Fatal Accident on board the Hong Kong Registered Chemical Tanker "*Melati 5*" on 12 February 2016

1. The incident

1.1 In the morning of 11 February 2016, at about 0848 hours, under light ballast condition, the Hong Kong registered chemical tanker "Melati 5" (the vessel) arrived and berthed at Kuala Tanjung of Indonesia for loading cargo of raw palm oil. A portable gangway was arranged between the main deck at about midship of the vessel and the terminal.

1.2 At about 2130 hours on 12 February 2016, cargo loading was completed. At about 2230 hours, after the pilot had boarded the vessel through the gangway, nine deck ratings led by the chief officer started to pick up the gangway for securing it on top of deckhouse before proceeding to the stations for unmooring.

1.3 The chief officer split deck ratings into 4 groups. Each group handled a guide rope attached to each of the 4 corners of the portable gangway. The guide ropes were used for stabilizing the gangway when it was lifted up by the crane. During lifting up the gangway, the hooks at the end of the gangway were jammed by the railing. When the chief officer moved closer to examine, all of a sudden, the hooks freed from the railing causing the gangway to swing inboard rapidly and to strike the chief officer on his abdomen. The chief officer was assisted to stand up by his colleagues and went back by himself to the accommodation. The master conducted a visual inspection on the wound on abdomen of the chief officer and instructed him to take a rest. The vessel departed as per schedule.

1.4 At about 1806 hour on 13 February 2016, upon arriving at Pelintung, Indonesia, the chief officer visited doctor in a local hospital. Internal bleeding was found in the chief officer's abdomen by X-Ray and UT scanning, but the chief officer refused the advice of the local doctor of staying in the hospital for further observation and treatment. He got some pain killer only and returned to the vessel in the early morning of 14 February 2016.

1.5 At about 1640 hours on 15 February 2016, when the pilot boarded the vessel for departure after completion of loading, he assisted to arrange an ambulance to send the chief officer to hospital for emergency treatment upon the request of the master. However, by the time when the ambulance arrived at 1655 hours, the chief officer was reported dead by the shore paramedics.

2. Lessons learnt

2.1 Following with a proper plan under a thoroughly risk assessment, every lifting operation must be carried out in a safe manner and under an appropriate supervision. Loads should, if possible, not be lifted over a person or any access way, and personnel should avoid entering the dangerous zone under a load that is being lifted.

2.2 All 4 wire lifting slings of the gangway were of the same length, this could not distribute the weight of the inclined gangway evenly while the gangway was inclined between vessel and shore at an angle. The lifting at an angle to the vertical could cause the gangway seizing on the vessel's railing at first stage. Upon lifting up the gangway, the sudden release of jammed hooks of the gangway from the railing could cause the gangway to swing inboard dangerously.

2.3 Before any attempt is made to free object that has become jammed under load, every effort should first be made to take the load off safely. Precautions and extra care should be taken to guard against sudden or unexpected freeing. Others not directly engaged in the operation should keep in safe or protected positions.

2.4 In order to avoid any delay or missing the chance of medical treatment in a shore hospital, the master and the injured person should consider carefully the advice of medical experts (shore doctors), and take the medical treatment on time in a shore hospital as a first priority.