



DIGEST issue 4, Nov. 2023

SAFETY LESSONS

from HELMEPA's
Maritime Community



Sharing lessons learned

VIRP Digest is a quarterly e-bulletin, sharing 'lessons learned' from maritime accidents, incidents, and near-misses uploaded by HELMEPA member-vessels to the Voluntary Incident Reporting Platform (VIRP).

Collective impact

1,300+ Reports uploaded to VIRP by 38 member-managing companies that are logged on. Recent upgrade of the VIRP provides users with a wide range of new capabilities and statistical research, enabling smoother user interface and better detection of emerging trends.

Being part of safety cause

All managing companies-members of HELMEPA are provided, upon request, with an exclusive access code to upload their vessels' incidents and near misses and view all the database reports and emerging trends through a wide variety of filters.

Fostering proactiveness and sustainability

Sharing 'lessons learned' from the analysis of previous incidents helps avoid the human errors that lead to the repetition of similar incidents and accidents in the future. Active participation of a company in the VIRP reinforces a strong maritime safety culture at all company levels.

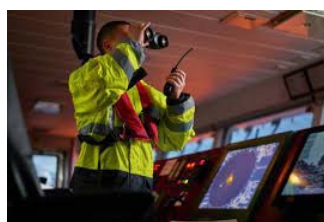
Collisions Averted: The Importance of Bridge Team - Pilot Communication



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This article highlights a pivotal safety concern that continues to recur in VIRP and other incident reporting tools/schemes: the challenge of poor communication between Bridge Team - Pilot which poses a serious risk of collisions at sea.



INCIDENT 1

During daylight, with good weather but poor visibility, a container vessel, under pilotage while transiting the channel outbound, collided with an inbound transiting bulk carrier, which was also under pilotage.

During the Master-Pilot exchange the expected inbound traffic had been discussed. Accordingly, the pilot confirmed that there should be only one inbound vessel, and there is an agreement with the pilot of the other vessel to pass Green to Green due to container's deep draft to keep close to green buoys, where there is greater depth.

The Master notified the Pilot that the inbound vessel was not allowing enough space by not keeping to his left side of the channel. The Pilot contacted the other vessel pilot on VHF channel 12 talking in their own language and confirmed that all was in good order and the vessel would pass Green to Green.

The Chief Officer notified the Master that the other vessel's intentions were not clear, turning to her starboard. The Master notified the pilot accordingly and asked the forecastle lookout to report if the other vessel was visible and in which position. The lookout responded that the other vessel was not visible yet.

Due to the risk of collision, the forecastle lookout was instructed to leave their duties and to proceed to safe area. After having a look at the radar screen, the Pilot realized the risk of collision was high. Therefore, to prevent collision, he instructed hard to port to keep the agreement for passing Green to Green.

About 2 minutes later the two vessels collided.



INCIDENT 2

A bulk carrier vessel was anchored in a river. The river pilot boarded the bulk carrier vessel in order to shift her upstream.

Once the vessel reached the pilot boarding area, the harbor pilot went on board. He was informed about the vessel's condition and characteristics by means of the pilot card, which he signed accordingly.

The pilot informed the Master that the vessel would be berthed portside alongside, dropping the starboard anchor, and without tugs assistance. The terminal was located on the right bank of the river; therefore, the vessel's berthing would be performed heading the downstream current.

The vessel's headway was stopped, and the main engine was set on 'slow astern' to move her parallel to the berth, but due to the current (between one to two knots), the stern turned to port towards the berth. Due to this fact, the pilot advised 'slow ahead' to stop said turn.

About 2 minutes later, the pilot advised 'half ahead', then 'full ahead' and rudder hard to starboard, in order to reduce the speed and keep the stern away from the berth. In spite of this, the vessel continued drifting towards the berth.

About a minute later, the vessel's port quarter contacted the upriver mooring dolphin. Consequently, the vessel and the dolphin sustained damages.



LESSONS LEARNED

- **Bridge team members must consistently communicate** to establish a shared understanding of a vessel's status, to ensure that crucial manoeuvres for safe navigation are adequately planned, coordinated, and executed.
- If a passage plan does not include **a realistic berth approach that integrates actual conditions and vessel characteristics**, there is a risk that bridge team members will not establish a shared mental model and therefore be unable to effectively monitor and anticipate the vessel's progress during the berthing manoeuvre.
- **Amend passage plan in ECDIS** as soon as possible and as agreed with pilot.
- **Be well familiar with ECDIS and use of prediction setting.**
- **Set up ECDIS alarm correctly** in order not to receive plenty alarms without sense and lose the real alert/alarm.
- Even when wind and current conditions are seemingly benign, **berthing a large bulk carrier without tugs is a tricky affair**, especially turning across a current (berthing or unberthing) and then having it astern.
- This is one more example of a vessel operator making an assumption about the intentions of another vessel operator which has led to a bad outcome. To reduce risk in this sort of situation, **clear and unambiguous communication is essential.**
- **Follow the rules!** In this case the operator of the container vessel should have called the inbound bulk carrier and confirmed the manner of passage. Had he done so in a timely manner the collision would have been avoided.
- **Amend passage plan in ECDIS** as soon as possible.

CORRECTIVE ACTIONS

- Head office informed, Emergency Team activated
- Proceeding at anchorage for hull inspections by Class, plus evaluation of the damage
- Local Authorities informed
- Flag Administration informed on the incident
- Charterers informed
- Repairs to class satisfaction were carried out

ALWAYS REMEMBER

THE SPEED OF THE VESSEL MUST BE CONTROLLED BY THE BRIDGE TEAM AND NOT THE OTHER WAY ROUND

Useful free resources

[Bridging the Gap: safeguarding the relationship between bridge team and pilot](#)

The Nautical Institute

[Bridge Resource Management during Pilotage: What to watch](#) – SAFETY4SEA

[Pilot on the bridge](#) – Gard P&I Club

[Bridge Team Management: Pilot on Board!](#)

TRAININGLink

[Ship Pilotage & Intervention](#) – Britannia P&I Club

[Bridge Resource Management: A Pilot's Perspective](#) – Hellenic Shipping News/ Gard P&I

[Bridge Resource/ Team Management under Pilotage. Lessons learned from the Port of Rotterdam Incident](#)

by Capt. Anastasios Chrysikopoulos

[Guidance notes for check pilot assessment voyages](#) – AMSA

[Pilotage and Master-Pilot Relationship](#)

Marine Teacher

JOIN EASY

UPLOAD ANONYMOUSLY SHARE YOUR KNOWLEDGE

Join VIRP + Upload your company's most significant incident or near-miss reports directly [here](#) and help us enhance maritime safety culture. Special importance is placed on submitting High Potential (HiPo) incidents or near-miss that under other circumstances could have resulted in one or more fatalities.

Note

All information uploaded is strictly anonymous. HELMEPA is the Administrator of VIRP.



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COMPANY'S ESG PURPOSES

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at sea 

This initiative was part of the project titled "Enhancing the Understanding of New and Enduring Challenges in Maritime Safety Culture in the Eastern Mediterranean"

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