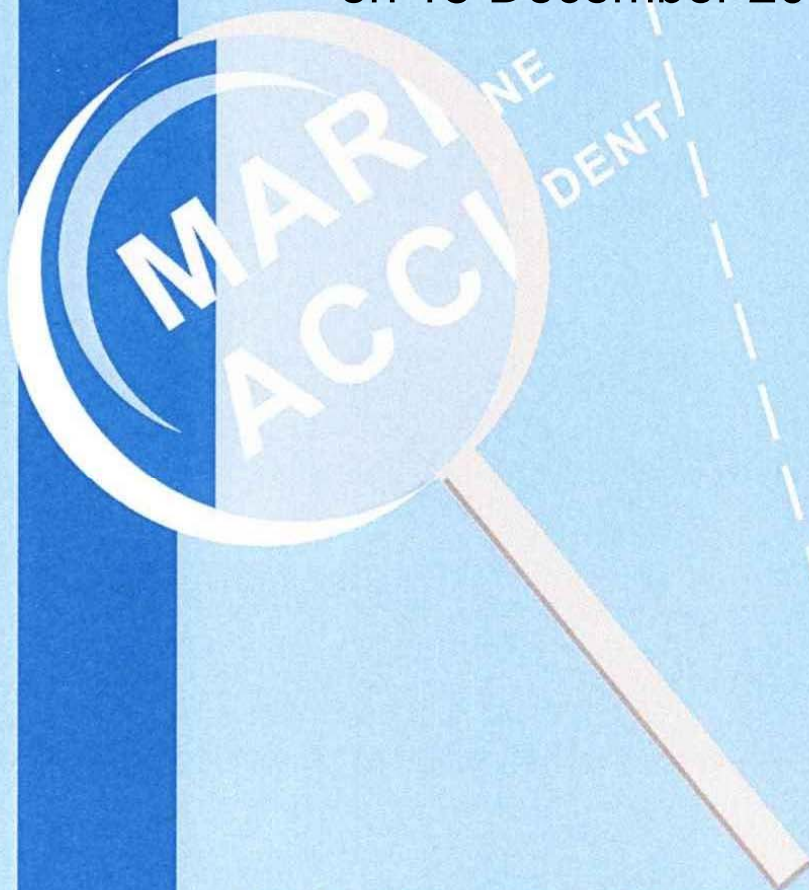




Report of Investigation  
into the fatal accident on board  
*Hua Chang Hai 3 Hao*  
at Tuen Mun River Trade  
Terminal  
at about 1905  
on 15 December 2006





## **Purpose of Investigation**

This incident is investigated, and published in accordance with the IMO Code for the Investigation of Marine Casualties and Incidents promulgated under IMO Assembly Resolution A.849(20). The purpose of this investigation conducted by the Marine Accident Investigation and Shipping Security Policy Branch (MAISSPB) of Marine Department is to determine the circumstances and the causes of the incident with the aim of improving the safety of life at sea and avoiding similar incident in future.

The conclusions drawn in this report aim to identify the different factors contributing to the incident. They are not intended to apportion blame or liability towards any particular organization or individual except so far as necessary to achieve the said purpose.

The MAISSPB has no involvement in any prosecution or disciplinary action that may be taken by the Marine Department resulting from this incident.

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## 1. Summary

- 1.1 A fatal accident occurred on board the PRC river-trade vessel *Hua Chang Hai 3 Hao* (華昌海3號) (hereinafter referred as *the Vessel*) at about 1905 on 15 December 2006. While *the Vessel* was berthing to the Berth No. 24 of the Tuen Mun River Trade Terminal, a sailor who was engaged in handling mooring rope at the stern was hit by the wire mooring rope of the dumb steel lighter *Transward No. 32*. He fell overboard into the sea and was drowned.
- 1.2 The accident was caused by a long wire mooring rope which sprang off under tension after being caught by the dog of bulkhead door at the stern of *Hua Chang Hai 3 Hao*. The lack of safety awareness of the deceased by locating himself in close proximity to the long wire mooring rope of the dumb steel lighter (DSL) *Transward No. 32* also contributed to the accident.

