Man overboard accident while renewing accommodation ladder wire at sea

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 departed from Port Dickson, Malaysia for the loading port in Paranagua, Brazil. When crew members were busy with the wire renewal work of the starboard side accommodation ladder, the deck cadet standing by the shipside to provide assistance suddenly fell overboard. The search continued for two days, but the missing cadet could not be found. 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 departed from Port Dickson, Malaysia and headed for the loading port in Paranagua, Brazil through the Malacca Strait. When deck crew members were restoring the accommodation ladder after the pilot disembarked, the wire of the accommodation ladder parted. The deck crew members, including the deck cadet, were assigned to repair the accommodation ladder and renew its wire on the main deck. The Bosun and the Carpenter were both equipped with lifejackets, safety harnesses and fall arrestors. They were working on the accommodation ladder after it was placed on deck while the others were responsible for handing over tools and wire materials. At the final testing and fine adjustment stage, the deck cadet standing by the shipside suddenly fell overboard.

2. When the crew members were aware that the deck cadet had fallen overboard, they threw a lifebuoy into the sea and informed the bridge. Rescue boat and lifeboat were lowered successively for the search and rescue operation. Vessel Traffic Center, Maritime Rescue Coordination Center and the management company were informed. Ships in the vicinity were
also alarmed to assist. The search and rescue continued for two days, but the missing deck cadet could not be found.

3. The investigation revealed that the main contributory factors of the accident were the non-compliance of the shipside guard rails with the Load Lines Convention; and the failure to strictly follow the safety instructions in the vessel’s safety management system (SMS).

4. The investigation also identified that the vessel did not return to a spot near the man overboard position as soon as possible for search and rescue in accordance with the International Aeronautical and Maritime Search and Rescue Manual Volume III. It was also found that the “permit-to-work and safety checklist” of the SMS did not fully meet the relevant requirements of the Code of Safe Working Practices for Merchant Seafarers.

**Lessons Learnt**

5. In order to avoid recurrence of similar accidents in the future, all Masters, officers, and crew members should:

   (a) ensure effective guard rails for the shipside openings in complying with the Load Lines Convention are installed in order to provide better protection in preventing the crew members from falling overboard;

   (b) strengthen the supervision in particular of junior seafarers and monitor the work over shipside strictly in compliance with the relevant safety instructions;

   (c) enhance familiarization with the permit-to-work procedures and safety instructions on working over shipside; and

   (d) enhance man overboard rescue training and drill.

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

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