Lost time injury (LTI): Crewman injured foot during offshore renewables mooring operation

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A Member has reported an incident in which a marine crewman sustained a serious injury to his foot during a 'routine' mooring operation.

What happened?

The incident occurred during cable laying operations on an offshore renewables project.

Background

A DP2 construction vessel and a number of purpose built crew transfer vessels (CTVs) were being used, the CTVs to transfer work parties between the DP vessel and wind turbine towers. When transfers are completed the CTVs 'routinely' moor up to one of the turbine towers until required. This enables them to save fuel. The mooring uses a 100 metre length of rope which is attached to the bow of the CTV at one end of the rope. The rope is then fed around an upright stanchion on the tower and the second end attached to another point on the bow of the vessel. The CTV then backs off from the tower and is held down-tide approximately 50 metres from the tower until required. This operation requires that around 100 metres of rope are lying on the foredeck before the CTV backs away from the tower.

The incident

During a mooring operation one of the CTV's crewmen attached the rope in the manner described above. He signalled to the Master in the wheelhouse that he was clear to back away from the tower. He then stepped out of sight of the Master. The Master applied full reverse power briefly, to get away safely from the tower, then put the engines into neutral. The crewman was then seen being dragged by the foot, which was attached to the mooring line, across the foredeck. The rope pulled him into a gap between the hand rail sections causing a serious injury to his foot. The operation was stopped and the CTV called for assistance. Medics from the DP2 vessel attended and provided initial treatment before the crewman was conveyed by helicopter to hospital. As a result of the injury the crewman suffered a partial amputation to his foot which included the loss of his toes.

What were the causes?

An investigation is still underway, but the following early findings were:

- There should have been formal procedures in place for this operation.
- The crewman should not have been working alone.

- There should have been an identified area where the crewman could safely stand during the operation, ideally where he could be seen by the vessel Master.
- A CCTV installation would have meant that the Master could see the operation taking place from the wheelhouse.
- There should have been voice communication between the crew operating on the foredeck and the Master.
- The mooring should have used a shorter length of rope.

Lessons learnt

In any mooring operation there is always the potential for crew entanglement with the mooring ropes, or for a rope to become over tensioned and break, causing the rope to whip across the deck and injure anyone standing within its range.

Members' attention is drawn to the following IMCA documents:

- Mooring practice safety guidance for offshore vessels when alongside in ports and harbours
- Mooring safety (poster)

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