



**British Tugowners Association**  
**22<sup>nd</sup> Annual Safety Seminar**  
**14 November 2024**



The 2024 BTA Annual Safety Seminar was held on Thursday, 14 November, at The Leith Cruise Terminal in Edinburgh, kindly hosted by Forth Ports. The event welcomed over 100 attendees, including representatives from towage operators, pilots, port and harbour authorities, insurers, accident investigators, regulators, and manufacturers.

With a central theme of vital communications and tug use in firefighting, the seminar provided an invaluable platform for the tug industry to exchange lessons learned and share best practices.

**With sincere thanks to our sponsors for the day**



**Scott Baker, immediate past Chairman** of the BTA, opened the event with the Chairman's Address, standing in for BTA Chairman, Nick Jeffery who regrettably couldn't attend. Scott welcomed delegates to the 22nd Safety Seminar, highlighting the critical role clear communication plays in ensuring safe towage operations and encouraged crews to enhance their information-sharing practices to support seamless collaboration among stakeholders within towage operations.

**Alasdair Smith, BTA Technical Chairman**, compered the day and in his opening remarks emphasised the abundance of safety information available to tug crews. He noted the importance of integrating the wide scope of knowledge, possessed by seafarers, including skills, developing company culture, speed, haste, positioning, emergency release and watertight integrity into daily operations. Alasdair commended the seminar's focus on communication, describing it as a cornerstone of safety in the towage industry.

The seminar's first speaker was **Bill Evans, Inspector of Marine Accidents** at the **Marine Accident Investigation Branch (MAIB)**. Bill presented an overview of the recently published MAIB report on the girting of the CMS Biter, a tragic incident that resulted in the deaths of two tug crew members.



*Image courtesy of the MAIB report.*

Bill explained that the incident occurred during the escort of the cruise ship Hebridean Princess into James Watt Dock in Greenock by two small conventional tugs.

**Bill outlined the findings of the report, with the following safety issues identified as contributing factors:**

- the marine pilot's training had not prepared them to work with conventional tugs
- master/pilot and pilot/tug exchanges were incomplete and, with no shared understanding of the plan, the passenger vessel's master and the tug masters were unable to challenge the pilot's intentions
- the passenger vessel's speed placed significant load on the tug's lines and almost certainly caused the gob rope to render
- the tug's gob rope did not prevent it being girted
- the tug's rapid capsize, in under 10 seconds, meant the crew had insufficient time to release its towlines

- an open hatch compromised the tug's watertight integrity and limited the crew's chance of survival

Bill urged delegates to examine ways to enhance communication between pilots and tug crews, as well as between pilots and vessel masters, stressing the need for robust bridge resource management practices and a culture where passage plans can be openly challenged when necessary to ensure safety.

Bill set the audience three questions to reflect on and consider their own operations against:

- 1) How do you communicate?
- 2) What information do you exchange?
- 3) Can you do it better?

The investigation report contains a number of recommendations for the BTA, Pilots' Association, Harbour Masters and others and all were recommended to read, digest and act upon them to improve safety.

**James Evans** from **Boluda Towage** presented on the BTA's 2023 Annual Safety Statistics, highlighting the following key points:

- Most first aid cases and medical treatment cases occurred whilst 'safely' alongside
- Most first aid cases occurred from a slip trip or fall event
- Most LTIs occurred whilst handling ropes
- That whilst illicit heaving line incidents had dramatically declined since 2016 to 0 in 2023, there remained 9 near misses.
- Working with machinery was the most likely cause of a near miss.
- An increase in first aid cases involving ropes, as well as a doubling of LTIs

James challenged tug operators to explore why first aid cases and medical treatment cases continue to be prevalent whilst the vessel is alongside, which should be the area of least risk for crew. There was also discussion surrounding the differences between a near miss and an incident involving illicit heaving lines and what can be done to further reduce their use.

Following the refreshment break delegates were separated into working groups and asked to discuss questions surrounding key communications, with responses highlighted in the boxes.

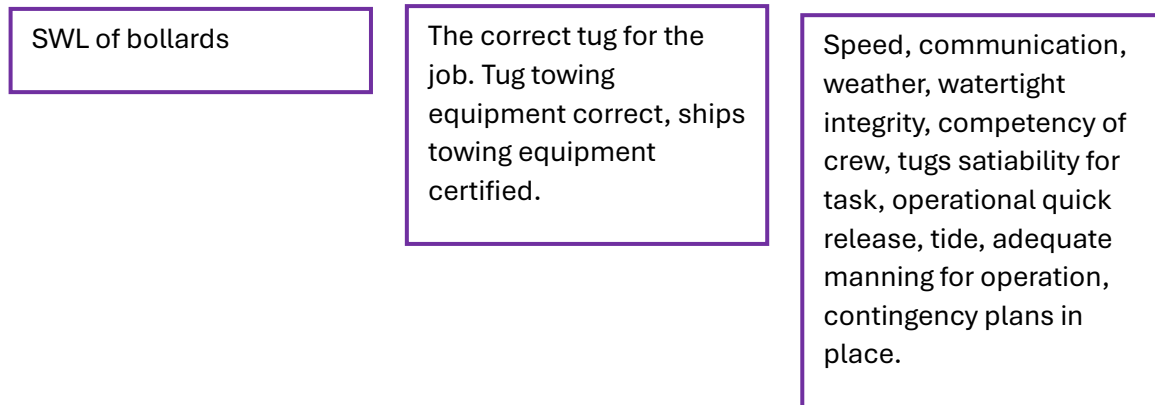
### **What communications are required between Pilot, Ship's crew and Tug's master?**

