



# 香港商船資訊

## HONG KONG MERCHANT SHIPPING INFORMATION NOTE

### **Fatal accident of a crew struck by a portable gangway**

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

#### *Summary*

When a Hong Kong registered chemical tanker was at berth, the vessel's portable gangway (the gangway) was placed between the main deck of the vessel and the berth as access. Before departure, when the gangway was being lifted back on board by the vessel's crane, it struck at the chief officer. The chief officer went ashore for medical treatment, but he refused the doctor's advice of hospitalization. He returned to the vessel and was declared dead on board later. 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. When a Hong Kong registered chemical tanker was berthed at Kuala Tanjung, Indonesia, the vessel's portable gangway (the gangway) was placed between the main deck and the berth as access. By using the vessel's crane, the chief officer led a team of deck ratings to lift the gangway back on board before departure from the berth. While the chief officer was investigating the cause that made the gangway got stuck with the vessel's railing, the gangway suddenly moved and struck at him. The master conducted a visual body check for the chief officer and instructed him to take a rest. The vessel departed the port as per her schedule. The chief officer visited a doctor when the vessel arrived at Pelintung, Indonesia on the next day, but he refused the doctor's advice of hospitalization. The chief officer returned to the vessel and was declared dead on board later.

2. The investigation revealed that the contributing factors to the accident are as follows:

- (a) as the crane, limited by the arm span, could not reach the gangway's centre point, the gangway was lifted under an asymmetrical centre line of hoisting thus causing the gangway being subjected to an inboard pulling force when lifted. As a result, the hooks at the end of the gangway were stuck with the vessel's railing. When the hooks were suddenly freed from the railing, the gangway slid inboard in an uncontrolled manner. The uncontrolled gangway struck the chief officer who was standing at a spot within the danger zone of the gangway's moving path; and
- (b) the deployment of four guard ropes failed to withhold the sudden inboard swing of the gangway. The risk assessment and the work plan prepared before the gangway lifting operation had not been done properly.

3. A safety issue was also observed in the accident. Seafarers should always consider accepting a doctor's advice when attending medical treatments. The chief officer might save his own life if he decided to stay in the hospital as advised by the local doctor.

### **Lessons Learnt**

In order to avoid recurrence of a similar accident in future, masters, officers and crew should:

- (a) conduct a proper risk assessment for lifting heavy objects. During lifting operation, no person should stand in the danger zone. Lifting operation under an asymmetrical centre of the lift should be avoided as far as practicable;
- (b) check the medical report of an injured person to confirm whether he/she is still fit for duties/sailing on board; and
- (c) consider duly and accept the doctor's advice when attending medical treatments.

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

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