

## **KISH P & I LOSS PREVENTION CIRCULAR KPI-LP-82-2012** **(An Unberthing Accident & Lessons to be Learnt)**

► **Incident: Gangway damaged during unberthing**

The vessel was to move from her berth (port side alongside) and tie up at another berth (starboard side alongside) further up the dock. A pilot and two harbour tugs arrived at the designated time and Master - Pilot information was exchanged before commencing the movement. The pilot requested that the port accommodation ladder be hoisted by only a few metres and retained there, as he intended to use it for disembarking from the 'sea' side at the next berth. Due to the ship's draught, height of the pier and the state of tide, in this 'raised' position, the gangway was only about a metre clear of the jetty. During the unmooring operation, there was a strong offshore wind and moderate rain, and due to the latter, both the Master and the Pilot remained inside the wheelhouse throughout. On the pilot's advice, all headlines and stern-line(s) were first let go, retaining only the back-springs fore and aft. After the stern-line(s) had been retrieved on board, the deck officer in charge of the aft mooring station went over to the back-spring winch, which was situated on starboard main deck, forward of the accommodation. He engaged the gear of the mooring winch and slackened the aft back-spring. From his location across the full width of the ship, the deck officer had no view of the quayside, and was relying on and responding to hand signals from an A/B stationed at the ship's port side. Due to the low clearance between the gangway and the jetty, the length and lead angle of the mooring line and the widening gap between the ship and the berth, the slack back-springs became fouled with the accommodation ladder and could not be cleared despite efforts by the shore mooring gang. The A/B indicated the dangerous situation by hand signals to the deck officer, creating some critical seconds' delay in responses and in communicating the information to the bridge. Once aware of the situation, the Master requested the Pilot to instruct the tugs to push the vessel back towards the jetty, but by the time this was done, the entangled gangway had been subject to severe axial, twisting and crushing forces and was severely damaged.

► **Root causes/contributory factors:**

1. The Bridge team failed to effectively use the Pilot and tugs to retain the vessel alongside until all lines were retrieved, especially since there was a strong offshore wind;
2. The Bridge team failed to exercise basic seamanship and wear rain protective clothing and station himself on the bridge wing during the unmooring operations;
3. The unusual layout of the back-springs, gangway and low clearance over the berth should have precluded leaving the gangway suspended over side;
4. The deck officer at the aft mooring station wrongly assumed the role of winch operator, instead of directly supervising the operation and delegating tasks to his crew.

► **Corrective/preventative actions:**

Instructions issued to all vessels in the company requiring:

1. The master-pilot information exchange & coordination to be emphasized upon effectively;
2. Bridge team members & especially the master to position themselves appropriately on the bridge & wings as necessary during mooring and unmooring and closely oversee and control operations;
3. Adequate weather-protective gear to be always be available in the wheelhouse and other working areas;
4. Officer in charge of the mooring station to supervise the operation and effectively communicate with the shore and ship's staff and delegate tasks to the team;
5. It is advisable to heave up the accommodation ladders/gangways or any other hindrances during mooring/unmooring operations & actions of the incident type intended to save time may end up with expensive damages.



Another view ► of damaged accommodation ladder

◀ View of damaged accommodation ladder

