

Grounding when not using bridge equipment efficiently

The vessel had picked up the pilot and was approaching the fairway to the port. It was morning with clear skies and light winds. On the bridge were the Master, the pilot the OOW and the helmsman. The Third Officer was the OOW and had completed the pre-arrival checklist. The vessel was in hand steering mode and the pilot had the conn. The Master had given the pilot a pilot card, but they had not carried out a pilot briefing. The pilot asked for 7 knots in the fairway and lined up the vessel between the buoys.

The OOW was monitoring the vessel's position on the radar and the ECDIS and was also filling out the logbook. The vessel passed the first buoys, and everything seemed in order to the Master when he looked outside.

Suddenly the vessel vibrated heavily and the speed fell rapidly until the vessel completely stopped. The Master realised that the vessel had run aground. He told the pilot that the vessel was aground but the pilot did not believe him as the vessel was in the middle of the fairway.

When the pilot also realised that the vessel had run aground he started to talk on the VHF in the local language.

The vessel had run aground on a bank which was outside the fairway. The vessel was clearly visible outside of the channel on the ECDIS and radar. This was also confirmed when the position was plotted.

The Master began to deballast the vessel and carried out engine manoeuvres in an attempt to get the vessel off the bank. Subsequently the Chief Engineer called the Master and told him that the steering gear was not responding.



The Master immediately stopped the engines and asked the Chief Officer to sound all tanks and also take soundings around the vessel.

The pilot told him that two tugs were coming from the port to assist the vessel.

The Master had not signed any salvage contract, but the two tugs began to attempt to refloat the vessel with the assistance of the pilot and authorities. The tugs managed to remove the vessel from the bank the following day.

There was a leading line for the approach, but for some reason it was disregarded. The passage plan was not berth to berth. If the plan had been berth to berth there would have been a planned route into the port which would have highlighted the discrepancy in the vessel's position on the ECDIS. The bridge team did not monitor the vessel's progress with all the available means. ■

Discussion

Go to the "File" menu and select "Save as..." to save the pdf-file on your computer.

You can place the marker below each question to write the answer directly into the file.



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. This passage plan was not berth to berth. Are our passage plans berth to berth?

8. Should we deballast in a situation like this?

9. What are our procedures regarding refloating and salvage?

10. Is it appropriate to try to get off the bank or not?

11. What sections of our SMS would have been breached if any?

12. Does our SMS address these risks?

13. How could we improve our SMS to address these issues?

14. What do you think was the root cause of this accident?

15. Is there any kind of training that we should do that addresses these issues?