

KISH P & I LOSS PREVENTION CIRCULAR KPI-LP-60-2012 **(A Fatal Accident during Mooring & Lessons to be Learnt)**

► **Brief description of the accident:**

A general cargo ship arrived with an import cargo that was stacked high on the hatch covers, exposing a large lateral wind area. A strong offshore wind was blowing during the final approach to the berth (starboard side to) with a pilot on board, but it had been already decided that the docking could be safely completed without tug assistance.

The forward mooring team on the forecastle consisted of the C/O, Bosun and an able seaman (AB). The vessel was fitted with a large wave-breaker right forward, which meant that the forecastle deck had very little clear area. Standing on a small bulwark platform on the starboard side, the C/O was leading the team and also operating the mooring winches remote control levers located close by. The bridge team had no view of the forward mooring station due to the tall wave-breaker and high deck cargo.

The ship approached the berth at an angle of about 30 degrees and, with her bow close to the jetty; the forward spring line was sent ashore and belayed on a bollard. In order to bring the stern closer to the quay the pilot requested slow ahead on the engine and full port rudder. In addition, the bow-thruster was activated to port so as to align the ship parallel with the wharf.

Before undertaking this manoeuvre, the Master warned the foredeck team on the portable VHF radio that the engine would be working ahead and that all personnel should stand clear of the taut back-spring. This was acknowledged by the C/O, but for unknown reasons, he remained at his position.

The engine and rudder movement was performed but had to be repeated within minutes as the stern did not move sufficiently towards the quay. Again, before the engine movement, the Master called out a warning to the foredeck team and got confirmation from the C/O but he remained at his location near the winch remote control unit.

This time, the engine order lasted longer and probably due to the bow moving ahead and away from the shore, the back-spring came under very high tension and suddenly parted. The broken rope end snapped back violently and hit the C/O on the head and neck, who was felled and lay motionless. Unfortunately, despite all efforts by crew and paramedics, the ambulance doctor declared the C/O dead soon after.

► **Result of investigation:**

1-The spring line had only been in use for a month and appeared to be in good condition;

2-The method used to berth a high-sided vessel without tug assistance in the prevailing conditions by working

engine, rudder and bow thruster against a single back-spring constituted a high risk manoeuvre;

3-The C/O failed to move away from snap back zone even after being warned by Master;

4-Poor design - Confined/restricted area on the forecastle deck and improper location of winch remote control unit;

5-The company had no specific guidelines for mooring and the company management had not identified mooring to be a hazardous operation.

► **Lessons to be Learnt:**

- 1- The mooring operation is a risky one and a proper risk assessment should be conducted, especially in conditions not matching the routine operations like having deck cargoes & high windage area.
- 2- Complacency is a major cause for many accidents; in this very case the chief officer has apparently ignored a safe practice requirement & warning.
- 3- The operator of the winch control & the command of the operations should not be mixed & done by one person. It is very much possible to confuse & do an incorrect operation, although this one not the case here. The command of the stations is a task requiring concentration & this fact should not be overlooked.
- 4- The accident has happened partially due to a decision for reduction of costs & taking no tugs at all. This seems to be primarily quite risky. There should always be a contingency plan for "What ifs", when & if things do not go the way expected or planned.
- 5- Moreover using no tugs would probably necessitate additional caution & relying on one spring to take all the pressure has got added hazards. Doubling up the line or having another line to share the weight could have avoided the incident.
- 6- Recipients are also advised to study the following information available in the club's web-site:

**"KISH P & I LOSS PREVENTION
CIRCULAR KPI-LP-42-2012
(Mooring Accidents Analysis &
Lessons to be Learnt)"**