



香港商船資訊

HONG KONG MERCHANT SHIPPING INFORMATION NOTE

A man overboard accident happened on board while sorting dunnage on the main deck

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

Summary

A man overboard accident happened on board a Hong Kong registered bulk carrier when she was en route to Chile for loading cargo. At the time of the accident, the crew were transferring the dunnage stowed on the starboard side main deck to the cross deck by the No.3 crane, the bosun was suddenly hit by a taut stern tug line connected to the crane hook. As a result, the bosun was bounced over the shipside handrail and went missing after falling overboard into the sea. This Note draws the attention of shipowners, ship managers, ship operators, masters, officers, and crew to the lessons learnt from this accident.

The Incident

1. A Hong Kong registered bulk carrier (*the vessel*) was en route to Chile for loading cargo, the crew were sorting the dunnage stored on the main deck for the last voyage and were going to dispose of ashore at the next loading port. At the time of the accident, the crew were transferring the dunnage stowed on the starboard side main deck by the No.3 crane to the cross deck between the No. 2 and No. 3 cargo holds. In order to restrict the movement of the crane hook when transferring the dunnage, three tug lines connected to the crane hook through the deck rings were held by the crew at the starboard forward, the aft main deck and the hatch cover of No. 3 cargo hold. During the transfer process, the tug lines were found entangled with the hoisting sling connected to the packed dunnage. The bosun tried to untangle the tug lines from the sling when the crane hook was lowered to a position of about 4 metres from the deck. Suddenly, a long swell made the crane hook swing, which caused the slack stern tug line to become taut and hit the bosun. The bosun was bounced over the shipside handrail and went missing after falling overboard into the sea. Unfortunately, the bosun could not be found after a search and rescue operation which lasted for a few days.

2. The investigation identified that the contributory factors leading to the accident were that the crew operated the shipboard crane beyond the operational limits set out in the “Rules for Lifting Appliances of Ships and Offshore Installations” issued by *the vessel’s* classification society; the supervisor at the scene of the lifting operation failed to follow the requirements of the “Code of Safe Working Practices for Merchant Seafarers” (*the Code*) to terminate the lifting operation before its situation deteriorated to the extent that the operation had become dangerous; the crew failed to follow the requirements of the shipboard Safety Management System (SMS) to attach the tug lines directly to the packed dunnage; the shipboard toolbox meeting and its risk assessment on identifying preventive safety measures against the risk of the lifting operation were not effective; the crew lacked sufficient safety awareness and the deck and engine departments lacked effective communication when executing their duties onboard; and that the risk of unexpected tensioning of stern tug lines during the lifting operation was not identified by the crew.

Lessons Learnt

3. In order to avoid recurrence of similar accidents during operation in the future, the ship management company, all masters, officers, and crew members should:

- (a) strictly operate the crane within its operational limits issued by the classification society or the maker, if available;
- (b) strictly follow the requirements of *the Code* to terminate a lifting operation before its situation deteriorated to the extent that the operation had become dangerous;
- (c) strictly follow the requirements of the shipboard SMS on the usage of tug lines during lifting operations;
- (d) ensure effective carrying out of shipboard toolbox meetings and their risk assessments, including identifying preventive safety measures against risks of lifting operations; and
- (e) enhance the crew’s safety awareness on the risk of unexpected tensioning of stern tug lines during a lifting operation as well as the significance of effective communication between the deck and engine departments when executing duties onboard.

4. The attention of shipowners, ship managers, ship operators, masters, officers, and crew is drawn to the lessons learnt above.

Marine Department
Multi-lateral Policy Division

22 February 2023