventing Collisions at Sea (COLREGs), PAPU was the **Give Way vessel** as NIWA was on her starboard side (Rule 15 - Crossing Situation).

c) Inadequate Lookout

The bridge team consisted of Master, OOW (Chief Officer), and Helmsman. **There was no dedicated lookout posted.** This constitutes a violation of **COLREG Rule 5** (Proper Lookout).

d) Over-reliance on AIS and Failure to Use Radar

The Chief Officer stated that C.S. NIWA could not be seen visually because she was behind the navigation buoys (1st set No. 1 and No. 2) and was showing "At Anchor" status on AIS, though actually approaching at ~8.1 knots. The bridge team was **not using radars for navigation** but relying on AIS information.

e) Failure to Respond to VHF Calls

M.V. PAPU **did not reply to any VHF calls** from C.S. NIWA on Channels 12/16.

f) Bridge Team Distraction

The bridge team appeared distracted by unknown activities or failed to anticipate that collision was possible despite observing C.S. NIWA.

6.2 Root Causes

a) Poor Bridge Resource Management (BRM)

No proper Master-Pilot information exchange followed

Pilot's advice was disregarded without proper justification

No effective monitoring of the developing situation

Inadequate communication among bridge team members

b) Navigational Errors

Over-reliance on AIS data without radar confirmation

Failure to maintain proper lookout

Failure to use all available navigational aids effectively

Misinterpretation of AIS information (NIWA showing "At Anchor" status)

c) Failure to Comply with COLREGs

COLREG Rule	Requirement	Violation
Rule 5	Proper Lookout	No dedicated lookout posted
Rule 7	Risk of Collision	Failed to assess risk properly
Rule 8	Action to Avoid	No timely action taken

COLREG Rule	Requirement	Violation
	Collision	
Rule 15	Crossing Situation (Give Way)	Failed to keep clear of vessel on starboard side
Rule 16	Action by Give-Way Vessel	No early and substantial action taken
Rule 17	Action by Stand-On Vessel	(Applicable to NIWA)

d) Failure to Comply with SOLAS Requirements

SOLAS Chapter V Regulation 15 - Bridge design, arrangement of bridge equipment, and procedures: Inadequate bridge resource management

SOLAS Chapter V Regulation 26 - Navigation: Failure to use radar and ARPA effectively

e) ISM Code Violations

Section 6 - Resources and Personnel: Inadequate training and competency of bridge team

Section 7 - Development of Plans for Shipboard Operations: No effective passage plan adherence

Section 8 - Emergency Preparedness: Inadequate response to developing emergency

6.3 Summary of M.V. PAPU Failures

COLREG Violations: Rules 5, 7, 8, 15, 16

SOLAS Violations: Chapter V Regulations 15 and 26

ISM Code Violations: Sections 6, 7, 8

Pilotage: Disregard of pilot's advice

Navigation: Failure to use radar; over-reliance on AIS

Watchkeeping: No dedicated lookout

Communications: Failure to respond to VHF calls

7. WHAT WENT WRONG - C.S. NIWA ?

7.1 Immediate Causes

a) Failure to Update AIS Status

C.S. NIWA **failed to change AIS status from "At Anchor" to "Underway using engine"** after getting underway. This caused confusion for M.V. PAPU's bridge team, who believed NIWA was at anchor. This is a violation of **SOLAS Chapter V Regulation 19** regarding AIS carriage and use.

b) Last Moment Improper Maneuver

Just before collision, the Master ordered **"Hard to Port"** which was a not prudent action as a good practice of Seaman ship

c) Failure to Take Early Action

Despite observing M.V. PAPU, C.S. NIWA **did not take early avoiding action**, relying on her status as the stand-on vessel. (*violation of Rule 2 and 17*)

d) Failure to Reduce Speed

C.S. NIWA **did not reduce speed** until the last moment (Full Astern ordered just before collision). Speed at collision was 7.8 knots.

e) Failure to Maintain Effective Radar Watch

Although both vessels were fitted with operational radar and ARPA equipment, the available evidence indicates that these aids were not effectively *used* for continuous target acquisition, risk assessment and collision avoidance. Excessive reliance on AIS information reduced the effectiveness of the bridge team's situational awareness.

f) Ineffective Bridge Resource Management (BRM)

The bridge teams failed to effectively share information, challenge navigational decisions or collectively monitor the developing close-quarters situation. Proper application of Bridge Resource Management principles may have prevented the collision.

g) Failure to Verify Electronic Navigation Information

Bridge teams relied primarily upon AIS information without adequately cross-checking radar, visual observations and ECDIS information as required by SOLAS Chapter V and accepted principles of good seamanship.

h) Inadequate Risk Assessment

Neither vessel carried out a dynamic navigational risk assessment when it became apparent that both vessels would meet in the narrow channel entrance under restricted maneuvering conditions.

