MAIB – The Marine Accident Investigation Branch of United Kingdom has conducted a preliminary examination into an accident to a crewmember on board TOR FUTURA at Immingham Dock, River Humber, on 20 June 2007. The sole purpose of this examination is to determine its circumstances and causes with the aim of improving the safety of life at sea and the avoidance of accidents in the future. It is not the purpose to apportion liability or blame.

Completed PE Summary – ***Tor Futura***

Category: Dry cargo

Registered Owner:	DFDS A/S
Port of registry:	Esbjerg
Flag:	Denmark
Type:	Ro-ro/lo-lo freight only
Built:	1996
Classification Society :	Lloyds Register
Construction:	Steel
Length overall:	183.27m
Gross Tonnage:	18,725 tonnes
Date &Time:	20/06/07 0658 (UTC +1)
Location of incident:	Immingham Lock
Incident type:	Accident to person
Persons onboard:	17
Injuries:	1
Damage/ Pollution:	None

Synopsis (All times are UTC +1)

At 0515 on 20 June 2007, a pilot boarded *Tor Futura*, which was inbound from Rotterdam to Immingham. The river passage was uneventful and the ship approached Immingham Lock at 0630. The bollards, located along each side of the lock, were original to the time of its construction, and were of a "dolly" design, not having any horns. To prevent the eye of a mooring rope from slipping off a bollard, it was standard practice to hitch the eye when securing high-sided ships such as *Tor Futura*.

During the locking procedure, the bridge team consisted of the master and chief officer, and, because the master was being assessed for his pilotage exemption certificate, the pilot played no active part in the proceedings. The forward mooring party consisted of an able seaman and a leading hand, the latter of whom was standing on the stem platform relaying distances to the bridge team as the ship was manoeuvred into the lock at a speed of about 1 knot.

The forward 64mm backspring was passed down to the berthing master and a linesman. The berthing master placed the eye of the mooring line over the allocated bollard, without

following the standard practice of using a hitch. He and the linesman then moved towards the inner gates to operate the machinery controlling the sluice gates. When the ship was in position, the forward backspring was heaved in to hold the ship in position. The leading hand took over from the able seaman at the winch controls, which were located at the ship's side and immediately next to the fairlead through which the backspring passed. As the ship was rising in the lock, the backspring slipped off the bollard and struck the leading hand in the face, causing lacerations and fractures to his cheek bone and nose.

Action taken:

While Associated British Ports and DFDS have taken a number of actions to prevent an accident of this nature occurring again, the Chief Inspector has written to:

1. The Immingham dockmaster, advising him that best practices in respect of supervision, shift patterns and revisiting risk assessments do not appear to have been followed in this particular case, and recommending him to:

    - **Identify the key bollards in Immingham Lock that are used for high-sided vessels and modify or replace those bollards with ones of an appropriate design.**

2. DFDS, strongly advising that the company considers the following additional measures:

    - advise ship's staff of snap-back areas at mooring stations;

    - provide means for remote operation or re-position winch controls outside snap-back areas; and

    - promote the established practice of wearing safety helmets when ship's staff are at mooring stations.