MCIB
Marine Casualty Investigation Board

REPORT INTO THE FATAL INCIDENT ON BOARD THE ANTIGUAN AND BARBUDAN REGISTERED VESSEL THE MSC "SUFFOLK" DURING BERTHING OPERATIONS AT DUBLIN PORT ON 5TH MARCH, 2003.

The Marine Casualty Investigation Board was established on the 25th March, 2003 under The Merchant Shipping (Investigation of Marine Casualties) Act 2000

CONTENTS

1. SYNOPSIS.

The Antigua and Barbuda vessel MSC "Suffolk" entered the port of Dublin on the 5th March 2003. As it berthed Mr. Oleksandr Romanyuk (able seaman) either fell or was snagged on a mooring line as he fed it onto the mooring rope drum and was dragged under the drum of the winch. He suffered fatal 'crush' injuries to his head and body.

2. FACTUAL INFORMATION

2.1 DETAILS OF DECEASED

Name of Deceased:	Oleksandr Romanyuk
Date of Birth:	24th February 1961
Nationality:	Ukrainian
Address:	Odessa, 65000, Ukraine
Qualifications:	Able Seaman Certificate issued by Ukraine

2.2 VESSEL INFORMATION

Name of Vessel:	MSC "Suffolk"
Flag of Vessel:	Antigua and Barbuda
Type of Vessel:	Containership (1033 TEU)
Port of registry:	St. John's
Company:	Marconsult & Thode Schiffahrt (GmbH & Co.) KG, Kohlbrandtreppe 2, 22767 Hamburg, Germany
Built:	1983
Place of Build:	Werft Nobiskrug GMBH, Rendsburg, Germany
Length overall:	151.10 Metres
Gross Tonnage:	10,544
Classification Society:	Germanischer Lloyd
Engine Type:	Krupp Mak Type 8 M 601 – 8000kW
Bow Thruster:	HatlapaFixed Propeller - 600kW
Crew Number:	14

2.3 CREW LIST

NAME	RATING	NATIONALITY
Milan Popovic	Master	Yugoslavian
Sergiy Murkin	Chief Officer	Ukrainian
Volodymir Tyrchalov	2nd Officer	Ukrainian
Mijodrag Krsanac	Chief Engineer	Yugoslavian
Oleg Arabadzhi	2nd Engineer	Ukrainian
Oleksly Shchukin	Bosun	Ukrainian
Oleksandr Romanyuk	A/B	(Deceased) Ukrainian
Andriy Derkach	A/B	Ukrainian
Oleg Ryabov	A/B	Maldovian
Slawomir Piankowski	O/S	Polish
Maciej Janas	Oiler	Polish
Yuriy Kormishyn	Oiler	Ukrainian
Leoncio Fortes Barros	Oiler	Cape Verde
Andrzej Myszk	Cook	Polish

3. EVENTS PRIOR TO THE INCIDENT

3.1 The Antigua and Barbuda vessel MSC "Suffolk" entered the Port of Dublin on the 5th March 2003. The vessel had just completed a passage from Antwerp with a cargo of containers. The vessel is on a liner service around European ports and returns to Dublin on a monthly basis.

3.2 Mr. Romanyuk was listed on the watchkeeping schedule as keeping a bridge watch from 04.00 to 08.00 hours and from 16.00 to 20.00 hours.

3.3 Keeping to this schedule Mr. Romanyuk would have had eight hours rest between 20.00 and 04.00 hours and would have been scheduled to go off duty once the vessel was securely moored alongside.

3.4 According to on-board personnel Mr. Romanyuk was an experienced seafarer and had previously served as Bosun. He was regarded as hard working and diligent.

3.5 After breakfast Mr. Romanyuk assisted Mr. Piankowski with routine deck work. According to Mr. Piankowski, Mr. Romanyuk was in good form prior to the incident.

3.6 The day was fine and clear with moderate southwesterly winds.

3.7 Dublin Port pilot boarded at approximately 11.04 hours and the vessel proceeded towards the berth. As the vessel was due to berth at Marine Terminals on the south side of the river it was necessary to take two tugs as the vessel had to swing off the berth to go starboard side alongside. The tug aft was made fast through the centre lead.

3.8 The mooring team aft consisted of the Second Officer Mr. Tyrchalov, Ordinary Seaman (O.S.) Mr. Piankowski and Mr. Romanyuk.

3.9 According to the Second Officer it is normal practice for him to man the winch controls and let the crewmembers handle the ropes and keep him informed.

3.10 As the vessel approached the berth the first line sent ashore from aft was the spring line.

3.11 Mr. Piankowski and Mr. Romanyuk arranged to send ashore the first sternline. The sternline was a polypropylene mooring rope common to most vessels and of an appropriate size and strength for its purpose. As the aft tug was made fast through the centre lead it became necessary to send the sternline ashore via two roller leads on the poop deck.

4. THE INCIDENT

4.1 Immediately prior to the incident Mr. Piankowski noted that Mr. Romanyuk was just aft of the port mooring winch. Mr. Piankowski then turned his attention towards the shore and noted that the eye of the stern line was on the shore bollard. He then indicated to the Second Officer on the controls that he could commence heaving. When the Second Officer commenced heaving, Mr. Piankowski looked again towards the port mooring winch and saw that Mr. Romanyuk was under the mooring rope drum of the winch. He gave the hands crossed sign to stop heaving and the Second Officer did so.