7.2 Root Causes

a) Complacency

The Master and bridge team of C.S. NIWA, knowing they were the stand-on vessel, became complacent and **did not take timely avoiding action** despite observing the developing dangerous situation.

b) Improper AIS Management

Failure to update AIS status is a serious breach of navigational practice and SOLAS requirements.

c) Poor Decision Making

"Hard to Port" order at the last moment was *not prudent*

Failure to take early avoiding action despite having time

No consideration of Rule 17(a)(ii) - allowing stand-on vessel to take action when it becomes apparent give-way vessel is not taking appropriate action

d) Inadequate Monitoring

Despite having the outbound vessel in sight, the bridge team did not adequately monitor the developing close quarter situation.

e) Deficiencies in Safety Management System (SMS)

The investigation indicates that bridge procedures prescribed under the ISM Code were either not fully implemented or not effectively supervised, particularly regarding Bridge Resource Management, Master's standing orders and navigation in confined waters.

f) Human Factors

The occurrence demonstrates the influence of human factors including expectation bias, overconfidence, complacency and reduced situational awareness, resulting in delayed decision-making.

g) Inadequate Master's Oversight

The Masters of both vessels did not exercise sufficient command oversight to ensure timely compliance with COLREGs and safe navigational practices during the developing close-quarters situation.

h) Failure to Apply Good Seamanship

Although the COLREGs establish legal responsibilities, both bridge teams failed to exercise prudent seamanship by taking positive and early action to avoid collision.

7.3 Summary of C.S. NIWA Failures

COLREG Violations: Rule 17 (Stand-on vessel action when give-way fails to act)

SOLAS Violations: Chapter V Regulation 19 (AIS status not updated)

ISM Code Violations: Sections 6, 7, 8

Navigation: Improper AIS management; last moment wrong maneuver

Complacency: Failed to take early action despite being aware of danger

8. DAMAGE ASSESSMENT

8.1 M.V. PAPU Damage

Hull breach damage **above the water line** on starboard bow area

Three containers lost overboard (2 x 40' + 1 x 20')

Containers did not contain IMDG cargo

No water ingress, no ballast tanks damaged

Vessel remained afloat

Temporary repairs completed as per class requirements

Flag administration granted one voyage dispensation to Türkiye for permanent repairs

Vessel speed limited to 10 knots, significant wave height limited to 2.5m

8.2 C.S. NIWA Damage

Extensive collision damage to forward section between **Frame No. 160 and Frame No. 220:**

Structural Damage:

Bow structure severe deformation, tearing, crushing

Substantial distortion of hull form (above and below waterline)

Multiple shell plates fractured and folded inward

Frames, web structures, brackets, stiffeners, bulkheads damaged

Collision bulkhead fully damaged

Forepeak tank collapsed

Outfitting Damage:

A-Frame foundations damaged

Sheave and associated structure damaged

Mooring chocks and fairleads damaged

HPU (Windlass and Bow Thrusters) damaged

Power cables, piping, ducting damaged

Lighting and fire alarm systems damaged

Various electrical equipment and spare parts damaged

8.3 Vessel Status

Vessel	Status	Location
M.V. PAPU	Detained, released for single voyage to Turkiye	Sailed out on 23 rd july2026 (Karachi → Turkiye)
C.S. NIWA	Under detention, undergoing temporary repairs	Awaiting owner's instructions (KPT berth no.5)

9. REGULATIONS BREACHED

9.1 International Regulations for Preventing Collisions at Sea (COLREGs) 1972

By M.V. PAPU:

Rule	Description	Violation
Rule 5	Proper Lookout	No dedicated lookout posted
Rule 6	Safe Speed	Excessive speed (14.5 knots) in confined channel
Rule 7	Risk of Collision	Failed to properly assess risk
Rule 8	Action to Avoid Collision	No timely action taken
Rule 15	Crossing Situation	Failed to keep clear as give-way vessel
Rule 16	Action by Give-Way Vessel	No early and substantial action
Rule 17(a)(ii)	Action by Stand-On Vessel	(Not applicable - was give-way)

