

M2082

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Category: [Maritime](#)

Report Title Fouled Towing Line Bridle

Initial Report

Our reporter stated they were on a tug, towing a 47ft tender and approaching the anchorage in the early morning (0130 hrs).

“There were just three crew on duty: me, the master, and the engineer. About a mile offshore, the master reduced speed to prepare for unhooking the tender. He directed me to the aft deck and to stand by. I started to put out fenders, ready for the tender to come alongside after anchoring. As I was doing this, I heard the engines go astern. The tender was only about 40m astern using a 75m tow line, and the tow line was slack. I radioed the bridge to say disengage/neutral, but it was too late.

The port end of the tow bridle got wrapped in the starboard propellor, and the engine shut down. We were drifting away from land, which was too deep to anchor. I put a mask on with a dive light and entered the water to assess what had happened. The tow line had gone through the middle of the rudders and, fortunately, had not damaged the propeller shaft or rudder. The towing bridle was, however, bar-tight and had to be cut off. I alerted the other dive master to assist me, and we went under the hull and cut the line off the propeller. This took about 10 minutes to complete.

Once we had re-positioned and anchored, I spoke with the captain about what had happened. He said he looked into the stern-facing camera when he was in neutral. He saw the tender approaching and thought that we were pulling it in, so he gave the tug a kick astern to assist with retrieval. He was unaware that the bridle was already slack in the water. None of this was communicated until after I shouted to go into neutral.

Our usual procedure is to have a minimum of two people astern and constant communications. We were ten days into a charter, and everyone was very fatigued. The captain was well over his hours. The fault lay on both sides: I should have radioed the captain and said I was sorting the fenders first. He assumed I was standing by but didn't confirm or ask if it was okay to come astern. We were fortunate!

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Comment

A work operation such as this is risky at any time, especially in the early morning. A toolbox talk beforehand would have ensured that everyone understood the plan.

A risk assessment and comprehensive brief were required for this work, and all underwater equipment and inlets/outlets were correctly and appropriately isolated with a LO/TO system.

Carrying out work in darkness and in the early hours when everyone is tired increases the risk of a mistake. Getting rest before carrying out this work in daylight with all crew available to assist if anything goes wrong is a much safer alternative.

Key Issues

Fatigue– Early morning activities are always difficult, especially if crews are already fatigued, and decision-making can be affected. Could this operation have been timed for daylight when the crew could be better rested?

Communications– Establishing communications before the activity commences is essential, and for safety-critical tasks such as this, closed-loop communications are the safest method.

Teamwork– Teamwork in small teams usually works very well, but in this case, it broke down. This is a reminder that from time to time, even on very well-run vessels, we all need to check on each other to ensure everyone knows what is happening.

fatigueFatigue

poor_communicationCommunication

teamworkTeamwork