4.2 The Second Officer who was manning the winch controls stated that the last time he saw Mr. Romanyuk prior to the incident he was outboard (to port) of the port winch and stern line.

4.3 The Second Officer stated that after the aft spring line was made fast arrangements were made to send the stern line ashore. It would be normal practice to use the fixed mooring rope drums to make fast the first sternline and first spring line. After this, ropes would be turned up (made fast) on the four sets of mooring bitts available on the aft deck. Due to the tug being fast through the centre lead the stern line was rigged via two roller leads. According to the Second Officer during the rigging of the stern line Mr. Romanyuk was positioned near the port set of roller leads (See Sketch at Appendix 8.1 & Photograph at Appendix 8.2). Prior to heaving the sternline the Second Officer saw Mr. Romanyuk outboard of the sternline in clear view.

4.4 When the Second Officer got the signal from Mr. Piankowski he commenced heaving and continued to do so until he got the signal to stop.

5. EVENTS AFTER THE INCIDENT

5.1 When the Second Officer saw Mr. Romanyuk under the winch he called the bridge and the Captain came to the scene. The Captain searched for a pulse and found none. The Emergency Services were called and the Fire Brigade Ambulance removed Mr. Romanyuk to St. Vincent's hospital where he was found to be dead on arrival.

6. CONCLUSIONS AND FINDINGS

6.1 The exact cause of the accident cannot be established. Mr. Romanyuk was an experienced seafarer and in addition to taking directions from the Second Officer would have been expected to use his initiative to progress the mooring operation.

6.2 On board records indicate that Mr. Romanyuk had received appropriate onboard familiarisation training.

6.3 There are a number of possibilities including the following:

(A) Mr. Romanyuk was attempting to feed the mooring line correctly on to the mooring winch drum and snagged his clothing within the mooring line. When a mooring line is to be sent ashore the mooring crew will flake the line along the deck to ensure sufficient slack to reach the shore. When the mooring line is turned up on the shore bollard it may then become necessary for the mooring crew to feed the left over slack on to the mooring drum as the mooring line is being heaved taut. Mr. Romanyuk may have been feeding the slack rope on to the drum and he may have become entangled at this time.

(B) There may have been a riding turn on the winch drum. At times a mooring rope may not feed correctly onto a mooring drum and a section of line may protrude which may jam the drum. Mr. Romanyuk may have been attempting to free the mooring line as it was being heaved and may have become entangled within the mooring rope.

(C) It is also possible that an item of clothing such as Mr. Romanyuk's working gloves may have become snagged in the line.

(D) Mr. Romanyuk may have been standing quite close to the winch drum and had no time to call out or perhaps was not heard due to the background noise.

6.4 Mr. Romanyuk was wearing working shoes and working gloves at the time of the accident.

6.5 The deck in way of the accident was clear of oil and grease. Deck mooring machinery was found to be functioning satisfactorily.

6.6 All personnel at the aft mooring station were rested in accordance with international regulations. Fatigue does not appear to been a contributing factor. It should be noted however that container vessels on short sea trades are in general operating to tight schedules with a resultant heavy workload on crewmembers.

6.7 The weather does not appear to have been a contributory factor. The day was fine and clear and the berth was relatively sheltered from the moderate southwesterly winds.

6.8 The mooring arrangement on the aft deck of the MSC "Suffolk" is designed so that the mooring ropes feed onto the mooring winch drums from the underside, the roller leads are at a height above the deck which make it impractical to lead the ropes over the top of the mooring drums.

6.9 On the MSC "Suffolk" there is no guard or protection to prevent a person from being dragged underneath a mooring winch.

6.10 There were 14 crew on board the MSC "Suffolk" on arrival at Dublin. In addition to the deck crew there were three oilers. In the normal course of events the oilers were not utilized for mooring operations. The Minimum Safe Manning Certificate issued by the Flag State indicates that a minimum of fourteen crew are required to man this vessel. A footnote indicating special requirements clearly states that the grades and personnel listed (on the Minimum Safe Manning Document) reflect the minimum number of persons necessary for the safety of navigation and operation.

6.11 The Second Officer operated the winch controls at the aft mooring station. The Master and Officers on board are of the view that it was the duty of the crew to manhandle ropes whilst the Second Officer remained in control of the mooring operation and attended the aft winch controls.

7. RECOMMENDATIONS

7.1 A copy of this report should be forwarded to the Antigua and Barbuda administration.

7.2 All vessels should make appropriate use of onboard personnel whilst engaged in operations such as mooring operations.

7.3 The IMO Resolution A.890(21) gives guidelines on the requirements for issue of a Minimum Safe Manning Document. Perhaps the IMO should consider revising the title of this document to e.g. an "Operational Safe Manning Document" with allowances for minimum or reduced manning when circumstances or operational allow.

7.4 All vessels should carry out risk analysis to highlight areas of high risk and high risk operations such as mooring operations. When risks are identified appropriate precautions can then be put in place.

