The Swedish Club

MONTHLY SAFETY SCENARIO

APRIL 2024

Mooring rope caught in the propeller

The vessel was preparing to depart and had singled up. The mooring teams were standing by forward and aft. All members were wearing the correct PPE.

The Second Officer was in charge forward, assisted by two ABs. The bosun was in charge aft with the assistance of one AB. The Master gave the order to let go all lines.

The bosun was in charge of the mooring winch and the AB was designated to ensure that the mooring rope was stored correctly on the drum. When the last stern line was on board, the bosun realised that his radio's battery was dead. He had been involved in the cargo operation and hadn't found time to charge or replace the radio. He was trying to fix his radio when he suddenly heard a scream and could see the AB was being dragged by the mooring rope through the bollard and hard into the bulwark.

The AB had not realised that he was standing in a rope bight and the mooring rope suddenly came under severe tension. The rope bight trapped the AB's leg and dragged him astern through the bollards and into the bulwark, where he suffered serious head injuries. The mooring rope had been caught in the propeller and the instant tension caught the AB off-guard.

Because the bosun's radio was not working he had to run to the closest phone, which was on the bulkhead of the superstructure. He called the bridge and informed the Master about the accident.

The Master pressed the emergency stop for the engines and ordered the Chief Officer to run down and examine the AB. The Chief Officer gave the AB CPR as he was not breathing, he was taken to hospital where he was pronounced dead.

The forward mooring deck had been painted with non-slip paint, but not the aft deck. None of the objects that are a trip hazard had been highlighted, forward or aft. There were no markings indicating the snapback zone for the mooring lines when the rope was under tension.

The vessel had undertaken a mooring risk assessment for

arrival but not for departure. The crew members stated that they had come up with their own routines for departure. No toolbox meeting had been completed.

Questions

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. Which sections of our SMS would have been breached if any?
5. Is our SMS sufficient to prevent this kind of accident?
6. If procedures were breached, why do you think this was the case?
7. Do we have risk assessments for mooring operations for both arrival and departure?
8. Highlighting hazards is particularly important for the safety of any crew new to the vessel, new hires, cadets and other trainees. Are new mooring party members briefed sufficiently about their duties?
9. Is there a requirement in our company to have a toolbox meeting with all concerned crew members before arrival and departure?
10. Highlighting hazards can be of great assistance and show the dangers. Are trip hazards and snapback zones highlighted on board our vessel?
11. Are the mooring decks painted with non-slip paint?
12. Is there any kind of training that we should do that addresses these issues?
13. What can we learn?