

## PILOT'S REP

## **AT OF MARINE SAFETY OCCURRENCE**



Board of Pilotage Commissioners 2901 Third Avenue, Ste 500; Seattle, Washington 98121

(206) 515-3904 FAX (206) 515-3906

3/21/22 Date: FILE WITH COMMISSION WITHIN 10 DAYS

Report of Marine Safety Occurrence - WAC 363-116-200 1 (b). A state licensed pilot and state licensed pilot trainee involved in a nearmiss occurrence shall complete the board required Report of Marine Safety Occurrence form and file it with the board as soon as possible after the near-miss occurrence, but in no event more than ten days afterwards. If a pilot trainee is involved, both the pilot trainee and the supervising pilot shall file a Report of Marine Safety Occurrence. A near-miss occurrence is where a pilot and pilot trainee successfully takes action of a non-routine nature to avoid a collision with another vessel, structure or aid to navigation, to avoid a grounding of the vessel or to avoid causing damages to the environment. Information relating to near-miss occurrences provided by a pilot and pilot trainee on this form shall not be used for imposing any sanctions or penalties against the pilot or pilot trainee involved in the occurrence. A state licensed pilot or pilot trainee may also use this form on a voluntary basis for reporting out of the ordinary occurrences or concerns for navigational safety encountered or observed during the course of piloting a vessel as well as safety issues encountered or observed on the vessel, the dock, or in the area around the vessel.

If you are reporting a near min

Date of Occurrence:		1500	Navigational Safety Concern :		
Length:	Registry: Liberia  Beam  AFT 42.6ft  container ship  Other  coma		No 🔲		
Wind: Speed: 15-20 kts Direction:  Light Condition:		Tide / Current: ebb  Direction: windy	Height: 1.2 ft Other:		
	Type of C	CCUFFENCE nan one, please explain in your narrative)			
Close Aboard Associated With:	Shallow Water Associated With:	Near Allision Associated With:	Docking Difficulty Associated With:		
Rules of Road Rule Situation:	Avoidance Maneuver	Avoidance Maneuver	Tug use Difficulty		
Restricted Visibility	Unanticipated Wind / Current Effects	Unanticipated Wind / Current Effects	Unanticipated Wind / Current Effects		
Narrow Channel	Navigation Problem	Navigation Problem	Order Execution		
Traffic Density	Equipment Malfunction	Equipment Malfunction	Equipment Malfunction		
Other:	Other:	Other:	Other: Crane position		
Completion of this form does n	ot replace or relieve the individual of	any other reporting requirements unc	der federal, state, or local law.		

Name (type/print) Willaim Sliker	Contact Phone ()	795-9199
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Please describe the occurrence, including the chain of events leading to the occurrence and human performance considerations, and suggest items that you think could prevent recurrence of a similar situation. Fill out additional pages and include diagrams, if appropriate.

Gantry Cranes at Terminal were not positioned close together near the midships section of the vessel (avoiding the vessel s bow and stern flair), per Puget Sound Pilots (PSP) Guidelines as expected. Prior to boarding vessel, reviewed the job notes which had the exact bridge location at the berth at the 1650ft mark. Shoreside personnel are responsible for the positioning cranes. Due to the size of the ships, it is not always possible to determine the exact crane location in relation to the bow until after the ship is alongside. After docking it was determined by the pilot that there were 2 cranes near the bow. With a ship this size an error of only 1 or 2 degrees can be enough for the bow to make contact with the cranes. Safe piloting requires the support of the shoreside facilities. This support was not present on March 9 at Pier 4.

Boarded the 9,954 TEU Containership Athos at Port Angeles Pilot Station for transit to Tacoma Pier 4, starboard side alongside, in the Blair Waterway. The Athos is a large ship with a deep draft requiring 3 tugs for berthing per PSP Guidelines and each had a bollard pull of 50mt. The strong winds in Tacoma on arrival required careful planning, consideration and timely response given the 10,150 cubic meters of sail area, the ship s Master calculated and provided. This equated to 47 tons of static wind force and 94 tons of dynamic wind force.

As we approached Tacoma, due to the strong winds I contacted the tugs to meet the vessel farther out than usual, near Brown s Point so that I could gain a better feel of the tugs effectiveness and vessel handling in the wind conditions. After slowing, one tug was made fast centerline aft for brakes (using between one-third to one-half power, one tug was made fast centerline forward and the third tug was running free pushing on the starboard quarter to compensate for the wind on the vessel s port quarter (pushing one-third to one-half power). With the tugs staying safely within tolerable limits with plenty of reserve power to compensate for any wind gusts, I deemed it safe to continue the approach to the Blair Waterway and to the berth. On the final approach to the Blair, the vessel started to encounter a North set due to the river, I stopped the tug that was pushing on the starboard quarter and had the tug shift to the port quarter in preparation for berthing as I no longer needed the assistance on the starboard quarter and the centerline aft tug was able to hold the ship s stern from closing too quickly towards the berth. Upon entering the waterway until the final approach to the berth, I used the bow thruster to starboard at 75% power and the bow tug as needed to push the bow towards the berth. I also used the stern tug center lead aft and the third tug to control the stern s movement towards and away from the berth. At approximately 600ft to final position, it was apparent that the cranes were not stowed midships as required. The exact location of the bow in relation to the cranes, given the distance from the bridge (where I was standing) to bow of 846.3ft was very difficult to ascertain. I thought that it was very likely that the cranes were in the wrong position. Given the difficult weather and the size of the ship, stopping the maneuver could have proven to be hazardous. It would have taken a significant amount of time to have the crane positions checked and then to move the cranes. Moving the cranes while the ship is close to the berth can also throw off a pilots sense of relative motion. I decided the safest course of action was to maneuver the vessel alongside the berth as opposed to stopping or backing out of the Blair waterway

## Narrative Topics to Consider How the Problem Arose How the Problem Discovered Contributing Factors **Corrective Actions** Perceptions **Judgments** Decisions Procedures Communications Ship Design Actions or Inactions Experience Language Difficulty Personal Alertness Did you notify the vessel master of your intent to file this report? Yes [ No 🗆

This form should be submitted as soon as possible, but no more than 10 days after the occurrence. Submit the completed form to the Washington State Board of Pilotage Commissioners.							
(Address on first pa	nge)	Vessel #1 Name:	Athos				
Pilot Name:	Willaim Sliker	Signature:	<u> </u>				

I decided the safest course of action was to maneuver the vessel alongside the berth as opposed to stopping or backing out of the Blair waterway while the cranes were checked and moved. I brought the vessel alongside the berth paying close attention to preventing any rotational motion of the vessel due to the quartering wind and propeller torque when backing the engine. The vessel was safely berthed parallel to the dock in the correct location, with 2 gantry cranes overhanging the bow and the vessel's gangway landing on the 20ft long platform on the berth.

To avoid the risk of allision between a container ship and a gantry crane at Pier 4 Tacoma, the Port of Tacoma should develop and enforce procedures to monitor the status of crane positions and communicate those positions and the preferred safe vessel berthing location or locations to the Puget Sound Pilots well in advance of an incoming container ship proceeding to a berth at Terminal 4.