REPUBLIC OF CYPRUS
MINISTRY OF TRANSPORT
COMMUNICATIONS AND WORKS

DEPARTMENT
OF MERCHANT SHIPPING
LEMESOS

ACCIDENT REPORT

Name of the Ship : **KURLAND**

Type of Accident : **Labor accident on 17.1.2013**

Title and date : **Fatal accident during mooring operation**

Introduction

A seaman lost his life on 17.1.2013 a when a mooring rope broke and hit him while on duty in a mooring operation in Husum, Sweden.

Events

On 16.1.2013 m/v KURLAND was mooring at quay #4 in the Husum Paper and Pulp Mill. Two seamen on the forecastle deck carried out mooring duties. When the ship had approached the quay at 10 meters, the crew gave a spring line (rope) to the shore personnel. There was ice on the sea and so the ship was placed with the stern out, at an angle with the quay, in order to make ice move away by operating the thrusters. A second line was received, a head line, placed on a bollard. Then a seaman from KURLAND made a sign that the ship intended to send on more head line. Both head lines were placed on the same bollard and came out of the same fairlead of the ship. The lines were tight and they creaked. Suddenly at 00.40 am of 17.1.2013, one of the forward head lines parted and hit one of the seamen on the forecastle. The injured seaman had safety shoes and wore helmet and boiler suit. He was seen bleeding from the head and nose. The emergency services of the port were called and the seaman was in the way to a hospital when he died.

Investigation and Analysis

It was the Master's decision to approach the quay in an angle and use the lines to pull the ship alongside. This practice is not unusual but it can be argued that the Master might bring the ship closer to the quay before he used the lines.

It could not be established whether both head lines were on the same capstan or one of them remained loose while the other remained tight and as such, taking all of the tension.

With the tight ropes and the ship away from the quay using her own deck machinery to come alongside, the ropes could not take the developed tension.

Ropes used in in similar conditions of high tension and low temperatures (as the case was in Husum on the date of the accident) tend to lose their properties earlier than ropes used in routine service. An examination of the broken rope was ordered by the Swedish Accident

Investigation Authority, to a laboratory in Sweden, specializing in the testing of materials. The result of the examination and test was that :

i. The rope was extremely worn and its strength was reduced
ii. The average percentage of failed threads in each strand is 35%
iii. The break occurred as a result of friction damage
iv. The certificates produced for the rope do not correspond to the rope.

Conclusions

A worn out rope was used for a difficult mooring operation in low temperatures.

It was not made possible to produce the rope certificate.

Recommendations

To the Management Company :

Instructions for the use and maintenance of ropes should be revised. The Company should take measures (training) to ensure the officers and crew regularly examine the ropes and replace same before they are worn out. Records should be kept for each rope taking care to know which rope is which.

To the bodies auditing the management of ships and to the Memoranda on port state control, through the Department of Merchant Shipping :

During the auditing and inspections, to focus on the ropes since all sides tend to leave them out of attention.