

KISH P & I LOSS PREVENTION CIRCULAR KPI-LP-152-2014 **(Ineffective BRM & Lack of Communication Led to Collision)**

► **The incident:**

In darkness, two vessels under pilotage were approaching each other in a very restricted canal. Shortly after rounding the bend in the canal, the vessels came into view of one another. It appeared to the pilot of vessel A that vessel B was slightly crowding the north side of the channel. Accordingly, he decided to give a little more room for the meeting to take place by moving closer to the north bank. The pilot did not communicate his intentions to either the pilot of the other vessel nor to the navigation personnel of his ship. When satisfied with the vessel's position in the channel, he asked the helmsman to steer 248° gyro (G). The helmsman complied but found that the vessel needed regular inputs of 5° to 10° starboard helm in order to maintain the heading. The OOW was standing by the helmsman, verifying his actions.

For the next few minutes, more than 10° starboard helm was applied to maintain the heading on vessel A. Thereafter, 20° to 30° starboard helm was necessary to steer the desired course and, as the vessel had a flap type rudder, the helmsman was able to keep the required course of 248°. During this time, the pilot reportedly glanced at the rudder angle indicator from time to time, but there was no exchange of information among bridge team members. During this time the pilot gradually reduced the propeller pitch to slow the vessel down before the meeting. Since completing the bend at 7.6 knots, vessel A was now making 5.7 knots.

There is conflicting information with respect to the helm orders given next on

vessel A. The navigation personnel maintain that the pilot ordered the helm amidships, whereas the pilot does not recollect this order. The helm was nonetheless put to midships and the vessel immediately started to sheer to port. Full starboard helm was then applied, but the vessel's heading continued to swing to port. The two vessels collided near mid-channel at a combined speed of approximately 6 knots.

► **Some of the findings of the report were as follows:**

- ✓ The bank suction effect on vessel A became progressively more pronounced, requiring increasing starboard helm; placing the helm amidships caused the vessel to sheer to port.
- ✓ There was no relevant communication between the pilots of the two vessels throughout the developing situation.
- ✓ Ineffective Bridge Resource Management (BRM) aboard vessel A resulted in critical information not being shared with the pilot, thus precluding timely action.



Additional notes:

1. Much time and effort has been expended in the past 20 years on providing BRM training for pilots and officers. However, year after year accidents continue to happen due to poor BRM – poor communication. ‘Thinking out loud’ is one technique that allows the free flow of information and allows other team members to comprehend the action. In this instance, had the pilot said ‘I’m coming to the north side of the channel to allow more room for the meeting’, the officer may have been more attuned to the bank suction. Additionally, coming from the officer or helmsman, ‘Mr. Pilot, we now need 20 degrees starboard rudder to maintain the course’ would have alerted the pilot to the bank suction in a timely manner.

2. In any case of collision; the primary deduction is that the collision avoidance regulations have not been abided by. In this situation like many other channel collisions, the pilot has relied on his own judgments & has not communicated his intentions. On the other hand, the OOW has not sought the reasons for the inadequacy & lack of efficacy of orders in order to avoid collision. The tricky matter that *"The responsibility lies with the master & not the pilot"*; should normally instigate the courage in the ship staff to be more vigilant & take every step to avoid such dangerous encounters - even if that might necessitate a departure from rules - as the ultimate goal is to remain safe & untouched by the other vessel. The fact that the ship staffs believe in the pilot, especially in matters like his knowledge & experience concerning the very particular bank suction or cushion, should not deter them from being cautious & alert towards things that seem not right & have grave consequences.