By C.S. NIWA:

Rule	Description	Violation
Rule 5	Proper Lookout	Inadequate monitoring
Rule 17(a)(ii)	Stand-On Vessel Action	Failed to take action when give-way failed to act

9.2 SOLAS 1974 (as amended)

Chapter/Regulation	Requirement	Violation
Chapter V Reg 15	Bridge design, equipment arrangement, procedures	Inadequate BRM on both vessels
Chapter V Regulation 22	Navigation Bridge Visibility	(where applicable if visibility from the bridge was affected by container loading)
Chapter V Reg 19	Carriage and use of AIS	NIWA failed to update AIS status
Chapter V Reg 26	Navigation	PAPU failed to use radar effectively
Regulation 27	Nautical Charts and Publications	(if ECDIS route monitoring was not effectively employed)
Chapter II-1 Reg 3-1	Structural integrity	Both vessels sustained structural damage

9.3 MARPOL 73/78

Annex/Regulation	Requirement	Violation
Annex V (Garbage)	Prohibition on discharge of garbage, including plastics and cargo residues, into the sea	No violation -- the three containers lost overboard from M. V. PAPU did not contain IMDG cargo or harmful substances, and no garbage or pollutant discharge was reported. Accidental loss of containers is not classified as a deliberate disposal under MARPOL.
Not otherwise applicable	--	No pollution reported from either vessel.

Note: Although three containers (2 x 40' and 1 x 20') were lost overboard from M.V. PAPU, they were confirmed to contain no IMDG dangerous goods or MARPOL-defined pollutants. No oil, chemical, sewage, garbage or other harmful substance was released into the marine environment. Consequently, no MARPOL 73/78 violation has been identified in respect of this casualty.

9.4 ISM Code

Section	Requirement	Violation
Section 5	Master's Responsibility and Authority	Gross negligence by Master
Section 6	Resources and Personnel	Inadequate training/competency (both vessels)
Section 7	Shipboard Operations	Poor passage plan adherence (PAPU)
Section 8	Emergency Preparedness	Inadequate emergency response (both vessels)
Section 10	Maintenance of Ship and Equipment	Equipment not properly maintained/used (PAPU - radar not used)
Section 12	Company verification, Review and Evaluation	Recommending Internal Audits

10. POSITIVE FACTORS AND WHAT WENT RIGHT?

10.1 General Overview

Despite the severity of the collision and the significant structural damage sustained by both vessels, a number of critical factors prevented this casualty from escalating into a catastrophic disaster involving loss of life, total loss of vessels, or environmental pollution. The following positive elements must be acknowledged and recorded.

10.2 Preservation of Life - No Injuries or Fatalities

The most significant and commendable positive outcome of this incident was that **there were zero fatalities and zero personal injuries** on board either vessel. Despite the violent impact which caused severe structural deformation and damage to compartments, all crew members on both M.V. PAPU and C.S. NIWA remained safe. The crew of both vessels either remained at their emergency stations or were quickly mustered, and no personnel were reported missing, fell overboard, or sustained physical trauma during or immediately after the collision.

10.3 Vessel Stability and Watertight Integrity

Both vessels sustained hull damage **strictly above the waterline**. This was a critical positive factor:

M.V. PAPU: The hull breach on the starboard bow was above the waterline. Cargo hold No. 1 remained dry, and no ballast tanks were breached. The vessel maintained positive stability throughout the post-collision period.

C.S. NIWA: Despite extensive structural deformation and collapse of the forepeak tank, the vessel did not experience uncontrolled flooding of the main machinery spaces or engine rooms. The watertight integrity of the vessel was preserved below the waterline, which prevented the vessel from sinking and allowed it to proceed to berth under its own power.

10.4 Strategic Proximity to Port and Immediate Rescue Accessibility

The collision occurred in the immediate approaches to Karachi Port, in close proximity to the first set of buoys and the fairway buoy. This strategic location was highly advantageous and contributed significantly to the positive outcome:

Emergency response assets (tugs, pilot boats, and rescue teams) were able to reach the vessels within minutes.

