

Bulk Carrier Pacific Century Major Marine Occurrence

Executive Summary

At approximately 1909 local time on 9 June 2025, the Hong Kong-flagged bulk carrier Pacific Century (IMO No. 9568902, gross tonnage 94955, length overall 295.00 m, beam 46.00 m) made contact with Wharf No. 89 during departure operations at the Port of Kaohsiung, resulting in damage to the vessel's rudder and the wharf facility. In addition, the working boat CSBC No. 8, which was moored alongside Wharf No. 89, capsized and sank after being affected by the propeller wash generated by Pacific Century. No injuries or environmental pollution were reported.

In accordance with the Transportation Occurrence Investigation Act, Taiwan, and the definition of major transportation occurrences specified therein, the Taiwan Transportation Safety Board was the independent agency in charge of investigating the marine accident. The organizations and agencies invited to participate in the investigation included the Maritime and Port Bureau of the Ministry of Transportation and Communications, Taiwan International Ports Corporation, the Kaohsiung Harbor Pilot Office, China Shipbuilding Corporation (CSBC), M.I.T. Chartering & Agency Co., Ltd. and the Marine Department of Hong Kong.

Based on a comprehensive analysis of the factual information, the investigation identified 9 findings and issued 5 safety recommendations. The final report was reviewed and approved at the 86th TTSB Board Meeting held on May 8, 2026.

The finding related to probable causes:

1. During the departure operation from Wharf No. 98 at the Second Entrance of the Port of Kaohsiung, Pacific Century entered continuous sternway before establishing sufficient lateral clearance under restricted water space conditions, thereby reducing the time and space available for safe maneuvering corrections during departure.
2. During astern propulsion, the vessel developed a starboard-turning tendency due to the transverse thrust generated by the propeller and the pushing force applied to the port bow by the tug, causing the stern to gradually drift toward Wharf No. 89. When the distance between the stern and the corner of Wharf No. 89 had reduced to approximately 0.1 nautical miles and the sternway speed had reached approximately 2.5 knots, the pilot became aware of the drift and initiated emergency corrective actions. However, the available maneuvering space was limited due to the vessel's distance from the wharf and sternway speed, resulting in contact between the vessel's stern and Wharf No. 89 and causing the working boat CSBC No. 8, which was moored alongside the wharf, to capsize and sink.

The findings related to risk:

1. During the departure operation, the pilot and master of Pacific Century completed a basic Master-Pilot Information Exchange (MPX). However, the lateral clearance required for pulling the vessel away from the berth, as well as the timing and procedure for initiating astern propulsion and sternway movement, were not clearly discussed and agreed upon during the information exchange process. As the actual maneuver gradually deviated from the pilot's original expectations, the master and pilot did not identify the deviation at an early stage or adjust the maneuvering approach accordingly.

2. After Pacific Century entered the sternway phase, the bridge team primarily provided vessel speed information as part of the vessel's situational updates, but did not simultaneously incorporate critical information such as Course over Ground (COG), sternway track, and the vessel's relative position to the wharf as references for continuously monitoring the vessel's sternway direction, heading, and relative position.
3. During sternway navigation, the master primarily relied on real-time visual observation and prior shiphandling experience to monitor the pilot's maneuvering. However, the master did not sufficiently utilize relevant navigational information as a basis for timely reminders, resulting in the bridge team's monitoring function not effectively providing corrective suggestions or intervention when deviations in the maneuvering situation gradually developed.

The other findings:

1. At the time of the occurrence, the steering gear, main engine, navigational equipment, and other related systems of Pacific Century were operating normally.
2. The two pilots involved in this occurrence both held valid Kaohsiung Harbor Pilot Licenses issued by the Ministry of Transportation and Communications of the Republic of China (Taiwan). The master and crew members of Pacific Century also held valid certificates of competency issued by the maritime authority of the flag State. No evidence indicated that this occurrence was related to personnel fatigue.
3. According to weather and sea condition data, weather conditions during the occurrence included northwesterly winds at Beaufort scale 3 to 4, a rising tide of approximately 0.9 meters, and good visibility. No evidence

indicated that this occurrence was related to weather conditions.

4. The departure operation in this occurrence was conducted under a two-pilot arrangement. However, a review of the current relevant regulations and operational procedures identified no explicit provisions regarding the specific division of duties and responsibilities between two pilots assigned to the same pilotage task. Nevertheless, based on a comprehensive review of the sequence of events, relevant interview information, and actual operational practices in this occurrence, no evidence indicated that the occurrence was related to the two-pilot arrangement.

Safety Recommendations

To the Kaohsiung Harbor Pilot Office

1. Strengthen pilots' maneuvering judgment and risk identification capabilities during inbound and outbound pilotage operations through recurrent training and case reviews, including topics such as lateral clearance, conditions for initiating astern propulsion and sternway movement, and associated monitoring priorities, in order to enhance pilotage safety.
2. Strengthen the mechanism for continuous information exchange between pilots and masters during pilotage operations so that deviations in vessel movement or track from the original plan can be identified and corrected in a timely manner.

To the Hong Kong Ming Wah Ship Management Co., Ltd.

1. Review existing safety management and berthing/unberthing operational procedures to ensure that masters within the fleet continuously maintain awareness of the vessel's movement status during pilotage operations.

When a pilot's maneuvering judgment or actions are identified as potentially affecting navigational safety, masters should, in accordance with the principle of the master's overriding authority and responsibility, proactively intervene, direct corrective actions, or take over the maneuver when necessary to ensure navigational safety.

2. Review the implementation of existing operational procedures in practice and evaluate measures to strengthen their effective application so that bridge teams, during pilotage operations, can support the maneuvering judgment of the pilot and master by integrating critical information such as vessel speed, Course over Ground (COG), vessel track, and relative position in accordance with established procedures.

To the Maritime and Port Bureau of the Ministry of Transportation and Communications

1. Review the current pilotage-related mechanisms and strengthen pilots' maneuvering judgment and risk identification capabilities during inbound and outbound pilotage operations. In addition, evaluate improvements to relevant assessment, training, and supervisory mechanisms in order to enhance pilotage safety.

Note: The final report of this occurrence investigation is published in Chinese. To facilitate understanding for non-Chinese readers, the Executive Summary has been translated into English. While every effort has been made to ensure accuracy, discrepancies may occur. In the event of any inconsistency, the Chinese version shall prevail.