Agreement on speed, planned manoeuvre, safe working loads, rope arrangements

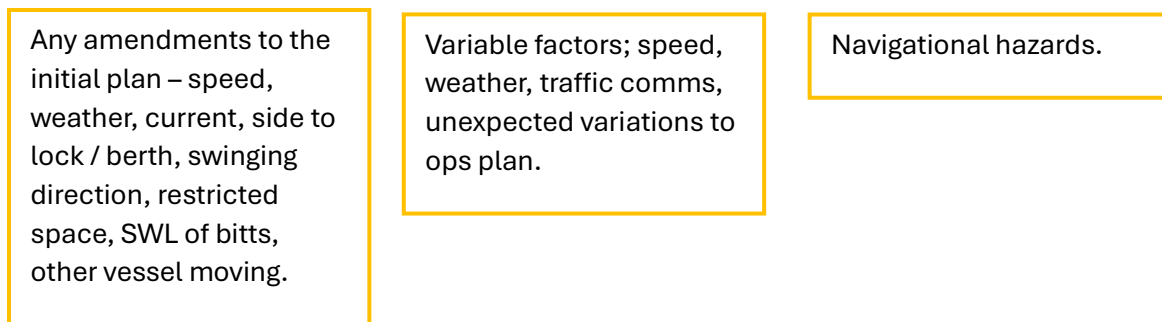
Formalised SMS communications via MPX & PTX. Speed and position checks. Intended manoeuvre, SWL and abort point changes in plan.

References to plan, standard phrases, speed, position, stop, checking everyone is with environmental factors.

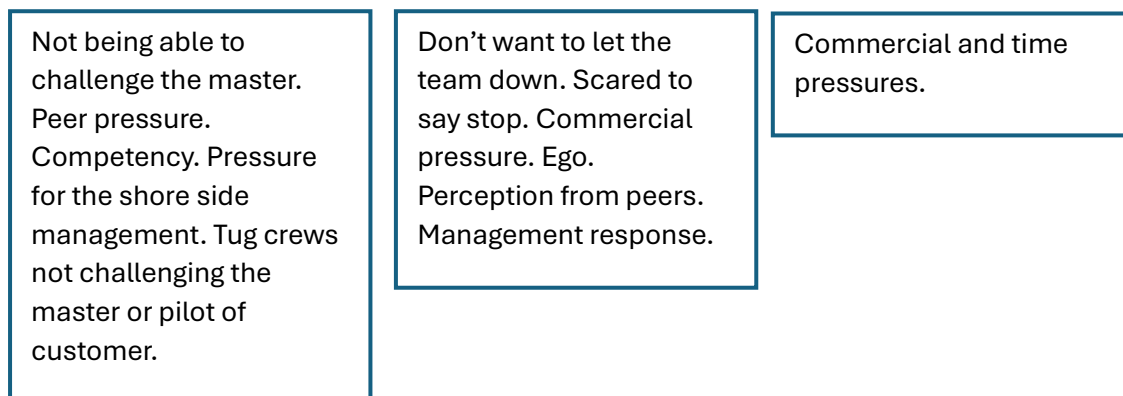
## What safety critical matters must be considered for safe towing?



## What changing factors to discuss during different anticipated stages of the towage operation?



## What behaviours prevent those involved in towage operations from stopping the job?



The BTA has collected the results of the working groups and are set to discuss them at the Technical Committee where the results will be analysed with it intended that best practices and recommendations will be made to industry.

**Scott Baker, Head of Marine Standards Europe of Svitzer** then provided insights into the findings of the extensive internal incident investigation into near girting of the conventional tug, Gray Test, in Felixstowe, which had many similarities to that of the Biter. The tug, carrying out ship assist towage got itself into a position which resulted in a 60-degree list and serious danger. Fortunately, the crew were able to release the emergency tow hook and there were no casualties or injuries as a result.



*Image courtesy of Svitzer.*

The incident highlighted how rapidly a routine towage operation through excessive speed can quickly turn dangerous.

An internal report on the incident revealed significant scope creep in towage operations, as assisted vessels had become consistently

larger and operating at higher speeds under tow, in this instance without a gob rope fitted either. Scott emphasised the need for consistency in training programmes and alignment between crew competency, the demands of each operation, and appropriate tug allocation.

Scott outlined the key outcomes from the internal investigation: including enhanced planned maintenance and understanding of equipment criticality, for example emergency hook releases; updated procedures and formal training programme; and better recognition of the idiosyncrasies of towage operations by all stakeholders involved including shore side and seafaring personnel. Scott further stressed the importance of knowledge sharing in promoting progressive safety procedures and that maintaining low speeds is a critical component of safe towage operations.



