No. : **28/2023**

香 港 商 船 資 訊

HONG KONG MERCHANT SHIPPING INFORMATION NOTE

A fatal accident happened on board during lifting operation

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

Summary

A fatal accident happened on board a Hong Kong registered oil tanker when she finished discharging cargo oil at a jetty. At that time, the deck crew were retrieving a portable aluminium gangway (*the portable gangway*), which was used as an access from the jetty to the main deck, by using the ship crane. During the lifting operation, two sling wires slipped out from the crane hook, resulting in *the portable gangway* falling off and hitting a nearby able seaman heavily, leading to 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. A Hong Kong registered oil tanker (*the vessel*) berthed at Jawaharlal Nehru Port of Mumbai, India, to discharge her cargo (*the cargo operation*). The deck crew, including one able seaman (*the AB*), were assigned to retrieve *the portable gangway* and place it in its storage location on the main deck after completing *the cargo operation*. *The portable gangway* was used to access the main deck of *the vessel* from the jetty during *the cargo operation*. The outboard end of *the portable gangway* was placed at the jetty, while its inboard end was placed on the rail of the main deck. During the retrieval process, instead of using a composite lifting unit which included a master link connecting with four wire rope slings and the crane hook as required by the manufacturer (*manufacturer-qualified lifting accessories*), *the portable gangway* was lifted by the ship crane using four sling wires with their eyes directly connected to the crane hook individually.

2. Before *the portable gangway* was lifted to the deck level, the inboard sling wires were slack as the inboard end of *the portable gangway* was supported by the deck rail. When the outboard end of *the portable gangway* was lifted slightly above the deck rail, the tension of the slings at the outboard end forced *the portable gangway* to swing inboard momentarily, causing the

Marine Department
Harbour Building
38 Pier Road
G.P.O. Box 4155
Hong Kong

Telephone No. : (852) 2852 3001
Fax No. : (852) 2544 9241
E-mail : hkmpd@mardep.gov.hk
Web site : https://www.mardep.gov.hk

inboard sling wires to slip out from the crane hook. As a result, the inboard end of *the portable gangway* fell onto the main deck and hit *the AB* heavily. He was found with blood in his mouth and lying unconsciously. Although first aid was immediately applied to *the AB*, including cardiopulmonary resuscitation on board, and he was sent to a local hospital by ambulance for medical treatment, unfortunately, *the AB* was declared dead later at the hospital.

3. The investigation identified that the contributory factors leading to the incident were that the crew failed to follow the requirements of the shipboard safety management system (SMS) and the "Code of Safe Working Practices for Merchant Seafarers" (*the Code*) to lift *the portable gangway* in a safe manner by using the *manufacturer-qualified lifting accessories*, and stay away from the dangerous area during lifting operation; during the risk assessment, the crew failed to identify the risk of using unqualified lifting accessories; the crew failed to follow the requirements of *the Code* to hold a toolbox meeting before commencing the work; the shipboard training on retrieving *the portable gangway* was ineffective; the ship-shore communication between the crew and the shore personnel was ineffective during the lifting operation; and failure to include work hazards and associated risks in the shipboard SMS as alerts to be discussed in the toolbox meeting according to the requirements of *the Code*.

Lessons Learnt

4. In order to avoid recurrence of similar accidents during operation in the future, the ship management company, all masters, officers, and crew members should note items (a) to (d) while ship management company should also note items (e) and (f):

(a) strictly follow the requirements of the shipboard SMS, the manufacturer and *the Code* to lift portable gangways in a safe manner;

(b) strictly follow the requirements of *the Code* to hold toolbox meetings before commencing the work;

(c) enhance effective shipboard training in retrieving portable gangways;

(d) ensure effective communication among all persons participating in lifting operations, including the shore personnel;

(e) ensure the work hazards and associated risks are included in the "Shipboard Management Manual" (*the SMM*); and

(f) ensure crew members to strictly follow the requirements of *the SMM* to carry out toolbox meetings onboard.

5. 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

20 April 2023