

## **MAIB SAFETY BULLETIN 2/2005**

Collisions and contacts  
between tugs and  
vessels under tow or escort  
in United Kingdom ports

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This document, containing safety lessons, has been produced for marine safety purposes only, on the basis of information available to date.

*The Merchant Shipping (Accident Reporting and Investigation) Regulations 2005* provide for the Chief Inspector of Marine Accidents to make recommendations at any time during the course of an investigation if, in his opinion, it is necessary or desirable to do so.

A number of collisions between harbour tugs and the vessels they were assisting have been reported recently to the MAIB. Investigations have highlighted a number of safety issues shared by each of the collisions. It is these shared issues which prompted this Safety Bulletin.

A handwritten signature in black ink, reading "Stephen Meyer". The signature is written in a cursive style with a long horizontal stroke at the bottom.

Stephen Meyer  
Chief Inspector of Marine Accidents

**This bulletin is also available on our website: <http://www.maib.gov.uk>**

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## **BACKGROUND**

During the first 4 months of 2005, the MAIB has been notified of three significant collisions involving harbour tugs. In the first incident, a tug running stern first ahead of a merchant vessel lost control, turned broadside across the bow of her charge and was holed beneath the waterline. In the second, a tug guiding the stern of a merchant vessel moving stern first lost control, struck the stern, and ended up with her tow line wrapped completely round her bridge superstructure. In the third incident, a tug attempting to pass a line to a merchant vessel underway lost control, ran in under the bow and struck the bulbous bow. Fortunately, in two cases the damage was reasonably minor; in the third, the tug had to be beached. No lives were lost, however the consequences could have been much worse.

The common theme to all three of the above incidents was that the tug master, although in each case quite experienced, was operating a tug with an unfamiliar propulsion system, and was attempting a manoeuvre with that system for the first time. The tug propulsion systems in the three incidents were not the same, however, each required a very different thought process on the part of the tug masters to manoeuvre the vessels effectively and safely when compared to the systems they were accustomed to. The key point is that, although the tug masters had a wealth of professional experience, they had received insufficient training and familiarisation with the systems they were using when the collisions occurred.

## **SAFETY LESSONS**

MAIB strongly urges that:

- All tug operators review their training schemes, to ensure that tug masters receive comprehensive familiarisation training before taking control of a tug which is equipped with a significantly different propulsion system. Such training should incorporate instruction and validation on all manoeuvres that the tug master is likely to be tasked in the port.
- All harbour authorities, pilots and tug operators regularly review the capabilities and limitations of their harbour tugs and their crews, to ensure a common understanding of each tug's strengths and weaknesses. This should be supplemented for each towing task with a local appraisal of the intended operation to ensure the "tug to task" allocation is appropriate before the tow or move begins.