8. APPENDICES

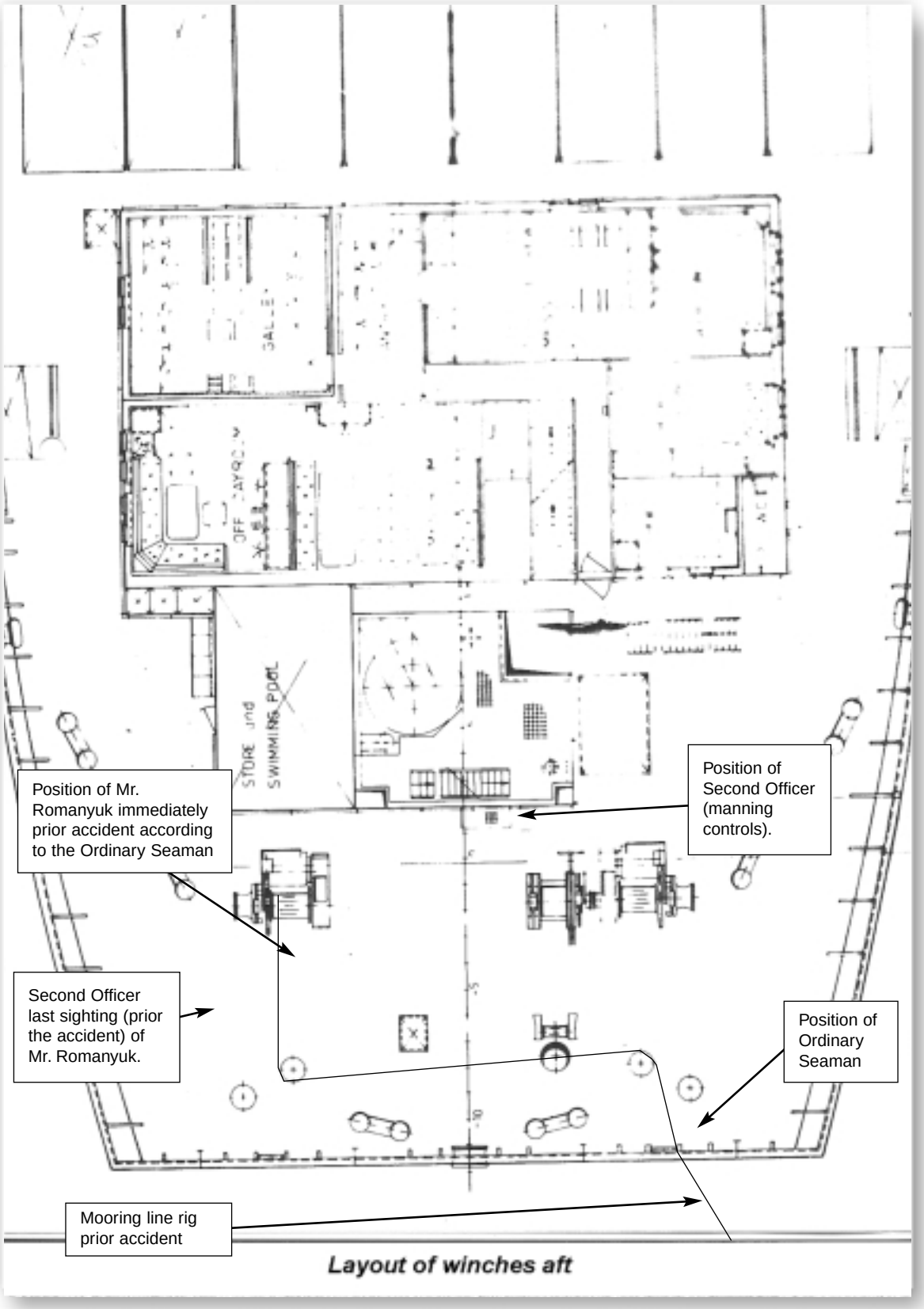
8.1 Sketch of Deck Layout.

8.2 Photograph of Starboard Aft Mooring Winch.

8.3 Photographs of MV MSC "Suffolk" in Dublin.

Appendix 8.1

Sketch of Deck Layout.



Appendix 8.2

Photograph of Starboard Aft Mooring Winch.

The starboard aft mooring winch was used to deploy the aft spring line. Note how the mooring rope leads from the underside of the drum.

Appendix 8.3

Photographs of MV MSC "Suffolk" in Dublin.

9. LIST OF CORRESPONDENCE RECEIVED

Calafort Átha Cliath

DUBLIN PORT Co

23rd March 2004

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Chairman,
Marine Casualty Investigation Board,
Leeson Lane,
Dublin 2.

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Re: MSC 'Suffolk' MCIB 66

Dear Mr. O'Donnell,

I am in receipt of the draft report of the accident on the above vessel on 5th March 2003, for which I thank you.

Please be advised that I do not have any observations upon the stated report.

Yours sincerely,

Capt. R.G.J. Wiltshire
Harbour Master.

MCIB RESPONSE

The MCIB notes the contents of this letter.