Port authorities could maintain continuous visual and radar contact with both vessels throughout the emergency.

10.5 Commendable Response by Karachi Port Trust (KPT)

The Karachi Port Trust demonstrated an **exemplary and commendable** emergency response. Within minutes of the collision being reported on VHF Channel 12:

Four KPT tugs were dispatched immediately: M.T. LYARI, M.T. KHARADAR, M.T. KEAMARI, and M.T. MITHADAR.

The Harbour Master activated emergency protocols and coordinated seamlessly with the **Pakistan Maritime Security Agency (PMSA)**, **Pakistan Navy**, and **Pakistan Coast Guards**, placing all relevant authorities on standby for potential rescue or recovery operations.

The Vessel Traffic Services (VTS) maintained continuous communication and provided navigational guidance to both vessels.

Navigational warnings were promptly promulgated to alert other shipping in the area about the containers lost overboard.

The systematic and efficient handling of the emergency, from the initial distress call to the safe berthing of C.S. NIWA at 2350 hours, reflects the good standards of port emergency management.

10.6 Effective Technical Response and Engineered Resilience on C.S. NIWA

The engineering department on board C.S. NIWA responded swiftly and professionally:

All **three main generators remained running in parallel** throughout the emergency, ensuring uninterrupted power supply.

All **thrusters remained operational**, allowing the vessel to maintain manoeuvrability despite significant forward damage.

The Chief Engineer immediately assigned engineers to prepare fire pumps and ballast pumps as a precaution against fire or water ingress.

The electrical and air supply to the damaged forward area was promptly isolated to mitigate further risks.

Soundings of all tanks were taken immediately, confirming that there was no progressive flooding.

10.7 Complete Absence of Environmental Pollution and Hazardous Cargo

This incident could have resulted in an environmental catastrophe had the lost containers contained dangerous goods or had hull breaches caused fuel oil spills. However:

The three containers lost overboard from M.V. PAPU were confirmed to **contain no IMDG dangerous goods or marine pollutants**.

There was **no oil spill, fuel leakage, or release of any hazardous substance** from either vessel.

The absence of pollution prevented significant environmental damage to the marine ecosystem of Karachi and the Arabian Sea and avoided a costly and complex clean-up operation.

10.8 Safe Post-Collision Navigation, Anchorage, and Berthing

Despite the collision damage:

C.S. NIWA was safely piloted and escorted into port, successfully executing berthing operations with tugs and being made all fast at Berth No. 5 East Wharf by 2350 hours.

M.V. PAPU maintained positive stability, executed an orderly drift at a safe distance from the channel, and subsequently proceeded to anchorage 'C' under her own power without further incident.

Both vessels remained in a stable and controlled condition throughout the post-collision period, allowing for safe inspections and subsequent repair planning.

10.9 Swift Class and Flag State Intervention for Regulatory Compliance

The involvement of Classification Societies **Bureau Veritas (for M.V.**

PAPU) and **RINA (for C.S. NIWA)** facilitated rapid damage assessments and the issuance of legally compliant temporary repair approvals.

M.V. PAPU was granted a single voyage dispensation by the Liberian Maritime Authority, subject to strict conditions (speed ≤ 10 knots, wave height ≤ 2.5 m), allowing the vessel to proceed to a repair yard in Turkiye without unnecessary delay. The temporary repairs were verified on board and found to be in accordance with class requirements, ensuring that regulatory compliance was maintained while balancing commercial practicality.

11. CONTRIBUTING FACTORS

11.1 Human Factors

Complacency - Both Masters demonstrated complacency

Poor Situational Awareness - Both bridge teams lacked awareness

Communication Failure - PAPU failed to respond to VHF calls

Inadequate Bridge Resource Management - Poor teamwork on both vessels

Decision Making - Poor decisions at critical moments

11.2 Environmental Factors

Fresh south-westerly winds

Moderate sea state

Traffic density at Karachi Channel approaches

Requirement for precise navigation within the dredged channel

11.3 Operational Factors

Pilot had already disembarked MV PAPU due to prevailing bad weather conditions

Transition from pilotage to Master's navigation

High workload on the bridge during departure and arrival

Multiple VHF communications occurring simultaneously

11.4 Technical Factors

AIS Misinformation - NIWA's AIS showed "At Anchor" status

Radar Not Used - PAPU relied solely on AIS

No Dedicated Lookout - PAPU failed to post lookout

11.5 Procedural Factors

Pilot Instructions Ignored - PAPU Master disregarded pilot's advice

No Effective Master-Pilot Exchange - Inadequate exchange of information

Inadequate Passage Planning - PAPU not following passage plan

12. IMMEDIATE ACTIONS TAKEN

12.1 By Karachi Port Trust

Karachi Port Operations Centre (KPOC) informed through VHF Channel 12 immediately after the incident

