

MARINE DEPARTMENT NOTICE NO. 74/2025

(Navigational & Seamanship Safety Practices)

An allision accident of a locally licensed work boat with a special-purpose vessel

The Incident

An allision accident happened in the waters of Tsing Chau Wan when a locally licensed work boat berthed to a steel special-purpose vessel at anchor. During the accident, the rubber tire used as a fender on the bow of the work boat came into contact with the guardrail of the access platform of the steel special-purpose vessel, causing the guardrail to detach from its base and fly off, striking a tester on board in the abdomen and causing minor injuries. In addition, a worker (*the worker*) reported being hit in the chest by the detached guardrail, but no visible injuries were observed. *The worker* initially continued with the planned tasks but later, during the morning break, expressed feeling unwell and requested medical attention. By noon, arrangements were made to transfer *the worker* to a shore hospital via another vessel. However, his health condition suddenly deteriorated on the way and he was later declared dead in the hospital.

2. The investigation revealed that the possible contributory factors of the accident were that the coxswain did not manoeuvre the work boat at a safe speed when approaching the access platform of the steel special-purpose vessel. Furthermore, the coxswain did not wear visual aids as required under the Certificate of Competency issued to him as a Coxswain when steering the work boat on the day of the accident. Also, the work boat was not manned with an engine operator as required under its operating licence. In addition, the workers near the access platform of the special-purpose vessel lacked safety and crisis awareness and failed to realise that the two vessels might come into contact and did not maintain a safe distance from the platform. Lastly, it could not be ruled out that the accident might have been caused by the improper installation of the guardrail base on the access platform.

3. The investigation also identified that *the worker* suffered from coronary artery disease. The autopsy report showed that *the worker* might have been affected by the allision accident, which led to physical and psychological stress and indirectly induced acute myocardial infarction, ultimately leading to his death.

Lessons Learnt

4. In order to avoid the recurrence of similar accident in the future, owners, coxswains and onboard personnel should learn lessons from this accident and pay attention to the following to:

- (i) strictly control the speed of vessel and manoeuvre with cautions to ensure safety during berthing operations;
- (ii) strictly adhere to the restrictions specified in the Local Certificate of Competency, including wearing visual aids, etc.;
- (iii) strictly comply with the requirements of the vessel's operating licence with sufficient crew, including the coxswain and engine operator;
- (iv) ensure that access platforms, including the structures of guardrails and bases, are properly fixed and secured; and
- (v) strengthen safety training to enhance the safety awareness of onboard personnel.

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