## 2. Description of the vessel

### 2.1 *Hua Chang Hai 3 Hao* (华昌海3号)

Registration No.	:	140006000017
Type of Ship	:	Container vessel
Year of Built	:	2003
Built At	:	Taizhou Zhejiang, China
Owner of Vessel	:	Shenzhen Gonghang Shipping Co., Ltd.
Length	:	49.98 metres
Breadth	:	15.80 metres
Depth	:	5.50 metres
Gross Tonnage	:	1,298
Net Tonnage	:	726
Engine & Power	:	2 x Diesel 600kW (Total 1,200 kW)
No. of Cargo Hold	:	1

*Hua Chang Hai 3 Hao* is a single hold container vessel registered in Shenzhen, the People's Republic of China. It was engaged in coastal trade between Hong Kong, Yantian and Shekou in China.



Fig. 1: Photograph of *Hua Chang Hai 3 Hao*

**3. Sources of Evidence**

3.1 Master of *the Vessel*

3.2 Bosun of *the Vessel*

3.3 Purser of *the Vessel*

3.4 Hong Kong Police Force

#### **4. Outline of Events**

- 4.1 At about 1150 on 15 December 2006, *Hua Chang Hai 3 Hao* sailed from Shekou and dropped anchor at Tuen Mun Immigration Anchorage at about 1355. At about 1630 *the Vessel* heaved anchor and shifted to moor side by side to the dumb steel lighter *Transward No. 32* which was alongside to Berth No. 24 of the Tuen Mun River Trade Terminal.
- 4.2 At about 1840 *Transward No. 32* with mooring ropes still attached to *Hua Chang Hai 3 Hao* was shifted to Berth No. 25 from Berth No. 24 by heaving her stern wire mooring ropes and slackening her bow wire mooring ropes. After completion of shifting, at about 1855 *Hua Chang Hai 3 Hao* was instructed by the company to berth alongside Berth No. 24. The Bosun was on standby at the ship's bow while a Sailor was at the stern.
- 4.3 At about 1905 when the Bosun was tightening the mooring rope at the bow, he heard a bang and saw the Sailor had fallen overboard. The Bosun immediately ran to the stern and threw a lifebuoy into the sea. He then jumped into the sea in an attempt to rescue the Sailor but was in vain.
- 4.4 The Sailor was recovered by a Fire Services Department's diver at about 2305 and was sent to Tuen Mun Hospital for medical treatment. He was certified dead at Tuen Mun Hospital at 2335.

## 5. Analysis of Evidence

- 5.1 The deceased joined *Hua Chang Hai 3 Hao* as a sailor on 3 December 2006 and previously he had worked as a sailor on other vessels for almost 6 months.
- 5.2 The weather was cloudy with a northeasterly light breeze and a good visibility. The sea was slight.
- 5.3 *The Vessel* consisted of a complement of eight crewmembers, a Master, a Chief Officer, two Engineers, a Purser, a Motorman, a Bosun and a Sailor. When the accident occurred, the Master was on the wheelhouse, the Bosun was on standby at the bow and the deceased was on standby at the stern.
- 5.4 There was no evidence that the Sailor had been affected by alcohol, drugs or fatigue. No crew members of *Hua Chang Hai 3 Hao* had seen the Sailor taking any alcohol or drugs on board *the Vessel*. As the Sailor had about 7 hours of rest after sailing from Shekou at about 1150 on 15 December 2006 and before shifting to berth alongside Berth No. 24 at about 1855, the Sailor should not be affected by fatigue.
- 5.5 When the accident occurred, *Transward No. 32* was moored to Berth No. 25 with two wire mooring ropes at each end (Figure 2). The long wire mooring ropes on the forward end of *Transward No. 32* would cause obstruction to and create a potential hazard to any vessels berthing alongside Berth No. 24. In approaching to Berth No. 24, one of the bow wire mooring ropes of *Transward No. 32* was caught by the dog of the bulkhead door on the stern of *Hua Chang Hai 3 Hao* (Figure 3). The wire mooring rope sprang off from the dog and hit the Sailor who was attending at the stern. The Sailor fell overboard and was drowned.
- 5.6 Long wire mooring ropes were used by *Transward No. 32* to shift alongside between Berth No. 24 and Berth No. 25. By heaving the wire mooring ropes on one end and slackening the wire mooring ropes on the other end will make shifting alongside adjacent berths easier without transferring the wire mooring ropes from one bollard to another when shifting.
- 5.7 The Autopsy Report confirmed that the cause of death was drowning. An abrasion was found on upper forehead while bruised abrasions were discovered on outer angle of left eye, left lower front of chest and the adjoining left upper abdomen. From the autopsy report, it was deduced that the Sailor was first hit by the wire mooring rope which sprang off from the dog of the bulkhead door and then fell overboard and got drowned.