*Image courtesy of Philip Bent.*

**Philip Bent, a Marine Pilot** working on the Humber then presented on improving communications through technology. Philip had noted that in various MAIB investigation reports, master pilot exchange was often found to be ineffective. As a result, Phillip had created a mobile application that facilitated master-pilot (MPX) and pilot-tug (TPX) exchanges in electronic form creating a clear communication link between the parties and an auditable trail with automatically generated emails detailing the agreed towage/pilotage plan. He acknowledged that there was still work that needed to be done in order to create a challenge and response culture within towage operations. The app “Pilotage Tools” is available now through the App Store and Google Play.



Image courtesy of the Maritime & Coastguard Agency.

**Kalvin Baugh, Port and VTS Advisor at the Maritime and Coastguard Agency** presented on the updated Port & Marine Safety Code, renamed the Port & Marine Facilities Safety Code. The change in title reflects the broad church of marine facilities that the code impacts upon. Calvin relayed to delegates that the code was a living document and that suggested amendments would be welcome and could be made to the Steering Group, to which the BTA is party. Issuance of the Code and Guide to Good Practice are expected early 2025, with the updated guide increased emphasis on guidance for other non-statutory harbour authorities' marine facilities on compliance with the Code.

Kalvin discussed the MCA's dataset for reports of use of Dangerously Weighted Heaving Lines (DWHLs) which covers the period April 2021 and October 2024. It was noted the overall trend in DWHL usage showed a slight decline from an average of five a month to an average of four, however the persistent pernicious use was recognised as needing further work to eradicate. Fines, letters to repeat offenders, Paris MOU inspections and presentations to IMO were all discussed as means to reduce incidents.

## Tug Master-Pilot Communications

The GTGP also references the Pilots Pocket Guide and Checklist

Pilot-Tug Master exchange

Discuss passage and use checklist and verify using closed-loop communications

Think of the tug(s) as an extended part of the bridge team-ensure bridge team on ship and tug are involved and aware of what has been discussed

Any deviations communicated to all parties

**PILOTS' POCKET GUIDE AND CHECKLIST**  
WORKING SAFELY WITH HARBOUR TUGS  
- REDUCING THE RISKS IN PORT TOWAGE

BTA

Second Edition

THE CHAMBER OF SHIPPING

Image courtesy of Forth Ports.

**Alan McPherson, Chief Harbour Master at Forth Ports** provided his expert insight into how communications relay into safe operations in harbours. He suggested that industry guidance was not being picked up frequently enough and further reading by those on the front line would lead to wider awareness of critical safety issues and how to counteract them.

He acknowledged that communication takes time and practice to get right but by tasking crews to act and following procedures such as closed loop communication the communication process could be immeasurably improved. The BTA's pilot pocket guide is available here - [Pilots' Pocket Guide and Checklist - Working safely with harbour tugs. Reducing the risks in port towage. Second edition - Witherbys](#)

### **Tug use in firefighting**

The final session separated delegates into working groups and asked to discuss questions surrounding emergency response, communications, and planning for a scenario when tug(s) are called to assist with a suspected tanker on fire. The responses from those sessions are summarised below:

#### **What initial communications would you make with a tanker that is on fire?**

Establish who is the on-scene coordinator.

Position, wind speed / direction, do they have power / propulsion, is there any pollution, what assistance do they require?

Agree working channel for communication. Who is in control of the tugs fire capabilities? Any crew on deck?

#### **What planning and actions would you take to ensure the safety of the tugs crew?**

Ascertain the type of cargo on board if loaded and request data sheets for characteristics. Test monitors, drenching system and foam system. Don firefighting suits and test BA

Forecast weather conditions, drift off direction, muster crew on bridge, clear deck policy, shutting off ventilation, prep FiFi gear, is tug manned for 24 hour operation.

Check systems are functioning. Is there an OSC / any casualties / pollution / nature of fire. Permission for use of foam. Depth of water.

#### **What factors would be key to planning the approach to the tanker and for firefighting?**

Nature of incident What is a safe distance to the casualty. Weather is important to consider. What other resources are on route.

Wind direction. Daylight / darkness.

Testing monitors prior to the approach. Brief all crew. Prepare additional firefighting gear.

The Seminar's compere, Alasdair Smith, welcomed the responses to the firefighting scenario planning and stated that the BTA's upcoming fire-fighting guide would reflect and include such items. Alasdair concluded the event with closing remarks emphasising the critical need for proactive communication and continuous improvement in safety. He further urged pilots, port authorities, and the broader towage industry to remain actively engaged in eliminating avoidable incidents.

The **BTA's Tug Trainee of the Year Award**, kindly **sponsored by Sanmar Shipyards**, highlighted at the Seminar, and will award its second recipient at the **BTA's Annual Conference and Dinner on 7 May 2025**.

The BTA wishes to celebrate and honour trainees, and recently certificated candidates working in the UK towage sector who have shown exceptional dedication and attitude to their learning and career development.

Full details of the terms of eligibility and scope of the award can be viewed via the [BTA's website](#)

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