The death of an Able-Bodied seaman and injury to the Second Officer onboard Hong Kong registered chemical / products tanker "MTM Hong Kong" at Roxas, Philippines on 11 October 2013

1. The incident

1.1 On 11 October 2013, the Hong Kong registered chemical/products tanker *MTM Hong Kong* (*the vessel*) was berthing at the terminal of Port Roxas, Philippines. Four crewmembers including the Second Officer, an Able-bodied seaman and two ratings were engaged in the mooring operation at stern.

1.2 When they made fast and tightened the third stern line using the warping drum of the mooring winch, a rope stopper was used to take the load on the mooring rope temporarily and facilitate the transfer of the mooring rope from the warping drum to the mooring bitts. While the crewmembers were trying to release the third stern line from the warping drum, the deceased AB stood at a position in between the mooring winch and a pedestal fairlead stand with his hands holding the mooring rope to prepare for the transfer of the rope to the mooring bitts. The rope stopper was suddenly parted rendered the whole mooring rope slipped quickly aftwards towards the stern. The AB was pulled towards the pedestal fairlead stand and his body was pressed by the rope against it.

1.3 The Second Officer rushed to pull the rope out of the pedestal fairlead stand by hands in order to release the AB but it was in vain. His two fingers on the right hand were hurted. Later on, the AB was certified dead and the autopsy report revealed the cause of his death was due to internal injury to his chest.

1.4 The investigation revealed the following contributory factors to the accident:

- The strength of the rope stopper was not adequate and it parted during the mooring operation; and

- Lack of safety awareness of the AB who was unnecessarily positioned himself in a hazardous situation as he was hurry to grab the mooring line for the transfer.

2. Lessons learnt

The lessons learnt from this incident are:

- the strength of the rope stopper if it is to be used must be adequate and the rope stopper arrangement should follow the ‘West Country’ method (double and reverse stoppering) as recommended in The Code of Safe Working Practices for Merchant Seamen; and
- No crew should enter or stay within the snap back zone of any mooring ropes without properly assessed the associated risks before the operation.