

Log M-384D



NATIONAL TRANSPORTATION SAFETY BOARD

Washington, D.C. 20594

Safety Recommendation

Date: June 25, 1993

In Reply Refer To: M-93-34

State Pilot Commissions
(address list attached)

On August 7, 1992, the United Kingdom passenger vessel RMS (Royal Mail Ship) QUEEN ELIZABETH 2 (QE2) was outbound in Vineyard Sound, Massachusetts, when the vessel grounded about 2 1/2 miles south of Cuttyhunk Island. No injuries or deaths resulted from this accident. However, damage was significant; temporary and permanent repairs cost about \$13.2 million. In addition, the total revenue lost for the period before the vessel returned to service on October 2, 1992, was estimated at \$50 million.¹

The Safety Board believes that in this accident, a critical need existed for improved communication between the pilot, the master, and the other crewmembers on the bridge. The master had apparently made incorrect assumptions about the pilot's intentions, and the pilot saw no need to inform the master about what he actually planned to do. Although the pilot expressed

¹For more detailed information, read Marine Accident Report—*Grounding of the United Kingdom Passenger Vessel RMS QUEEN ELIZABETH 2 Near Cuttyhunk Island, Vineyard Sound, Massachusetts, August 7, 1992* (NTSB/MAR-93/01).

full confidence in the ability of the officers on the bridge to perform navigational tasks and was aware that the second officer was monitoring the ship's progress and reporting that information to the master, the pilot still opted to pilot by his own methods rather than following the courses plotted by the navigator. The master stated that he assumed that the pilot was going to follow the reverse of the inbound course. Thus, the navigation of the vessel as understood by the pilot was not communicated to the master or the bridge watch.

Evidence from the investigation also indicates that the master did not fully understand how the pilot had planned to get to his debarkation point or that the pilot planned a course change at the "NA" buoy. The Safety Board believes that had adequate communication been established between the master and pilot, the master would have told the pilot of his preference to remain on a course that passed Brown's Ledge to the south. Moreover, the pilot probably would have explained his intention to stay north of the shoals near Brown's Ledge, and he and the ship's officers would have discussed the implications for safety in returning or not returning to the base course. Had the pilot and the ship's officers discussed the ship's course either immediately following the turn at the "NA" buoy or during a predeparture pilot/master conference, the factors increasing the risk of striking bottom would have become apparent.

One element that hindered effective communication in this accident was the substance and nature of the master/pilot conference currently required by Federal regulation (33 CFR 164.11(k)). Presently, the briefing only requires details of the vessel's status and its maneuvering characteristics at the beginning of a voyage. No requirements exist for a detailed navigation plan for maneuvering the vessel in pilotage waters or for followup conversations during the voyage. Furthermore, the nature of the conference requires only the inclusion of the master and the pilot. Thus, even if the master and pilot chose to discuss their navigation plans, other members of the bridge team may be excluded from those discussions.

Therefore, the National Transportation Safety Board recommends that State pilot commissions:


Require that State pilots, upon boarding a vessel, conduct a conference with the master and other relevant deck officers that includes a discussion of the pilot's proposed route, including courses, speeds, squat, and unique maneuvers that may be encountered. (Class II, Priority Action) (M-93-34)

Also, the Safety Board issued Safety Recommendations M-93-17 through -26 to the U.S. Coast Guard, M-93-27 to the Department of Transportation, M-93-28 and -29 to the National Oceanic and Atmospheric Administration, and M-93-30 through -33 to the Cunard Lines, Ltd. The Safety Board is also reiterating Safety Recommendations M-91-6 and -28 to the U.S. Coast Guard.

The National Transportation Safety Board is an independent Federal agency with the statutory responsibility "to promote transportation safety by conducting independent accident

investigations and by formulating safety improvement recommendations" (Public Law 93-633). The Safety Board is vitally interested in any action taken as a result of its safety recommendations. Therefore, it would appreciate a response from you regarding action taken or contemplated with respect to the recommendations in this letter. Please refer to Safety Recommendation R-93-34 in your reply. If you need additional information, you may call (202) 382-6850.

Chairman VOGT, Vice Chairman COUGHLIN, and Members LAUBER, HART, and HAMMERSCHMIDT concurred in this recommendation.

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