Marine and Safety (Maritime Incidents) Regulations 2007

INVESTIGATION INTO A COLLISION WITH MOORED RECREATIONAL VESSELS

TUG

"GODLEY"

MURRAY STREET PIER, HOBART TASMANIA

20th OCTOBER 2014

MAST
MARINE and SAFETY TASMANIA
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FOREWORD

Inquiries and investigations into Marine Casualties occurring within Marine and Safety Tasmania's (MaST) jurisdiction are conducted under the provisions of the Marine and Safety Tasmania (Maritime Incidents) Regulations 2007.

Incident investigation reports must be submitted to the Board of Directors of MAST.

It is MaST policy to publish such reports to increase the awareness of marine incidents so as to improve safety at sea.

Copies of the reports can be obtained from:

Marine and Safety Tasmania,
PO Box 607,
Hobart 7001

Or the web site:

www.mast.tas.gov.au (Resources, Incident Investigation Reports)

SUMMARY

At approximately 1315 on Monday the 20th of October 2014 the tug “Godley” was assisting with the berthing of the “HMNZS Te Kaha” at Princes Wharf No. 1. The tug was made fast to the starboard bow of the warship.

Once “HMNZS Te Kaha” was in position on the wharf, the location of “Godley” was quite close to the T-head at the end of the Murray Street Pier and two recreational vessels moored there.

At this point in time the “Te Kaha” was being secured to her berth and “Godley” was standing by with her tow line slack but still secured to the starboard bow of the warship. From the evidence of the Port Control CCTV it would appear that the tug moved slowly astern and her tow line became tight which caused her to move sideways to starboard and her starboard side collided with the two vessels moored on the T-head. This contact caused extensive damage to one of the vessels and the ‘T’ head jetty was displaced.

Following the collision, the pilot on “HMNZS Te Kaha” was informed and a report was submitted to the owner. An Incident Report was also submitted to MaST, by the Master.

SOURCES OF INFORMATION

- Incident Report from the Master.
- Pilotage Incident Report from the Pilot.
- Port Control closed circuit television footage of the incident.
- Voice recording of radio traffic between the Pilot and "Godley" during the berthing procedures on VHF channel 8.
- Interview with the Master of "Godley" on 30th October 2014.
- Interview with the Pilot on 5th November 2014.
- Interview with the engineer on "Godley" on 5th November 2014.
- Interview with a retired tugmaster relating to tug operation on 3rd November 2014.

DETAILS OF THE TUG "GODLEY"

Length:	28.73m
Beam:	9.73m
Engines:	Two 745kw diesel engines
Hull materials:	Steel
Year built:	1977

Survey status: AMSA Certificate of Survey as a Regulated Australian Vessel valid until 29.04.2017
Lloyds Certificate of Class valid until 29.04.2017
Lloyds Loadline valid until 29.04.2017

Crew qualification requirements:

Master:	Master Class 4 when operating within sheltered waters.
Engineer:	Marine Engine Driver Grade 2 when operating within sheltered waters.
Crew:	One general purpose deckhand.

Note: All manning requirements were complied with.

NARRATIVE

On Monday the 20th of October 2014 the New Zealand warship “HMNZS Te Kaha” was berthing at Princes Wharf No.1. She was bow in and berthing port side alongside. To assist with the berthing, two tugs had been requested these were the “Watagan” which was positioned on the starboard quarter and “Godley” positioned on the starboard bow. Both tugs used their own towlines which are mounted on winch drums on the bow of the tug. These winches are then controlled from the bridge of the tug so length and tension is directly under the supervision of the Master although the winch controls are operated by a second crew person, usually the engineer.

Both tugs are twin engine and propulsion is through 360 degree azimuthing propellers in nozzles commonly known as “Z drive”, this type of propulsion makes the tug highly manoeuvrable.

The berthing of “HMNZS Te Kaha” commenced at approximately 1300 on the day and the vessel was in position on the berth about 15-20 minutes later. During the berthing the pilot had talked to the Master of the “Godley” on VHF Ch 8 pointing out the close proximity of the recreational vessels on the ‘T’ head of the Murray Street pier and asked if this close proximity could pose a problem. The Master replied that he was comfortable with the situation. However if he was required to ‘pull off’ then this would be at about 45 degrees as a 90 degree pull would not be possible.

Once the warship was in position on the wharf, both tugs were standing by while the ship’s lines were made fast ashore. At this point in time the ferry “Ena” departed from Murray Street pier by reversing past the berthing operation and passing approximately 15-20m astern of the “Godley”. Shortly after the ferry had passed, the “Godley” slowly moved astern and away from the warship, her starboard side was approximately 10-15m from the vessels moored at the end of the Murray Street pier. As she continued to move astern, her tow line, which was leading at approximately 45-50 degrees on her starboard bow, came under tension, this tension caused her bow to swing to starboard and the whole vessel is seen to briefly heel to starboard at the same time. Following this occurrence the distance between the tug and the moored vessels is seen to decrease quite rapidly and shortly after her starboard side collided with both the small vessels moored on the ‘T’ head of the Murray Street pier.

Following the collision, the Master manoeuvred the tug clear of the small vessels and reported the incident to the pilot. The Master also completed a MaST Incident Report and the Pilot completed an incident Report and an AMSA Form 18.

COMMENTS

Following the various interviews which were conducted, as investigator, I feel the following comments are of relevance:

The use of Princes Wharf No.1 – Following discussions with the pilot, it would appear that this berth is seldom used, possibly 6-8 times a year for vessels similar to the "HMNZS Te Kaha" and also as a 'lay-up' berth for Antarctic vessels during the winter season.

