

KISH P & I LOSS PREVENTION CIRCULAR KPI-LP-141-2013
(Mooring Accident While at SBM & Lessons to be Learnt)

► **Description of the incident:**

-0210: A tanker ship was about to complete loading the cargo of S.P condensate at Asalouyeh port No.2 SBM, through two 16 inches cargo hoses with approximate rate of 3000 M3 per hour in the last two remaining tanks.

Wind was ESE, force 4, moderate sea, cloudy sky. Two SBM chains connected.

One duty watch man was stationed at forecastle deck -round the clock- reporting the direction and condition of SBM Chains every 10-15 minutes, throughout the operation.

-0215: Forward Watchman reported SBM chain direction by 10 o'clock, medium stay.

Chief Officer went to the smoking room and informed the pilot who was in the officer's smoking room along with one of the mooring gang members. Pilot came to CCR. Shore mooring gang rushed forward and asked pilot to order "Full Pull" by the tug-boat that was made fast right astern throughout the cargo operation.

Shore mooring gang panicked and started ruction on the radio. He asked the pilot to get the engines ready.

-0215: Second officer called Engine Room from CCR and gave notice to Engine room which was kept on short notice throughout the loading operation.

The tug-boat started pulling to correct the chain-lead (the job she was doing throughout the loading).

Shore mooring gang was stressful and started giving direct orders to the tug-boat. This fact caused pilot distraction from the orders given.

Tug-boat was on "full pull" while ship's watchman reported SPM chain 12 o'clock, long stay.

-0227: Second officer and pilot went on the bridge.

Due to stresses on the SBM hawser, both mooring hawsers parted from SBM while the ends of chains and the hawsers remained secured on board.

-0228: Second officer called master and Stand-By the Engines. Wheel was ordered hard a port and engines Dead Slow Ahead.

-0230: Master on the bridge, while the engine was on D.S.Ahead and wheel on hard a port, SBM direction 10 O'clock, tug pulling towards STBD quarter.

-0230: Vessel requested cargo loading to stop.

Pilot panicked and started shouting on VHF, giving orders to his mooring gang to prepare for hose disconnection, asking them to confirm whether the chains are broken and or the hawsers are parted. Pilot called shore foreman on the bridge claiming that Shore mooring gang had distracted him, which caused late orders being given to the tug-boat to stop pulling. Pilot seemed to have lost control.

Master requested the pilot to stay calm and reminded the pilot that the Master is in charge and responsible for the safety of the crew, vessel and any probable consequences.

-0235: Shore confirmed that the cargo operations have stopped & Master requested for additional tug-boat to be called out of harbour urgently.

Finally the master handled the situation until the vessel dropped anchor safely at 0654.

No Pollution or serious damages occurred.

► **Analysis of the incident:**

1. There is a miscommunication involved in the course of the incident.

2. Inadequate emergency preparedness is evident.
3. Chain of command & control amongst the shore side advisors (pilot- shore gang, etc) is disrupted & malignant.

► **Lessons to be learnt:**

1. It is important to remind ourselves that no matter how experienced or skilful the pilot is; the ultimate responsibility rests with the master of the vessel & if ever due to any reason the master or the officer in charge finds out that the situation is not handled properly & safely; he should seek clarification & exercise his authority in order to save lives, property & the environment. In this very case the master has intervened duly & handled the vessel to a safe and sound status.
Amongst the cases that the master should be more vigilant is in ports & areas that there is a likelihood & trend of possibility that pilots may be inadequately capable due to various conditions like fatigue; age; over-working or medicinal use.
2. The master-pilot & ship-shore communication & existent check-lists can be very critical matter & should always be adhered to. The efficacy of such communication can have

- detrimental effect on the whole operation.
3. One very serious flaw in the operations can be inconsistent & inadvertent misunderstandings in the command & control chain. In some cultures people like to be bossy & take charge of things that are not meant to. This can be worse in emergency situations & times of crisis. Once you see signs like many voices ordering crane hoist/lowering or challenges amongst the labour addressing that by whom & how the job should be done; you must be more cautious & vigilant.
4. As a general rule; as soon as there are mishaps around or confusion or panic; the first thing to do is to stop the operation & seek clarification & calming down to all parties involved. This is more important in a tanker operation which is a high risk activity & involves persistent oil or other severe or harmful pollutants.
5. Last but not the least; the ships' Safety Management System should include a systematic approach to risk assessment. The situations for which you need to have already assessed should include the incident in question & proper workmanship to handle them as smooth & as prepared as possible.

