



香港商船資訊

HONG KONG MERCHANT SHIPPING INFORMATION NOTE

Fatal Accident Involving Falling Overboard From Gangway

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

Summary

An accident occurred on an Indian registered tanker in Hong Kong in which a seaman fell overboard and drown. At the time of the accident the seaman was engaged in inspecting the ship's gangway from the shipside. This information draws the attention of company and shipboard staff the lessons learnt and the precautions that need to be observed when carrying out works near the side.

The Incident

1. On 23 April 2004 at about 2200 hours, after heaving up the anchor for departure from Hong Kong, the anchor team of an Indian registered tanker vessel stopped at the port side gangway to investigate the vibration noise heard earlier when the gangway was being operated. At that instance the gangway was hoisted up at deck level and was supported by two sliding frames in a hang-out position outboard of the shipside. There was a gap of about 0.7 metre wide between the shipside and the length of the gangway. The steel wires for operation of the sliding frames were running just above main deck level along the sheer strake. The protective handrail along the shipside ran inboard of the two sliding frames in way of the gangway.
2. To reach the gangway from the side at this position, one had to climb over the 1.5 m high handrail and stepped across the sheer strake of the ship. It is believed the deceased seamen, who was the Petty Officer Maintenance on board the ship and a member of the anchor team, had either tripped over the steel wires or slipped on the sheer strake and fell overboard while attempting to reach the gangway from the side. At the time he was not wearing any safety belt or buoyancy garment. The attention of other team members was focused on the gangway and they were not aware of what he was doing.

Contributory Factors

3. The investigation into this fatal accident has established that the lack of awareness of the deceased on the man-over-board hazards associated with working over the shipside had contributed to the occurrence of the accident. The work was carried out at night time in a potentially hazardous location where the illumination was not entirely satisfactory. No precautionary measures had been taken prior to commencement of the work. Furthermore, the actions of individual members of the anchor team were not properly coordinated.

Lessons

4. It is important to ensure that the safety precautions regarding ship personnel working over the shipside as stipulated in Chapter 15 of the Code of Safe Working Practices for Merchant Seamen are followed. While working over the side, buoyancy garments should be worn and a lifebuoy with sufficient line attached should be kept ready for immediate use. Safety harness should be used for personnel going outboard of the protective handrail. The work area should be adequately illuminated or the work postponed until daylight. Individual team members should communicate with each other on the action to be taken, and a responsible person should be posted on deck to observe the safety of the process.

5. The attention of shipowners, ship managers, ship operators, masters and officers is drawn on the lessons learnt above.

Marine Department
Multi-lateral Policy Division

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