Serious injury during mooring operation

It was early morning and the vessel was preparing to depart. The mooring parties were standing by forward and aft. On the bridge the master had a short briefing with the pilot. There was no pre-departure briefing, so the mooring risk assessment had not been discussed.

The mooring parties had just been woken up by the chief officer and assembled at their designated stations. The chief officer was setting up the bridge for departure and was not involved in the pilot briefing.

Everyone in the mooring parties was wearing the correct PPE equipment, i.e. helmet, safety shoes, coveralls and gloves. One of the ABs in the forward mooring party had just joined the vessel the previous day. He had three years of experience as an AB, but this was his first time working for the company. He had completed the mandatory safety briefing with the 3rd officer the previous day when he joined the vessel. At departure he was working in front of the mooring winch ensuring that the mooring lines were properly stored on the drum.

The vessel was moored with two head lines and stern lines, two brest lines and two spring lines forward and aft.

The master gave the order to single up, which meant that both brest lines, one spring line and one head/stern line were retrieved. The 2nd officer who was forward did not let go any of the head lines. The other lines were retrieved without any incident. When the master was satisfied, he gave the order to “let go all lines”.

When the head lines were slack the new AB hung them on the hook attached to each roller bollard instead of around the roller bollard which was the correct procedure as per the risk assessment.

Another AB was operating the mooring winch, but he could not see the new AB who was handling the lines. This was because the winch was too large.

The 2nd officer had difficulty seeing the most forward head line and assumed it was clear because the forward line handler had moved away from the bollard and seemed to be talking on his radio. The 2nd officer gave the order to the winch AB to heave in both head lines. The 2nd officer did not pay attention to what the new AB was doing but assumed he was directing the mooring lines. Unfortunately, the most forward head line was still attached to the bollard. When the AB started to heave up the headline it tightened quickly and came off the bollard hook with a heavy snap which hit the new AB in the waist.

The AB collapsed in serious pain and was taken to hospital where it was discovered that he had suffered serious back injuries. These injuries were so severe that the AB was not able to resume seafaring duties.

Discussion

Go to the “File“ menu and select “Save as...“ to save the pdf-file on your computer.

You can place the marker below each question to write the answer directly into the file.

When discussing this case please consider that the actions taken at the time made sense for all involved. Do not only judge but also ask why you think these actions were taken and could this happen on your vessel?

1. What were the immediate causes of this accident?

2. Is there a risk that this kind of accident could happen on our vessel?

3. How could this accident have been prevented?

4. Do we have a risk assessment for mooring operations?

5. If we do, could this risk assessment be improved?

6. Do we have a pre-departure and pre-arrival meeting where we discuss the mooring operation and how the vessel should manouver?

7. What sections of our SMS would have been breached if any?

8. Does our SMS address these risks?

9. How could we improve our SMS to address these issues?

10. What do you think was the root cause of this accident?

11. Is there any kind of training that we should do that addresses these issues?