



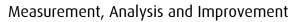
FMS.12.02.1301 Deficiency Corrective action and close out				
Created by: QA	Approved by:	Head of Fleet Management	Issued by:	QA
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General

- This form is to be used for deficiencies/observations noted for any PSC / External Class ISM, ISPS or MLC Audits (NC and Observations) / Terminal Inspection / Any Third Party Inspections
- Corrective actions are taken to eliminate the causes of actual non-conformities, observations or
 deficiencies to prevent recurrence. The corrective action taken shall be appropriate to the effects of the
 non-conformity, observation or deficiency encountered.
- Preventive actions are taken to eliminate the causes of potential non-conformities, observations or deficiencies to prevent their occurrence. These shall commensurate with the identified risks and effects of the potential problems.
- Fleet Teams and SMTs are responsible for ensuring that non-conformities, observations or deficiencies and potential non-conformities, observations or deficiencies are analysed and appropriate actions taken to eliminate the root causes

Ships Name:	BW Kestrel
Type of Inspection:	Pilot boarding deficiency report
Port:	Port Reading / South dock
Date:	15 April 2018
Total no. of Deficiencies:	1

Deficiency No : 1	Details: 70 Degree Angle Very dangerous climb. Transition from gangway to steps on ship was not Safe.
Root Cause Analysis:	 Non-availability of safe boarding arrangements from ship to shore. Failure to access gangway operational safety requirements. Alternative boarding arrangements not explored.
Corrective Action taken:	All pre-arrival communications for the ship's laden and ballast conditions were exchanged. The ships gangway could not be suitably deployed due to the layout of the jetty and the positioning of the vessel. On arrival, the freeboard permitted the safe deployment of the Ships MOT gangway and hence it was used.
	The ship/shore safe access was rigged in accordance with the ISGOTT, COSWP, industry best practices and company's guidelines. The access was monitored with due diligence and vigilance. Regular checks in accordance with the Ship Shore safety checklist with the terminal at the agreed intervals and recorded. Safety nets was rigged, observed in a good clean condition and safety equipment was in state of readiness.
	Towards the end of cargo operations, due to the vessel's freeboard, jetty structure and restricted space, the gangway could be shifted to a new location and hence the recommended angle for safe access was exceeded.
	In this condition, the transition point for a person moving from the MOT ladder on to the ship was on the hose rail and hence could not be fixed at





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	the end of gangway. The transfer area although was adequately protected with control safety measures, the access was not in compliance with the company procedures. The vessel's crew failed to explore alternate means for boarding
	arrangement. The offshore accommodation ladder was kept ready, but was not considered. The step ladder for the transfer from gangway to the deck is appropriate and safe for use.
Preventive action taken:	The Master reiterated to the ship's team the importance of having a safe boarding arrangement and the responsibility of maintain and monitoring its conditions lies with the ship. A training was conducted with ship's deck team (See attached file).
	If the recommended safe angle is anticipated to be exceeded during the vessel's stay, the Master will advise the agents to arrange for a suitable gangway. In the absence of that, the ship's crane/personnel transfer basket or offshore gangway with a service boat will be used.
	The vessel has fabricated an angle indicator on the portable ladder which will assist to readily identify the angle of inclination. (See attached file).
	This will be shared with the fleet.
Supporting evidence attached:	Photos of the angle indicator on MOT ladderCrew training log