

## MONTHLY SAFETY SCENARIO

MAY 2021

# Pilot forgot about moved buoy

It was evening and the vessel had completed loading and was ready for departure. All pre-departure checklists had been completed. The Second Officer had checked the tide in the harbour and departure was scheduled for just after low tide. The tide was running between 1.5 – 2.5 knots with a height of 0.4 metres. The maximum draft for vessels entering the port was 9 metres. After loading the maximum draft was 8.2 metres, which was aft.

Two pilots boarded the vessel and met the Chief Officer on the bridge, who presented the departure calculations and gave them the pilot card. The Master, who had visited the port numerous times before, arrived on the bridge just before departure. He had been delayed because he had to complete the final paperwork with the agent. No pilot briefing was held as the Master wanted to leave port as soon as possible. A helmsman was also present on the bridge.

The vessel departed, the pilot was given the conn and the Master stood alongside monitoring. The pilot

started to swing the vessel with the bow towards the quay. One tug assisted the vessel and was positioned pushing on the port quarter. The Second Officer, who was on the stern, reported that the vessel was swinging 80 metres clear of the buoy that marked the channel. The Third Officer was on the bow and reported that the bow was about 100 metres clear of the wharf. The vessel had a speed of little more than 1 knot astern. The channel was about 250 metres wide, about 1.5 times the vessel's length. The Chief Officer was in the cockpit and monitoring the radar and electronic chart. At that point the electronic chart indicated that the vessel was inside the 6 metre contour. The Chief Officer did not inform the Master or pilot about this discrepancy.

The pilot ordered dead slow ahead. Suddenly a loud noise was heard from the stern and the Master realised that the vessel had grounded, and he informed the pilot. The pilot did not respond. The vessel was now swinging quickly to port and the pilot tried to stop the swing by using both the





rudder and bow thruster, but the vessel continued to turn and once again touched the bottom. The Master again informed the pilot that the vessel had touched the bottom. The pilot did not acknowledge this and was clearly shocked. The vessel continued to swing to port.

The pilot struggled to stop the swing and tried to straighten up the vessel in the river but did not manage to do this. The bow hit the bottom for the third time, but this time on the port side, and the vessel heeled 2 degrees to starboard, finally coming to rest. The tug managed to push the vessel free while the vessel also used its bow and stern thrusters and the engine forward and astern.

Following refloating, the vessel proceeded to the pilot station with some difficulty because the bridge team had not realised that the rudder was stuck at an angle of 35 degrees to port.

It was later discovered that the buoy had been moved further out from its original position because the channel was being dredged. The pilot had been informed about the dredging operation by the port captain but did not inform the Master or the rest of the bridge team about this.

## Questions

When discussing this case please consider that the actions taken at the time made sense for all involved. Do not only judge but also ask why you think these actions were taken and could this happen on your vessel?

1. What were the immediate causes of this accident?
2. Is there a risk that this kind of accident could happen on our vessel?
3. How could this accident have been prevented?
4. According to our procedures what should we have done?
5. What are our requirements for the pilot briefing?
6. What are our procedures regarding bridge roles during arrival and departure, what information should the OOW give the Master and pilot?
7. Could training about assertiveness be improved upon?
8. What sections of our SMS would have been breached if any?
9. Does our SMS address these risks?
10. How could we improve our SMS to address these issues?
11. What do you think was the root cause of this accident?
12. Is there any kind of training that we should do that addresses these issues?