Fatal 6 - Seaman struck by mooring line

WHAT HAPPENED

BMAPA have issued the following alert outlining how a seaman was injured and the actions that have been recommended to improve mooring procedures following this incident.

A UK marine aggregate dredger was making a routine entry into a UK port, which necessitated transiting a Lock. As the vessel came into position in the Lock the order to ‘hold on’ (the spring mooring line) was given and astern pitch applied. The Seaman forward ‘turned up’ the spring on the mooring bitts (ship’s bollard) as instructed.

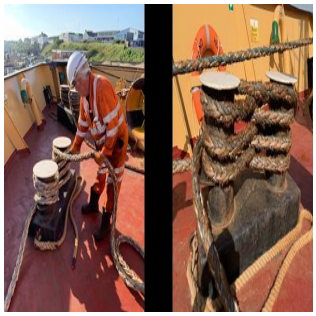
The vessel continued to move ahead slightly; placing strain on the secured mooring line. The mooring line surged (slipped) on the mooring bitts; the standing (unloaded) part of the line whipped from the deck, striking the Seaman in the groin.

The IP was evacuated to hospital by emergency ambulance and underwent exploratory/corrective surgery.

Key Findings

A review of the incident identified the following points:

- The mooring equipment in the vessel is undersized by contemporary standards for the rope size in use.
- Mooring equipment standards have been formalised/ amended several time since the vessel was constructed.
- No mandatory requirement for retrospective upgrading of mooring equipment exists.
- Mooring rope size in use is essential to ensure vessel safety in operational conditions experienced in service.
- The layout of mooring equipment in the vessel precluded use of best operational practice for use in service.
- Standard induction procedures were followed; however, could have been improved with more focus on ship specific issues.
- Co-ordination of communications and actions of the Bridge Team and instructions given to Deck Crew could be improved.
- Minor proportionate modification to Deck mooring equipment would be beneficial to eliminate an identified deficiency.
- There was no specific mooring plan in place for the task.



LEARNING POINTS / ACTIONS TAKEN

- The bridge team should review co-ordination between the timing of instructions given to deck crew and actions executed to control and manage the vessel; to ensure Deck Crew are not subjected to risk during mooring ops.

- The provision of induction in mooring operations to new crew members should be reviewed to ensure it is sufficiently focused on localised ship specific issues.

- The provision of induction refresher training to crew members established in the vessel should be considered.

- A task specific mooring plan should be developed to address the operation of securing the vessel during passage through Locks.

- On-board mooring practice while transiting Locks should be reviewed to determine whether operation of one mooring line at a time would improve safety without compromising other aspects of safe ship operation.

- A study to evaluate modification of the mooring bitts involved in this incident should be undertaken to determine whether a deficiency in layout can be eliminated.

- A fleet review to identify other potentially deficient mooring equipment design conditions should be undertaken.

- Guidance in assessing the experience of Deck Crew members assigned to vessels should be reviewed

LOCATION:	**AGGREGATE DREDGER**	**ALERT STATUS:**	**Normal**
ACTIVITY:	**MARINE OPERATIONS**	**DATE ISSUED:**	**01/10/2019 11:34:09**
SUB ACTIVITY:	**SHIP TO SHORE**	**INCIDENT No:**	**01528**