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香 港 商 船 資 訊

HONG KONG MERCHANT SHIPPING INFORMATION NOTE

A fatal accident happened on board during securing of deck log cargoes

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

Summary

A fatal accident happened on board a Hong Kong registered bulk carrier when anchoring at the port of Kavieng, Papua New Guinea. One Able Bodied Seaman (*AB*) and one Deck Fitter (*Fitter*) were struck by a wiggle wire while attempting to rectify the securing arrangement of the log cargoes loaded on deck. They both fell into the sea from the top of the log cargoes, resulting in the death of the *AB*. 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 general bulk carrier anchored at the port of Kavieng, Papua New Guinea for port formalities and the securing of log cargoes *(the securing operation)*. When the securing work on the top of the No. 2 hatch was finished, the *AB* and the *Fitter* found the hoisting wire of the hook block (*the block*) of the No. 1 crane was jammed with *the block* on the top level of the uneven logs. Without informing the Chief Officer of the problem, they attempted to rectify the situation by themselves. During their inspection, *the block* shifted and rotated suddenly, causing the taut wiggle wire to move abruptly. The moved wiggle wire struck the *AB* and *Fitter* which made them fall into the sea from the top of the log cargoes. The *Fitter* was conscious but the *AB* was seen with his face submerged after falling into the water. The *AB* received cardiopulmonary resuscitation immediately after being taken on board. Unfortunately, the *AB* was declared dead on board by the shore medical officer on the same day.

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2. The investigation revealed that the main contributory factors causing the accident were: the toolbox talk was not conducted on board before *the securing operation* in accordance with the requirements of the shipboard Safety Management System (*SMS*); the crew members failed to follow the requirements of the Code of Safe Working Practices for Merchant Seafarers (*the Code*) to rig suitable safety nets or temporary fencing while carrying out *the securing operation* on top of the deck cargoes; the *AB* and the *Fitter* had inadequate safety awareness and underestimated the risk of unexpected freeing of the jammed wire during the inspection of the wiggle wire lashing system; the crew members failed to follow the requirements of the shipboard Cargo Securing Manual (*CSM*) to carry out *the securing operation*; and the shipboard training to crew members in *the securing operation* was ineffective.

3. The investigation also revealed that the risk of *the securing operation* was not covered in the shipboard Risk Assessment Manual *(RAM)* of the *SMS*, and the *CSM* was not updated to meet the requirements of the Code of Safe Practice for Ships Carrying Timber Deck Cargoes, 2011.

Lessons Learnt

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

(a) ensure that the supervisor of *the securing operation* follow the shipboard *SMS* to carry out toolbox talk and risk assessment before commencing any securing operation on deck;

(b) ensure that the crew members strictly follow the requirements of *the Code* in rigging suitable safety nets or temporary fencing while carrying out *the securing operation* on top of the deck cargoes;

(c) enhance safety awareness and safety culture on board to ensure that the crew members keep themselves in a safe or protected position against the unexpected freeing of any jammed equipment under load;

(d) ensure that the crew members strictly follow the requirements of the *CSM* in *the securing operation* on board;

(e) enhance the shipboard safe operation training for the key operations, especially when carrying out *the securing operation*; and

(f) conduct an internal audit on the vessel to verify the shipboard *CSM* to meet the requirements of *the Code* and the shipboard *RAM* to cover the shipboard key operation of *the securing operation*. The internal audit should also ensure that:-

(i) the crew members follow the safety requirements strictly when handling *the securing operation* on deck; and

(ii) shipboard training is carried out effectively

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

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