Four KPT Tugs dispatched at approximately 2000 hours:

M.T. LYARI

M.T. KHARADAR

M.T. KEAMARI

M.T. MITHADAR

Pakistan Maritime Security Agency (MSA), Pakistan Navy, and Pakistan Coast Guards informed and placed on standby

Navigational warning promulgated for containers lost overboard

Both vessels instructed to carry out complete tank soundings and internal inspections

C.S. NIWA safely berthed at Berth No. 5 East Wharf at 2350 hours

M.V. PAPU directed to remain clear of main navigational channel

12.2 By M.V. PAPU

OOW made public address - vessel in collision

Crew assisted and checked extent of damage

Reported to Port Control

Temporary repairs completed as per class requirements

12.3 By C.S. NIWA

Chief Engineer assigned engineers to prepare fire pump and ballast pump

Emergency procedures followed

All tank soundings taken

Vessel proceeded to port under own power

13. RECOMMENDATIONS

13.1 Recommendations to M.V. PAPU / Owners / Managers

No.	Recommendation	Priority
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No.	Recommendation	Priority
1	Ensure strict compliance with Pilot's advice and instructions at all times	High
2	Implement effective Bridge Resource Management (BRM) training for all bridge officers	High
3	Ensure proper lookout is maintained at all times in accordance with COLREG Rule 5	High
	Mandatory use of radar for navigation in addition to AIS	
4	AIS (Automatic Identification System) is a aids to Navigation, but international regulations emphasize that it must AIS be used with caution and never as a sole means of navigation. The governing regulation is found in SOLAS (Safety of Life at Sea) Chapter V, Regulation 19.2.4, which states: <i>“AIS should be used to assist in collision avoidance decision-making, but it does not replace the requirement to maintain a proper lookout and should not be relied upon as the sole source of information.”</i>	High
5	Ensure all bridge navigational equipment is operational and properly used	High
6	Improve communication procedures - ensure all VHF calls are acknowledged	High
7	Implement robust passage planning and adherence procedures	Medium
8	Conduct thorough investigation and root cause analysis of the incident	High
9	Review and update SMS to incorporate lessons learned	High
10	Require Masters to positively verify AIS targets using radar and visual observations before making navigational decisions	High
11	Conduct periodic Bridge Resource Management simulator training involving realistic crossing and pilot disembarkation scenarios	High
12	Review company procedures governing navigation immediately after pilot disembarkation	High
13	Ensure Masters acknowledge and implement all navigational advice provided by harbour pilots unless there is a compelling safety reason not to do so	High

13.2 Recommendations to C.S. NIWA / Owners / Managers

No.	Recommendation	Priority
1	Ensure AIS status is updated immediately upon getting underway	High
2	Implement effective Bridge Resource Management (BRM) training for all bridge officers	High
3	Ensure proper lookout is maintained at all times	High
4	Review decision-making procedures - take early action when give-way vessel fails to act	High
5	Improve monitoring of developing situations	High
6	Conduct thorough investigation and root cause analysis of the incident	High
7	Review and update SMS to incorporate lessons learned	High
8	Introduce bridge procedures requiring mandatory verification of AIS navigational status before departure	High
9	Reinforce Masters' responsibilities under COLREG Rule 17 to take early and substantial action when it becomes apparent that the give-way vessel is not taking appropriate action	High
10	Include simulator exercises on stand-on vessel responsibilities and emergency collision avoidance	High

13.3 Recommendations to Karachi Port Trust (KPT)

No.	Recommendation	Priority
1	Enhance VTS monitoring and communication in port approaches	Medium
2	Review pilotage procedures for outbound vessels in adverse weather	Medium
3	Consider mandatory use of VHF for all vessels in port limits	Medium
4	Consider continuous radar monitoring of vessels until they have safely cleared the port approaches	Medium
5	Review pilot disembarkation arrangements during adverse weather to ensure	Medium

