UNITED STATES COAST GUARD
U.S. Department of Homeland Security

FINDINGS OF CONCERN

Office of Investigations and Casualty

December 6, 2022
Washington, D.C.

Findings of Concern 019-22

BRIDGE RESOURCE MANAGEMENT

Purpose. The U.S. Coast Guard issues Findings of Concern to disseminate information related to unsafe conditions that were identified as causal factors in a casualty and could contribute to future incidents. Findings of Concern are intended to educate the public, state, or local agencies about the conditions discovered so they may address the findings with an appropriate voluntary action or highlight existing applicable company policies or state/local regulations.

The Incident. A piloted 1,095-foot container ship was aground for over 35 days, after missing a turn south and grounding outside of the channel during an outbound transit. The vessel was eventually freed after dredging was completed to a depth of 43 feet, resulting in 206,280 cubic yards of material dredged, and the removal of 505 containers from the vessel.

Approximately 30 minutes before the grounding, the bridge team completed a scheduled watch relief which was comprised of the Pilot, the Third Officer, a Deck Cadet, and an Able-Bodied Seaman. The Master was below decks for the evening meal at the time of the casualty.

Contributing Factors and Analysis. As the crew's officer on the navigation bridge at the time of the casualty, the Third Officer observed that the pilot was on their cellular phone for approximately half of the two-hour transit. During the outbound transit, the Third Officer was aware that a turn needed to be made in order stay within the channel. However, rather than directly telling the pilot, the Third Officer repeated the ship's heading multiple times in an attempt to cue the pilot that the turn needed to be made.

The Third Officer correctly understood the Pilot to be in direction and control of the vessel, and he felt hesitant to speak up as the purpose of the pilot is largely to act as the local geographic and navigational expert on board the vessel. The Third Officer and two other members of the bridge team did not directly alert the pilot to the dangerous situation or summon the Master, until after the vessel had grounded.

In this case, the ship's Safety Management System (SMS) dictated that if the vessel experiences difficulty maintaining course or any doubts arise in regard to the vessel's situation, the officer on watch shall call the Master. All officers were required to review and sign that they understood this instruction.

Findings of Concern. Coast Guard investigators identified the following prudent measures to be implemented on vessels in similar service to mitigate the risks associated with the above identified contributing factors:

- Ensure and promote crew awareness of policies regarding the duties and obligations of officers on watch for the safety of the ship, even when a pilot is embarked.

- Promote a safety culture that when a pilot is embarked, the bridge team supports and is an integral part of the process of continual communications with the pilot for the duration of the transit.

Closing. These findings of concern are provided for informational purposes only, and do not relieve any domestic or international safety, operational, or material requirements. For any questions or comments, please contact the Office of Investigations and Casualty Analysis, Investigations Division, Commandant (CG-INV-1), at (202) 372-1029 or by email to CG-INV1@uscg.mil.