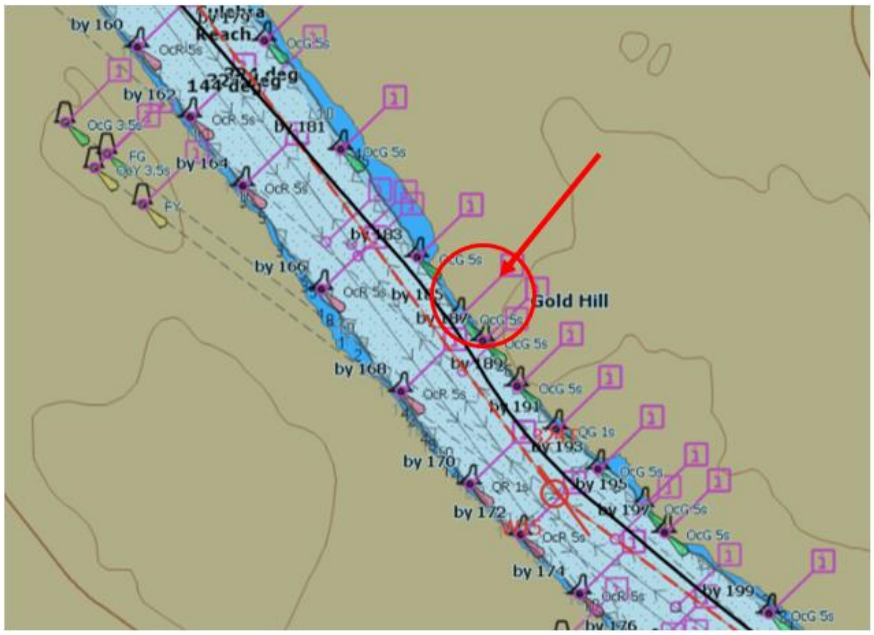
Case Study- Panama Canal Transit

What happened

- The following hazardous occurrences occurred during a Northbound Panama Canal transit on board a Fleet vessel :

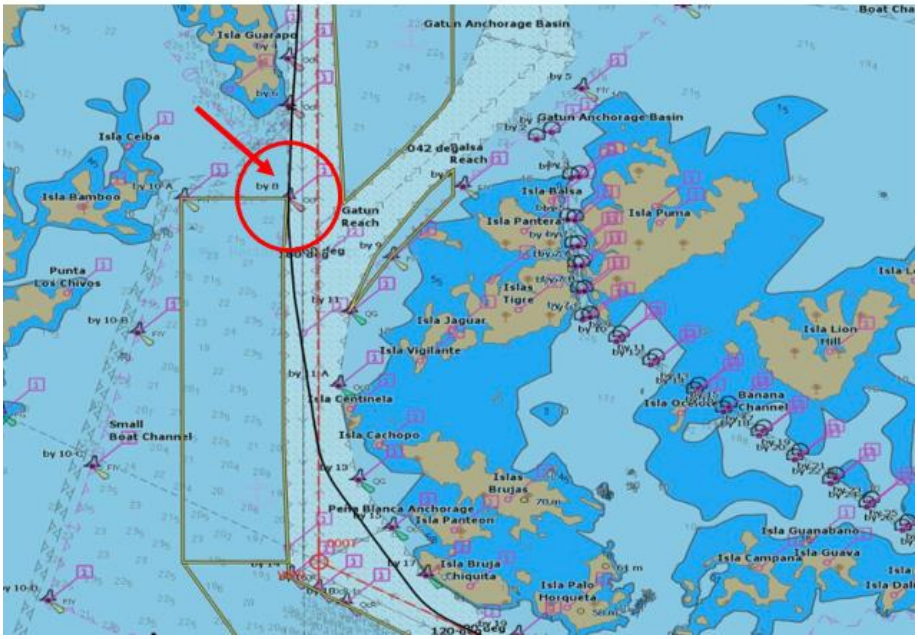
1. Pilot no.1 – After altering course to starboard between green buoys 195 -193 (Gold Hill) pilot did not pay attention enough that vessel was still turning to starboard and approaching starboard green buoys 187 and 185 and shore limit. Prompt action of Bridge Team (OOW, Staff Captain and helmsman) avoid the grounding and buoy contact asking the Pilot a safe course alteration. See attached ECDIS screenshot 1

Occurrence no 1 / 28th May 1935LT(UTC-5)



2. Pilot no.2 – on approaching Gatun Reach after turning starboard Pilot fell asleep and vessel was heading towards red buoy no 8 east of Isla Bamboo. Prompt action of Bridge Team as above including Captain to avoid again contact with buoy. There was enough water behind the buoy no.8 so there was no imminent risk for grounding. See attached picture 2.

Occurrence no 2 / 28th May 2157LT(UTC-5)



3. Pilot no.2 – Approaching Gatun West Lock from south with Easterly wind (15/25 kn). Pilot lost completely situational awareness and ability to estimate/control of vessel's movement. Captain took over the vessel command and safely arrived at entrance of the lock. Pilot first went to the port side bridge wing and later returned to the starboard side bridge wing. Proper Bridge Team was in place with Staff Captain informing Captain of vessel's position relating to the lock entrance and mooring stations. See picture 3.

Occurrence 3 28th May 2020 2205LT(UTC-5)

4. Pilot no.2 – Departing Gatun West Lock. Captain still in command with Pilot not part of vessel's navigation anymore. Pilot only advised the current (up to 2 kn) and vessel to sail with enough speed to overcome poor maneuvering. Pilot disembarked at Cristobal Signal station.

Causes and contributory factors

- Occurrence no.1 / Pilot 1 – Poor attention of Pilot on vessel movement after altering the course. Corrective action taken after OOW/Staff Captain's advice

- Occurrence no.2 / Pilot 2 – Pilot asleep and after Bridge Team's advice woke up but took a while to realize the dangerous situation before altering course

- Occurrence no.3 / Pilot 2 – Pilot was unable to effectively monitor the vessel movements, got nervous and lost his piloting ability and situational awareness. Age and fatigue of Pilot with late evening time (10 pm) maneuvering are contributing factors

- Occurrence no.4 / Pilot 2 – Captain in command with Pilot not participating to support the vessel's maneuvering. Pilot's age and fatigue and his after-shock condition due to his earlier mistakes may contribute for the reason for him not to participate anymore in the maneuvering evolution.

Vessel Command act according the procedures, with an effective and excellent Bridge Team Management

Corrective actions

Vessels:

Reiterate the VMS requirements on Pilotage including supporting Bulletin and procedures

- Fleet Ops > 4.0 Marine Operations > 4.1 Navigational Operations > 4.1.13 Pilotage
- Fleet Ops > 4.0 Marine Operations > 4.1 Navigational Operations > 4.1.4 Bridge (Team) Resource Management

The Company:

- Circulate a Case Study fleet wide

Completed