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香 港 商 船 資 訊
HONG KONG MERCHANT SHIPPING INFORMATION NOTE

Fatal accident on board while at anchor in heavy weather

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

Summary

A fatal accident occurred on board a Hong Kong-registered chemical tanker (*the tanker*) while it was at anchor in heavy weather. While two deck crew members (the bosun and the pumpman) were working on the forward mooring deck, a huge wave suddenly struck the bow, causing seawater to surge over the bulwark and wash across the mooring deck. Both crew members were seriously injured by the striking of the huge wave, with the pumpman ultimately died of his injuries. 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. While *the tanker* was awaiting a berth after dropping her anchor in the open sea east of Ningbo, it encountered gale force winds with rough seas and heavy swells. On the morning of the accident, the bosun and the pumpman went to the main deck to cover deck equipment with tarpaulin to prevent seawater ingress. They later found that the foam hose box and a mooring rope on the forward mooring deck had been damaged and displaced by the surging seas. They collected the foam hose and nozzle that had been scattered from the box. While they were trying to tidy the mooring rope, a huge wave suddenly struck the bow. Seawater surged over the bulwark, struck them violently and swept them across the mooring deck. About twenty minutes later, *the tanker*'s crew were alerted to the accident and organised a rescue operation. At around noon on the day of the accident, *the tanker* was instructed to proceed to meet the rescue helicopter as the condition of the injured crew members continued to deteriorate. The injured crew members were subsequently transferred to a shore hospital by the helicopter for medical treatment. The pumpman was ultimately declared dead by the hospital.

2. The investigation identified the following contributory factors leading to the incident, in addition to the heavy weather:

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(i) the crew did not adhere to the procedures for working on deck in heavy weather as required by the shipboard Safety Management System (SMS);

(ii) the risk assessment and toolbox meeting on board for working on deck in heavy weather lacked relevance and effectiveness;

(iii) the hazardous effects of the heavy weather were neglected. In particular, the Chief Officer, the bosun and the pumpman lacked sufficient safety awareness regarding the potentially fatal risks of working on deck in heavy weather, thereby underestimating the associated risks; and

(iv) the medical evacuation for the injured crew members was not arranged in a timely and efficient manner.

Lessons Learnt

3. In order to prevent the recurrence of similar accidents in the future, ship management companies, all masters, officers and crew members should note items (a) to (d) below, while ship management companies should also pay attention to item (e):

(a) strictly follow the shipboard SMS requirements regarding the procedures for working on deck in heavy weather;

(b) ensure that relevant and effective risk assessments and toolbox meetings are conducted on board as required;

(c) ensure that effective safety training is provided on board to enhance the crew's safety awareness when working on deck in heavy weather. Crew members should strictly adhere to the requirement of "not proceeding to deck area unless safety is ensured";

(d) ensure that prompt medical evacuation is arranged for injured crew members on board when necessary; and

(e) conduct necessary internal audits from time to time to ensure that crew members strictly follow the shipboard procedures relating to working in heavy weather, and ensure that relevant and effective risk assessments and toolbox meetings are conducted on board as required.

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

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