

Case study for onboard safety meeting

Case study no. 12: Pilotage

Please read the below story of an incident. Keep our procedures in mind while reading to compare with the actions of the crew below as we will discuss the factors which led to the incident occurring.

A 42 000 dwt bulk carrier was anchored at the outer anchorage awaiting clearance to enter port for discharge operations. At 0500 hrs the vessel was given instructions to heave up anchor and proceed to the pilot boarding ground situated 4 miles north of the breakwater entrance. The vessel was soon underway and commenced her approach towards the pilot boarding position. Upon reaching the pilot position the master informed the pilot station that they were in position, but that there was no sign of the pilot boat. The pilot station informed the master that the pilot would board closer to the breakwater and that the vessel should continue her approach towards the breakwater. When the vessel was two miles from the breakwater entrance, the master noticed the pilot boat approaching towards the vessel and soon after the pilot boarded the vessel.

As soon as the pilot arrived on the bridge, the pilot confirmed with the master the vessel's current engine setting, course, speed and maximum draft. There was no exchange of any other information and soon after the pilot ordered the helmsman to steer a course that would position the ship in the middle of the breakwater entrance. The pilot advised the master that two tugs would be assisting with berthing and considering there was no other traffic to impede the vessels passage they should have a straight run to the berth. The pilot asked the Master to call the ships crew to standby for mooring stations, and the master acknowledged the pilot's communication.

Soon thereafter, the pilot was informed by the harbour control that there was an outbound ship waiting for our vessel to enter the inner port basin. In view of this, the pilot increased the vessel speed by ordering half ahead. The master and the officer on watch were discussing other matters on the bridge while the pilot was communicating with the harbour control and at the same time conning the vessel. The vessel speed was seven knots when passing the breakwater and although the master was aware of both the vessel's speed and the local speed limitations, he did not seek clarification or question the pilot's intentions.

Two tugs were standing by inside the breakwater; however, the tugs had difficulty in keeping up with the vessel's speed as she made her way past the breakwater and into the inner port basin. As the vessel approached the terminal, communications were ongoing between the pilot and tugs in a local language (not English) which was not understood by the master. The aft tug eventually made fast when the vessel was quite close to the berth. The forward tug started pulling on the line before the line could be made fast on the vessel. The entire line then paid out into the water rendering the tug line of no assistance to the vessel. In the process of all this confusion and heated communication between the pilot and the tugs, the vessel speed was not reduced sufficiently and resulted in the vessel bow colliding with a mooring dolphin. Extensive damage was caused both to the vessel and to the mooring dolphin.

Suggested keywords for discussion

- Berth to Berth passage plan
 - including point of no return
- Master – Pilot exchange of information
 - when and what
- Roles & Responsibilities when pilot onboard
- Monitoring of pilotage – Situational awareness
- Seeking clarification if in doubt
- Necessity for Bridge Team Management
- Critical thinking – What if?
- When do you question or intervene?
- Communication and language challenges
- Role of fatigue in incidents



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Risk assessment form

Based on the case, we will now perform an onboard risk assessment of the incident and the factors which led to it. Bearing in mind our own procedures, please consider the following:

Hazard Identification

Based on the case description, identify at least 5 potential hazards involved.

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Identify unwanted practice onboard our ship related to pilotage.

Risk Assessment

Probability (From very likely to very unlikely): How often are the identified hazards present?

Severity (From very serious to not serious at all): How bad are the worst possible outcomes of the identified hazards?

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Risk Acceptance

Are the different risks identified acceptable in our company or should any of the identified risks be reduced?

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Risk Treatment

How can the identified risks be reduced? (Both probability and severity of a hazard should be assessed to determine the risk. Consider factors such as equipment, procedures and training.)

Which procedures do we have onboard that must be followed during an activity like this?

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