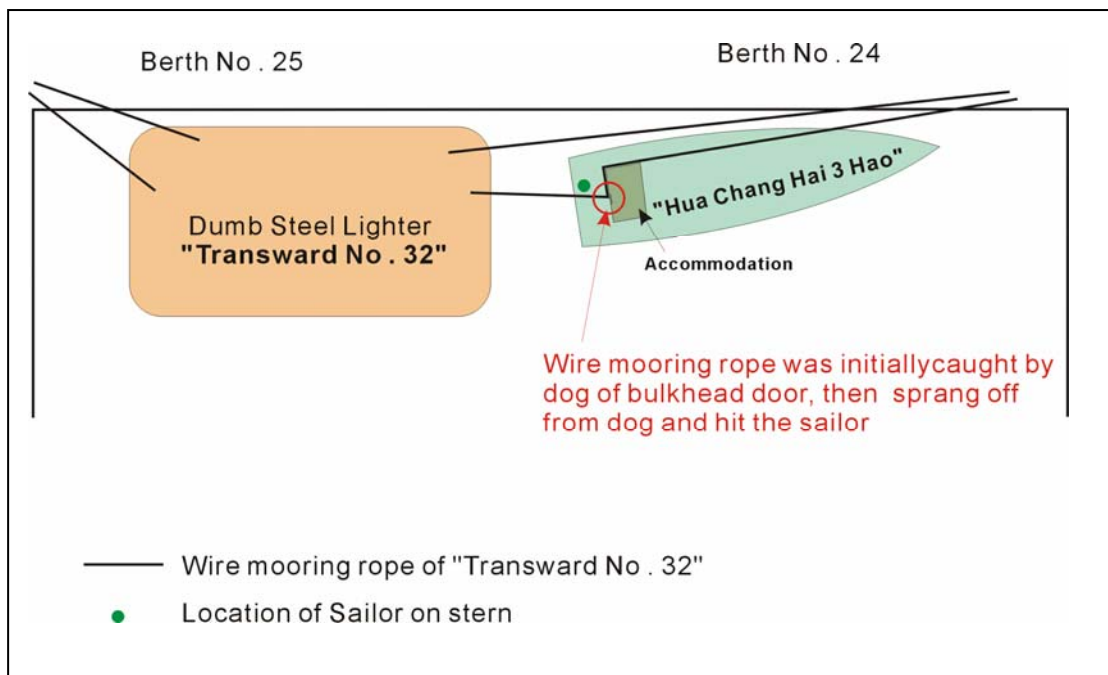


Figure 2 – Diagram showing the mooring arrangement of *Transward No. 32* which was moored to Berth No. 25 when *Hua Chang Hai 3 Hao* was approaching Berth No. 24



Figure 3 – Diagram showing the dog of the bulkhead door where the wire mooring rope of *Transward No. 32* was caught

## **6. Conclusions**

- 6.1 At about 1905 on 15 December 2006, a Sailor who was on standby at the stern on board the Chinese river-trade vessel *Hua Chang Hai 3 Hao* was hit by a wire mooring rope of the dumb steel lighter *Transward No. 32*. The Sailor fell overboard and was drowned.
- 6.2 The accident was caused by a long wire mooring rope which sprang off under tension after being caught by the dog of bulkhead door at the stern of *Hua Chang Hai 3 Hao*.
- 6.3 The lack of safety awareness of the Sailor who positioned himself too close to the long wire mooring rope of the dumb steel lighter *Transward No. 32* also contributed to the accident.

## **7. Recommendations**

- 7.1 A copy of this report should be sent to the operator and the owner of *the Vessel*, advising them the findings of the of this incident and the importance of advising their crew members to keep themselves well clear from mooring ropes when berthing/unberthing.
- 7.2 A copy of this report should be sent to the Tuen Mun River Trade Terminal advising them the findings of this incident. They should draw the attention of the operators of the dumb steel lighters working within the terminal that their mooring ropes should not cause obstruction and create potential hazard to other vessels which berth/unberth from the berths of the terminal.

## **8. Submissions**

- 8.1 In the event that the conduct of any person or organization is criticized in the investigation report, it is the policy of the Hong Kong Marine Department that a copy of the draft report is given to that person or organization so that they have the opportunity to rebut the criticism or offer evidence not previously available to the investigating officer.
- 8.2 The draft report (without recommendations) was forwarded to the Master and Bosun of *Hua Chang Hai 3 Hao*.
- 8.3 No submission has been received from them.