UNITED STATES COAST GUARD
U.S. Department of Homeland Security

FINDINGS OF CONCERN

Sector San Francisco

November 17, 2025
San Francisco, CA

Findings of Concern 013-25

UNSAFE ANCHOR RETRIEVAL OPERATIONS

Purpose. The U.S. Coast Guard issues findings of concern to disseminate information related to unsafe conditions that were identified as causal factors in a marine casualty and could contribute to future incidents. Findings of concern are intended to educate the public, state, or local agencies about the conditions discovered so they may address the findings with appropriate voluntary action or highlight existing applicable company policies or state/local regulations.

The Incident. As the crew of a towing vessel was hauling in their anchor, a deckhand was manually guiding the anchor wire onto the winch drum to keep the anchor wire shackle from contacting the wire eye coupler swage and avoid damage to the anchor wire rigging. The anchor got stuck on the bottom resulting in the anchor line becoming taut which caused it to shock-load and create stored energy. In an attempt to protect the anchor wire and associated gear, the deckhand pushed against it. When the vessel was repositioned, the anchor line shifted and resulted in a release of the stored energy. This caused the deckhand to be thrown into the nearby gantry A-frame and resulted in a fractured leg.

Contributing Factors and Analysis. The investigation revealed several causal factors related to unsafe anchor retrieval operations, including:

- Non-Compliance with the company's standard operating procedures (SOP): Per the SOP, the company requires a risk assessment when deviating from standard operations due to changes in equipment, procedures, or crew composition. The deckhand was directed by the vessel's Chief Engineer to deviate from the SOP during the anchor retrieval operation; however, no additional risk assessment was conducted based on this shift in procedure.

- The crew member supervising the operation did not ensure the deckhand was clear of the bow, winches, and associated rigging before the winch was engaged and the anchor wire was placed under load.

Consequently, the combination of noncompliance with company policies and insufficient supervisory oversight resulted in unnecessary risk to the crewmembers performing their anchor handling duties.

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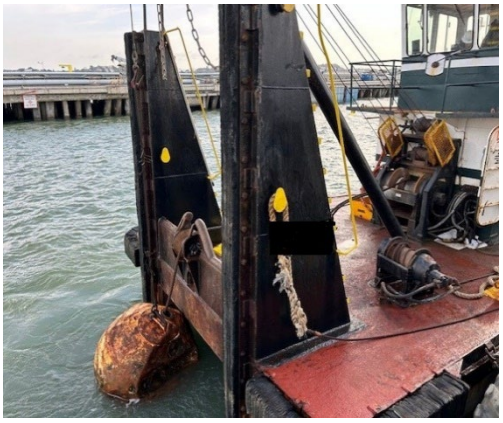

Dredge tug bow with anchor ball connected.

Dredge tug working deck and close-up of gantry A-frame.

Findings of Concern. The following voluntary actions are recommended for owner/operators of similar vessels to prevent future incidents.

- Review and update company and vessel safety procedures, including all Safety Management System documentation related to anchor retrieval. Ensure procedures thoroughly assess and mitigate risks associated with anchor wire handling, equipment (winches, shackles, swages, etc.), and emergency situations. Implement safety controls for identified high-risk activities prior to altering procedures.

- Before applying load or operating winches, ensure all personnel are accounted for and confirmed safe and/or safely positioned. In this incident, the failure of the supervisor to maintain visual contact and confirm the deckhand's location led to a communication breakdown and contributed to the incident. This casualty highlights the need for enhanced team coordination and communication protocols during higher-risk operations.

Closing. These findings of concern are provided for informational purposes only and do not relieve any domestic or international safety, operational, or material requirements. For any questions or comments please contact the Sector San Francisco Investigations Division by phone at (510)-813-9636 or by email at SFINV@uscg.mil.