Too Fast, Too Fatal: Excessive Speed and Communication Lapses Doomed Tug 'Biter'

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The UK Marine Accident Investigation Branch (MAIB) has released its report into last year's tragic capsizing of the twin-screw conventional tug *Biter* off Greenock, Scotland, resulting in the loss of two crew members' lives.

The investigation into the accident, which occurred on February 24, 2023, has revealed critical safety lapses and prompted urgent recommendations for the maritime sector.

The incident unfolded as the *Biter* was assisting the passenger vessel *Hebridean Princess* during its approach to James Watt Dock. At approximately 15:27 local time, the tug girted and capsized while attached to the stern of the larger vessel. The MAIB's findings paint a sobering picture of a cascade of events that led to the disaster.

"The investigation found that *Biter* girted and capsized because it was unable to reverse direction to operate directly astern of *Hebridean Princess* before the tug's weight came on to the towing bridle," stated the MAIB report. This crucial maneuver failure was compounded by the ineffectiveness of the tug's gob rope in preventing sideways towing.

Image courtesy of George Allison (UK Defence Journal)

Figure 1: *Hebridean Princess* leaving James Watt Dock on the morning of 24 February 2023, assisted by the conventional tug *Biter* forward and the azimuth stern drive tug *Wrestler* aft

Alarmingly, the investigation revealed that the *Hebridean Princess* was traveling at a speed that imposed a load on *Biter*'s towlines between two and five times higher than the port's recommended speed range. This excessive speed likely contributed to the rapid capsize, leaving the crew with insufficient time to activate the emergency tow release mechanism.

The MAIB's report also highlighted significant communication breakdowns and training inadequacies. "The master/pilot and pilot/tug information exchanges were incomplete," the report noted, indicating a critical lapse in operational coordination. It was also determined that the pilot's training had not sufficiently prepared them for their role, and the tug master may not have fully grasped the risks associated with the maneuver.

and securing, as well as safe speeds for key maneuvers. The company has also been urged to adopt a more robust training and qualification scheme for its tug masters.

Clydeport Operations Limited faces recommendations to commission an independent review of tug training for its pilots and to reassess its Pilot Grade Limits and Tug Matrix. The MAIB has also called upon UK pilot, harbourmaster, port, tug owners, and workboat associations to develop comprehensive marine guidance addressing the safety issues raised in this report.

This tragic incident serves as a stark reminder of the inherent risks in maritime operations and the critical importance of stringent safety protocols, effective communication, and thorough training in the shipping industry. As the sector grapples with the lessons learned from the *Biter* capsize, it is clear that improvement in maritime safety practices are essential to prevent future loss of life at sea.

You can find the MAIB report here.

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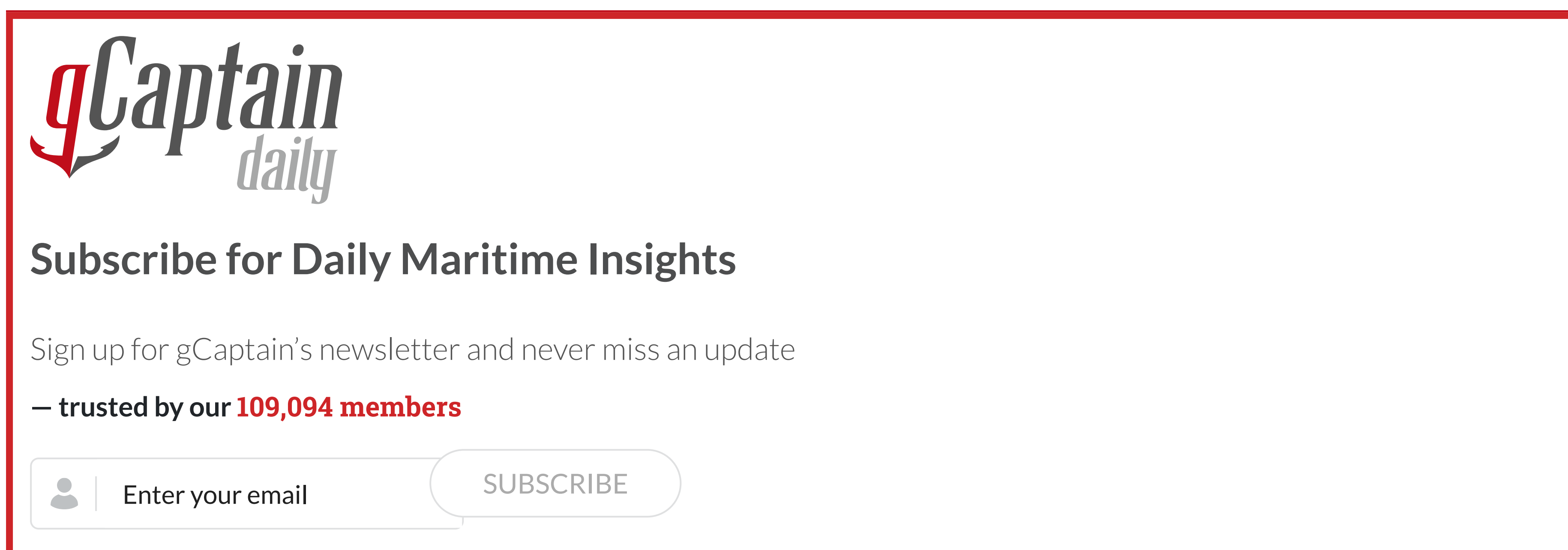

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