From MUA Members at Gladstone

Response of Members of Maritime Union of Australia, employed in Gladstone, to ATSB Transport Safety Report on Investigation into the capsizing of the Australian registered tug Adonis at Gladstone, Queensland, 11 June 2011, which resulted in the fatality of Captain Dudley Jacobs.

Having read the report on the capsizing of the Tug Adonis in the port of Gladstone, which resulted in a fatality, the members of the Maritime Union of Australia make the following comments based on our collective years of experience, our professional attitude towards the seafaring industry, our concerns at what we see as a total disregard for basic safety processes, and our belief that all the issues leading up to this fatal incident are not being put on the table because the investigation was limited to the actual incident rather than addressing all matters leading up to this incident.

The Members of the Maritime Union of Australia view the ATSB report as being flawed, incomplete and failing to place responsibility for the incident and consequent loss of life.

We, therefore, call on the Government to initiate a coronial inquiry into the death of Dudley Jacobs, with appropriate Terms of Reference.

In our view, incidents like this are not accidents. They are the culmination of improper processes and a lack of adherence to a set of required safety provisions, with the consequence of a fatality that could have been, and should have been, avoided. The incident raises a host of questions that go to the heart of the maritime operations in Gladstone, among them, a need to identify who, or what authority, has the overarching responsibility for monitoring shipboard safety in the Port.

We assert:

- If the Masters of both vessels were aware of the risks of tugs capsizing, then, their response would require the construct of a safe operational strategy which would be adhered to by both vessels involved in that operation on that day. Given the weather conditions of the day (overcast, intermittent rain, low visibility), and the tide run and water traffic congestion within the existing harbour channels, it was essential that an operational plan was in place with safety as the primary consideration.

- The ATSB's "fact sheet" listing the experience of the deckhands raises concerns about the competency of the report. The author/s of the report appear to be indicating that having years of experience as a fisherman equips the deckhand with the skills and ability to safely handle the tug deck in a commercial towing operation involving maritime construction. It would not matter how many years experience in the fishing game a deckhand has worked—catching fish will not equip them with the skills or experience necessary to operate safely in maritime construction.

- All of Sea Swift's operations should have been shut down until the final report was issued. Only after the report had cleared Sea Swift of any wrong-doing should its operations have recommenced. That Sea Swift is still operating in the port and, in fact, is still operating on the Australian coast is shocking. It appears there have been no ramifications for Sea Swift or Bechtel following the death of Dudley Jacobson.

- Under the heading “Safety Summary – What the ATSB found”, the Report states that “neither of them (masters) realised that Adonis had entered a classic capsize scenario when it moved abaft of the barge’s port bow before the barge begun to slow down’. This statement speaks volumes about the lack of experience and the dangerous work practices associated with this company’s operations. The Report goes on to say that “the fitting of the H bits and a towing winch, also resulted in the Adonis being unstable when undertaking towing operations over the stern. This fact was not identified by the tug owners because the tug’s stability had not been recalculated following the fitment of the additional equipment’.

As part of the inquiry, we believe the following questions must be asked:

- Was there a due diligence report done on Sea Swift for the Project Management before it was engaged in towing operations?

- Was there a check on the qualifications and experience of crews from the bridge to the deck before the Adonis was pressed into service on the C.S.G. project?

- Were adequate crewing levels in place to ensure shipboard safety, operating of vessels at the limit of their capacity, leaving no room to retrieve a safe working position while having the barge in tow?

- Job safety begins with Project Management, so, does the responsibility to monitor the safety component of contractors lie with Bechtel?

- At what time in the letting of the contract did Bechtel require Sea Swift to produce its certificates of sea worthiness?

- If Sea Swift did not inform Bechtel of the additions, added to the fact that the company did not, then, get a clearance from a marine surveyor following a recalculation of the vessels stability, who will be held to account for this Incident?

- A review of Sea Swift’s training assessment of new Masters or potential Masters for the towing fleet has extended the period of training to include mentoring runs and supernumerary runs with other Masters to facilitate the development of a greater understanding of towage requirements. Why wasn’t this done prior to this Incident occurring?

- With the reconfiguration of the back deck of the Adonis and the addition of the h/bits aft of the towing hook, is there a Marine Surveyors stability report on the tugs operation with these h/bits being under operations?

- Are all sea going operators required to produce and follow S.M.S. requirements or only some?

In summary, the distressing thing for us is the length of time authorities are taking to investigate the matter, all the while Seaswift and Bechtel carry on as if it is forgotten by the maritime community in Gladstone. The fact is that on board union vessels, which are currently being driven out of the harbor because of costs, this incident would not have occurred. As experienced seafarers, we know that the lead up to this would have involved a more professional approach from the company to the crew.

We look upon the series of events with despair. The company's approach, the vessel, the crew—all add up to basic seamanship. Why was there not a tow hook release drill until directly before the barge move? What was the locking pin doing in the quick release hook and the deckhand doing standing directly above the towline? Had it parted, he would have lost his life as well. Standard practice on the Australian coast would have had the deckhand in the safety of the wheelhouse during a tow, standing by the quick release lever with the locking pin out ready to release in emergency.

It is quite simple for us to see why things went wrong here. Yet, we sense a cover up. We still see today a blind eye being turned to unsafe operators in the Gladstone harbor where it seems costs matter more than safety.

The Gladstone community and future safety in this port deserve better than this.

Regards
Maritime Union of Australia, Gladstone members