SYNOPSIS

At 2047 on 20 June 2007, the 4804 grt passenger ship *Logos II* made contact with a shore crane and two small vessels when berthing alongside Victoria Pier in St Helier, Jersey. At 1200 on 26 June 2007, *Logos II* also made contact with a pier head as she was leaving St Helier after the tow line with which she was connected to a tug parted. Harbour pilots were embarked during both accidents with the tugs *Marineco Toomai* and *Titan* assisting during berthing operations and *Duke of Normandy* and *Titan* assisting during the departure from St Helier. Damage to *Logos II* was limited to indentations on her starboard bow, bent pulpit railings and superficial damage to paintwork. Structural damage was caused to the pier head and the two small vessels. There were no injuries.

The investigation identified a number of factors which contributed to the contacts, including:

During the berthing operation:

- As the vessel was pushed bodily towards her berth by two tugs, her speed of approach increased as she came into the lee of the harbour wall and the effect of the wind, which had been blowing off the berth, was lost.
- The actions of the pilot to reduce the speed of approach of the vessel's bow were unsuccessful because *Marineco Toomai* was positioned just aft of amidships of *Logos II* and not on the port quarter as the pilot had assumed.
- The pilot did not accurately monitor the position of *Marineco Toomai*.
- The two small vessels which were damaged were not moved prior to the arrival of *Logos II* as they were not considered to be at risk.

When departing St Helier:

- There was a lack of co-ordination and communication between the pilot and the tug's skipper.
- A ship's line was used to secure *Duke of Normandy*, which was probably not as strong as lines specifically manufactured for towing.
- After the tow line parted, *Logos II* drifted onto Victoria Pier head due to the effect of the moderate north west breeze.

A number of factors affecting the overall safe operation of the port of St Helier and its compliance with the Port Marine Safety Code were also identified during the investigation. These included:

- No audits to verify the port's compliance with the Port Marine Safety Code had been undertaken.
- The port's safety management system was a working draft and had not been formally reviewed since its introduction in 2001.
- Risk assessments had not been accessible since March 2007.
- There had been no formal risk assessment for the visit of *Logos II,* which was an unusually large vessel to enter the port's inner harbour and was known to be difficult to manoeuvre.
- No towage guidelines had been developed.
- There was no continuous professional development programme for pilots.

To prevent similar accidents in the future, Jersey Harbours has commenced a review of its marine safety management system, developed an audit plan and a procedure for the initiation of a risk assessment when accepting unusually large vessels, commenced the development of towage guidelines, and implemented a review of pilot training requirements.

Recommendations have been made to the States of Jersey Economic Development Department and Jersey Harbours, with the aim of improving Jersey Harbours' safety management organisation and providing verification of its compliance with the Port Marine Safety Code through an independent audit body.