



香港商船資訊

HONG KONG MERCHANT SHIPPING INFORMATION NOTE

A fatal accident happened on board during a vessel shifting operation

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

Summary

A fatal accident happened on board a Hong Kong registered bulk carrier (*the vessel*) at the port of Pascagoula, USA, when it was undergoing a shifting operation in the berth. When *the vessel* was in position, the master instructed the crew to heave the slack aft spring line. All of a sudden, the aft spring line escaped from the upper edge of the mooring platform fender and heavily hit the second officer (2/O), who was checking the condition of the aft spring line near the port side bunker hose crane, resulting in his death. 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. *The vessel* was alongside the berth at the port of Pascagoula, USA, for loading petroleum coke in bulk. Due to the operational limits of the shore loading machine, *the vessel* was required to shift forward or backward for loading cargoes into different cargo holds of *the vessel* according to the loading plan. While *the vessel* was shifting forward for 60 metres (*the shifting operation*), the master of *the vessel* instructed the 2/O to heave the slack aft spring line when *the vessel* was in position without knowing that the aft spring line was entangled by the upper edge of the mooring platform fender. The 2/O relayed the order to an able-bodied seaman by a Very High Frequency (VHF) radio, and then ran forward to a position near the port side bunker hose crane to check the condition of the aft spring line. Unfortunately, the aft spring line suddenly escaped from the upper edge of the fender and hit the 2/O heavily, resulting in the 2/O lying on the main deck with blood in his mouth and nose, and without breath and pulse. Despite the shipboard first aid by the crew of *the vessel* and medical treatment by the shore medical team, the 2/O was declared dead on board eventually by the shore medical team.

2. The investigation identified that the contributory factors leading to the incident were that the crew failed to follow the requirements of section 26.3.13 of “Code of Safe Working Practices for Merchant Seafarers”¹ (*the Code*) to remain in a safe position when mooring lines are under strain, and *the Code’s* recommendation to identify the dangerous areas by using a bird’s eye view of the mooring deck arrangement during *the shifting operation*, including the provision of illumination around the mooring platform fender area which was far from *the vessel*; the crew failed to follow the requirements of section 26.3.12 of *the Code* to hold a toolbox meeting before *the shifting operation*; the crew lacked a safe working culture of good communication and clear leadership during *the shifting operation*; the shipboard training on mooring/unmooring operations to the 2/O was ineffective; the shipboard risk assessment for mooring and unmooring operations was ineffective; and the 2/O lacked safety awareness to the risk of snap-back zones of the mooring lines when they were under strain.

Lessons Learnt

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

- (a) strictly follow the requirements of *the Code* to remain in safe position and its recommendation to identify dangerous areas by using a bird’s eye view of the mooring deck arrangement including the provision of illumination around the fender area which is far from the vessel;
- (b) strictly follow the requirements of *the Code* to hold a toolbox meeting before the operation;
- (c) strictly follow the requirements of *the Code* and shipboard safety management manuals to carry out an effective risk assessment for the operation;
- (d) enhance safety awareness of the crew to the risk of snap-back zones of mooring lines;
- (e) ensure the operation to be carried out under a safe working culture, including good communication and clear leadership; and
- (f) ensure effective onboard training to the crew for safe mooring and unmooring.

¹ Amendment 7, October 2022

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

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23 August 2023