

# Severe Mooring Incident on container vessel

A large container vessel was preparing to depart a berth at a major seaport in the afternoon. After completing cargo operations, the vessel's crew readied the ship for departure. Port movements had been delayed due to weather conditions, but once conditions improved, it was cleared to proceed.

## **Pilot Boarding and Setup (Early Evening):**

After the weather-related delay, a Pilot boarded the vessel at approximately 1815 LT. The crew prepared to let go of the mooring lines. Forward, the team consisted of the Chief Officer (in charge of the operation), the Carpenter, the Ordinary Seaman (OS), and a Motorman. They had singled up, in readiness for the tug assistance.

## **Mooring Line Arrangement for Tug Assistance (Shortly After Pilot Onboard):**

The tug was to be secured at the vessel's bow using a ship's line. The Chief Officer supervised as the line was lowered under power from the mooring winch, passed around the bitts, and led through a multi-roller fairlead on the forecastle deck. The Carpenter prepared to rig the rope stopper once the line was in place, while the OS stood by at the bitts to

make the line fast once the stopper was secured.

## **Lowering the Tug Line and Attempted Securing (Before Incident):**

With the line lowered toward the tug, the Carpenter positioned himself to fix the rope stopper, and the OS remained close to the bitts, ready to take turns on the line. The Chief Officer maintained visual contact with the tug and provided instructions, while the Motorman assisted as needed. At this stage, communication and timing were critical to ensure the line was made fast safely.

## **Sudden Tug Movement and Line Over-Tension (Approx. 1915 LT):**

Before the rope stopper could be properly engaged and without any clear signal from the vessel, the tug began to move away. This premature movement dramatically increased tension in the line, which had not yet been fully secured.

Under sudden and excessive strain, the line stretched taut, jumped from its intended lead, and snapped back violently. The Carpenter, partially prepared to avoid the recoil, was still





struck and thrown to one side. The OS, positioned closer to the snapback path, was hit with full force.

### **Immediate Aftermath and Medical Response (Shortly After 1915 LT):**

Both the Carpenter and the OS sustained severe injuries. Emergency medical assistance arrived within minutes, and the injured crew members were evacuated from the ship's forecastle deck to a waiting ambulance.

The OS was declared deceased shortly after evacuation. The Carpenter, initially admitted to a local hospital and showing some signs of recovery, later succumbed to injuries.

In the meantime, the unmooring operation was halted, and the vessel remained alongside. Local authorities, including the Coast Guard, boarded the vessel and conducted an investigation. The vessel eventually departed the berth once formalities were concluded.

## **Questions**

1. 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?
2. Does our SMS address these risks?
3. What sections of our SMS would have been breached if any?
4. What specific communication methods should be used to ensure that the tug and vessel are fully aligned before lines are tensioned?
5. How can we standardize or improve the use of hand signals, radios, or checklists to prevent misunderstandings?
6. What steps can we take to verify line angles and leads are optimal before applying tension?
7. What training or reminders can we provide so crew members consistently position themselves outside potential recoil paths?
8. How can we encourage every crew member, regardless of rank, to speak up if something appears unsafe?
9. How can we encourage the team to share "good practices" observed during everyday operations to further strengthen safety?
10. Is our current equipment set-up (fairleads, bitts, stoppers) ideal for minimizing snapback risk, and what improvements could be made?
11. How do we currently conduct pre-departure briefings, and what additional information or clarity could make them more effective?
12. Would more frequent debriefings after routine operations help us identify subtle improvements and reinforce safe practices?
13. What support do we need from management (additional training, updated procedures, more resources) to strengthen our mooring safety practices?
14. What immediate, actionable steps can we take from today's discussion to reduce snapback risks and improve communication with tugs?