No.	Recommendation	Priority
	Masters retain adequate situational awareness after pilot transfer	
6	Evaluate whether enhanced VTS traffic advisories should be provided where outbound and inbound vessels are expected to meet near the channel entrance	Medium
7	Review buoy protection and contingency measures to reduce the risk of secondary impacts following marine casualties	Medium
8	Consider mandatory AIS status verification for all vessels approaching port	Medium

13.4 Recommendations to Mercantile Marine Department

No.	Recommendation	Priority
1	Verify mandatory BRM training for all foreign flag vessels calling at Pakistani ports	Medium
2	Enhance Port State Control inspections focusing on bridge procedures	Medium
3	Conduct focused Port State Control inspections on Bridge Resource Management, radar operation and ECDIS use	Medium

13.5 Recommendations to Director General Ports & Shipping Wing

No.	Recommendation	Priority
1	Share the safety lessons from this casualty with IMO GISIS and regional Port State Control Memoranda, where appropriate	Medium

13.6 Recommendations to Flag States

No.	Recommendation	Priority
1	Liberia Maritime Authority - Ensure M.V. PAPU owners implement corrective actions	High
2	UAE Maritime Administration - Ensure C.S. NIWA owners implement corrective actions	High
3	Both Flag States to verify implementation of recommendations	High

14. FINAL CONCLUSION

14.1 Primary Cause

The Investigation team concludes that this casualty was entirely preventable. The collision resulted from a combination of human error, failures in Bridge Resource Management, inadequate situational awareness, ineffective use of available navigational equipment, non-compliance with the International Regulations for Preventing Collisions at Sea (COLREGs), and shortcomings in the implementation of the vessels' Safety Management Systems. Had either vessel taken early, positive and substantial avoiding action in accordance with the COLREGs and principles of good seamanship, the collision would almost certainly have been avoided.

The Committee further concludes that the safety actions and emergency response undertaken by Karachi Port Trust, Pakistan Maritime Security Agency, Pakistan Navy and other responding agencies were timely, professional and effective, preventing escalation of the casualty and ensuring there was no loss of life or marine pollution.

14.2 Primary Responsibility

Based on the evidence available:

M.V. PAPU bears primary responsibility for the collision due to:

Failure to comply with COLREGs (Rules 5, 7, 8, 15, 16)

Ignoring Pilot's instructions

Failure to maintain proper lookout

Failure to use radar

Failure to respond to VHF calls

Excessive speed in confined channel

No timely action to avoid collision

C.S. NIWA contributed to the collision due to:

Failure to update AIS status

Failure to take timely action when give-way vessel failed to act (COLREG Rule 17)

Wrong last moment maneuver (Hard to Port)

Complacency in relying on stand-on vessel status

14.3 Key Findings

Both vessels sustained damage above the waterline

No personal injury or loss of life occurred

Three containers lost overboard from M.V. PAPU (non-IMDG)

Karachi Port Trust response was commendable

Temporary repairs completed on both vessels
M.V. PAPU released for single voyage to Turkiye
C.S. NIWA under detention at Karachi Ship Yard for repairs

14.4 Final Remarks

This collision was **avoidable** had both vessels

Maintained proper lookout
Used all available navigational aids effectively
Communicated properly
Followed COLREGs
Exercised good seamanship

The investigation emphasizes the critical importance of:

Bridge Resource Management

Proper Lookout

Effective Communication

Compliance with COLREGs

Use of all Navigational Aids

15. LIST OF ANNEXURES

Annexure	Description
A	Ship Particulars - M.V. PAPU and C.S.NIWA
B	Ship Particulars -C.S. NIWA
C	Statements of Facts - M.V. PAPU
D	Statements of Facts - C.S. NIWA
E	Master and Pilot Joint Statement - Papu
F	Damage Photographs - M.V. PAPU
G	Damage Photographs - C.S. NIWA
H	Joint Survey Report - C.S. NIWA
I	Damage Assessment Report - C.S. NIWA

Annexure	Description
J	Release Order - M.V. PAPU
K	ECDIS Photos - C.S. NIWA
L	Logbooks and Records - C.S. NIWA
M	Logbooks and Records - M.V.PAPU
N	Crew List- C.S NIWA
O	Crew List - M.V. PAPU
P	KPT Documents

16. SIGNATORIES

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END OF REPORT

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