Movement planning prior to berthing – In this particular instance the various notifications were transmitted via email approximately 3 days before the arrival of the warship and all parties were informed. After receiving the notification, the pilot drew the attention of the ship scheduler to the possible problems with the close proximity of the recreational vessels moored at the Murray Street pier and requested that the vessel be positioned closer to the eastern end of the berth. However, it would appear that this request was not acted upon and the navy positioned portable fenders further to the west of the pilot's suggested position, this necessitated the final berthing position being closer to the Murray Street pier.

Tug engine controls – The tug "Godley" was built in 1977 and her propulsion controls are opposite to the other 'Z drive' tugs owned by the owner. That is to say that a tugmaster moving from one tug to another, as they are required to do, has to reacquaint himself with the controls as they are not the same.

Winch control operation – The winch controller on this tug is a simple lever with three positions, pushing the lever forward pays out the tow line, back retrieves it and the central position stops the drum and applies the brake. This control is operated by a crewman who is usually the engineer as the Master has to use both hands to control the engines. However, the winch operator will only operate the winch at the instruction of the Master.

Closed Circuit TV recording – The whole berthing and incident was recorded by the port control camera and even wash and propeller turbulence is easily discernible. Consequently, this information, together with the VHF radio recording, allows for a good assessment of the incident.

Operation of the ferry "Ena" – The movement of the ferry is not considered contributory to this incident. However, it could have caused a distraction and its operation so close to a ship berthing operation is questionable (see the final Recommendations).

Recreational vessels moored at Murray Street pier – It has been suggested that any recreational vessels moored on the 'T' arm at the pier should be moved prior to ship berthing/unberthing operations at Princes Wharf No.1 (see the final Recommendations).

Weather conditions – The reported weather conditions suggest that weather was not a contributing factor to this incident.

CONCLUSIONS

These conclusions identify three different factors which, in the opinion of the investigator, may have contributed to the incident.

- ***Tug manoeuvring and tow line handling*** – As is the case in any commercial vessel operation, the Master is responsible for the handling of his vessel. In this incident, the tow line coming under tension when the tug was in close proximity to the moored vessels is considered a contributing factor and should it have remained slack the collision may not have occurred.

  Furthermore, as the berthing operation was almost completed and the tug was 'standing by' prior to letting the tow line go, it may have been prudent of the Master to maintain a greater distance between the moored vessels and the tug. It could also be possible that the 'different' engine controls confused the Master when he was trying to manoeuvre clear of the moored vessels however he has had some years of experience in handling this vessel.

- ***Berth planning*** – From my discussions with the pilot it could well be possible that had the "HMNZS Te Kaha" been berthed further to the east on Princes Wharf No. 1 then the operation of the bow tug would have been more removed from the moored vessels.

- ***Control of commercial vessels manoeuvring in close proximity to berthing operations -*** While the "Ena" reversing clear of its berth on Murray Street pier and coming in close proximity to the tug did not, in my opinion, contribute to the incident, it may have caused a distraction.

RECOMMENDATIONS

In all incident investigations the recommendations are made by the appointed investigator in order to assist the Board of MaST in reaching a decision regarding the actions to be taken when an incident occurs. In most instances, such actions are primarily concerned with the prevention of a recurrence and secondarily may require punitive action against a person or persons depending on the nature and severity of the incident.

In this particular incident, there was no injury or loss of life and the recommendations are directed at preventing a recurrence.

Recommendation One: MaST request the owner of “Godley”, to implement additional training of the Master in ship manoeuvring and tow line handling on this vessel. Furthermore, should this training reveal that that the ‘dissimilarity’ of engine controls on this vessel may or could cause confusion, then all Masters that are required to operate the tug, also undergo an updated training regime.

The possibility of standardising all tug controls may also be a consideration.

Recommendation Two: MaST request the owner to review their planning procedures with regard to berthing vessels at Princes Wharf No.1. In all cases the pilot in charge holds responsibility for the safe berthing of a vessel and as such should be included in all discussions. These discussions are usually between agents, schedulers, Port Control and any other organisations, such as Navy in this case, but ultimately it is the pilot who should make the final decision on berth suitability and position. This recommendation may also apply to other wharfs within the port.

Recommendation Three: Given the circumstances of this incident, MaST should request the owner to review the pilot/tugmaster planning procedures for berthing vessels on restricted berths. These procedures may include such matters as; clearance distances to be maintained, the most appropriate positions to ‘lash up’ on the vessel and any other matters that the pilot/tugmasters may consider appropriate in order to avoid a similar situation in the future.

Recommendation Four: MaST to request the owner to review the oversight of commercial vessel (ferry) operations when this may include a vessel passing in close proximity to berthing operations. It is usual for Port Control (VTS) to make a general announcement on VHF Ch 12 when ship movements are expected in the port. It is suggested that, in this instance, Port Control should have requested the “Ena” to remain in her berth until Port Control had been advised by the pilot that the berthing operation had been completed. Alternatively, the use of a minimum clearance distance could be implemented, such distance to be determined by the pilot and tugmasters.

Recommendation Five: MaST to recommend to the owner that part of the planning procedure in Recommendation Two should be to inform the operator of the boat brokerage on Murray Street pier that a berthing is planned for Princes Wharf No. 1. This information may suggest that consideration should be given, by the brokerage, to removing any vessels moored against the ‘T’ berth.