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香 港 商 船 資 訊

HONG KONG MERCHANT SHIPPING INFORMATION NOTE

A fatal accident while unmooring operation on poop deck

To : Shipowners, Ship Managers, Ship Operators, Masters, Officers and Crew

Summary

During unmooring operation for departure from berth on board a Hong Kong registered container ship, a crewmember was killed after being hit by a towline. This information note draws the attention of Shipowners, Ship Managers, Ship Operators, Masters, Officers and Crew to the lessons learnt from this accident.

The Accident

The accident happened on board a Hong Kong registered container ship at the time of unmooring operation. The operation team including a second officer, a senior quarter-master (SQM), an ordinary seaman (OS) and a deck cadet (DC) were led by the second officer. They conducted unmooring operation at the aft mooring station of the vessel for departure from a berth.

2. The operation team retrieved two stern lines, which had been originally made fast to the berth bollards, by a stern mooring winch. A sufficient length of one of these two lines was subsequently unreeled from the winch drum for being used as a towline. The towline was arranged to pass a double bollards on deck without making any turn on them and a universal fairlead before hanging down over the ship side for towing operation.

3. When arranging the towline, the second officer was standing at the stern to communicate with the tug operators by hand signals. When the SQM was operating the mooring winch, the OS together with the DC were standing close to the towline, but the DC was standing inside the dangerous snapping area.

4. After engaging the towline, the tug boat started to move and pull the towline without the second officer’s instruction. The towline slipped out of the bollards under a sudden tension force exerted by the tug boat and it hit against the chest of the DC. He sustained serious injuries and was confirmed dead in the hospital at shore.

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5. Investigation into the accident revealed the following contributory factors causing this accident:

- the second officer, who was person in charge of the unmooring operation at the aft station, was not familiar with using the vessel's mooring rope as towline. He also did not carry out risk assessment before the operation and made necessary safety precautionary measures;
- the deck cadet, who had limited sea experience, was not closely supervised when he was engaged in critical shipboard operations, like mooring and unmooring operations. He was not reminded to stay clear of the snapping zone of towline at all times during operation; and
- no effective communication between the second officer and the tug boat for starting the towing operation.

Lessons learnt

6. It is important that officers and crew on board ships should strictly follow the shipboard safety procedure whenever they are engaged in the mooring operation. In particular:

(i) carry out risk assessment to determine the precautionary measures and the officers and crew should be familiarized with any peculiar situations;

(ii) establish comprehensive action plans and ensure effective communication among all parties involved in the operation; and

(iii) brief all members of the team about the potential snap-back zone in the mooring stations and closely monitor all junior seafarers such as ordinary seamen and cadets.

7. The attention of Shipowners, Ship Managers, Ship Operators, Masters, Officers and Crew is drawn to the lessons learnt above.

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