

# M2095

*Posted on 23.03.2023 by Adam Parnell*

**Category:** [Maritime](#)

**Report Title** Loss of steering control on a bulk carrier approaching a berth

## Initial Report

The master-pilot exchange was completed with no defects or limitations recorded. A tug was made fast aft on the centre line before arrival at the harbour entrance.

The pilot altered to starboard at the entrance to the harbour in accordance with the passage plan, but no counter helm was applied, and the ship continued to swing to starboard. The pilot gave a positive order of hard to port, and at this point, the helm indication was showing hard to starboard. The bridge team reported to the pilot that the ship had lost control of the steering. There was no audible alarm on the bridge to indicate any defect or loss of control of the steering control system.

The engine was immediately stopped, and the tug was ordered to pull back easily to arrest the ship's headway which was reduced from 4.2kn to 0.4kn.

The master re-established control of the rudder in Non-Follow Up (NFU) mode, and the rudder was brought back to midships. With the ship in a safe position in the harbour, the master and engineers reported that the defect had been rectified. The pilot instructed the master to thoroughly test the steering gear system before proceeding to the berth. When completed, the vessel was berthed safely.

## Comment

This report is an example of a good safety culture in action. As a result of a comprehensive risk assessment that included contingency planning, the tug was ordered and made fast astern. The master-pilot exchange allowed the pilot to integrate quickly into the bridge team, and they acted as one team during the incident.

Depending on the nature of the breakdown, an audible alarm may not sound, and the rudder indication is the most reliable indicator of a breakdown occurring. This was quickly detected by an alert bridge team, and the pilot could reduce speed by ordering the stern tug to take action. Once the engineering team reported that the problem was fixed, the bridge team carried out confirmatory checks, and the vessel continued safely alongside.

## Key Issues

**Culture** – Are you confident that the safety culture on board your vessel is similar to the one demonstrated here?

**Communications** – Because the communications were so good, even the outstations (engine room, tug, and parts of ship) were aware of what was going on and what they had to do. This is an excellent example to follow.

**Teamwork** – The pilot, master, bridge team, engineers and tug crew all operated in harmony because they had a shared mental model of the issue and the actions required. The pilot’s insistence that the entire steering control system is tested before berthing was correct. The port authority should be commended for adopting this thorough approach to risk mitigation.

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**lack\_of\_knowledge**Knowledge

**poor\_communication**Communication

**teamwork**Teamwork



