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香港商船資訊

HONG KONG MERCHANT SHIPPING INFORMATION NOTE

A fatal accident happened on board during mooring operation

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

Summary

A fatal accident happened on board a Hong Kong registered container vessel (*the vessel*) at the port of Qingdao, China while berthing at a terminal. At that time, the mooring operation was nearly completed and only one stern line (*the line*) was left to be tightened. *The line* under tension suddenly parted and heavily hit the head of the third officer (3/O) who was stationed within the snap-back zone of *the line*, resulting in his death. 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. The vessel arrived at the port of Qingdao, China and was berthing at the terminal. The 3/O led three deck crew members to carry out the mooring operation on the aft deck and planned to fasten the stern with seven mooring lines, i.e. five stern lines and two aft spring lines. When all the fore and aft mooring lines (except one stern line i.e. the line) were secured and the mooring operation was about to be completed, the 3/O was stationed within the snap-back zone of the line and by giving hand signals instructed a crew member who was operating the winch to tighten the line. However, the line under tension suddenly parted and the 3/O's head was heavily hit due to rebound effect, resulting in his death. With the assistance of the local authorities, the 3/O's body was delivered from the vessel to shore and was later transferred to a local mortuary.
- 2. The investigation identified that the contributory factors leading to the incident were that crew members failed to follow the requirements contained in the MSC.1/Circ.1620¹ (the guidelines) issued by the International Maritime Organization (IMO), the "Code of Safe Working Practices for Merchant Seafarers" (the Code) and the shipboard procedures for mooring

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¹ MSC.1/Circ.1620 dated 24 December 2020 "Guidelines for Inspection and Maintenance of Mooring Equipment Including Lines"

operation to inspect, maintain and replace *the line* before its failure; crew members failed to comply with the requirements stipulated in *the Code* to properly arrange the layout of *the line*; crew members lacked safety awareness of the mooring operation and its associated hazards; both the risk assessment and the toolbox meeting for mooring operation on board were ineffective; and the training on safe mooring provided to the crew was ineffective.

Lessons Learnt

- 3. In order to avoid recurrence of similar accidents during mooring operation in the future, ship management companies, all masters, officers and crew members should note items (a) to (e) while ship management companies should also note item (f) to:
 - (a) strictly follow the requirements of *the guidelines*, *the Code* and the shipboard procedures for mooring operation to inspect, maintain and replace the mooring lines before their failure;
 - (b) strictly follow the requirements of *the Code* to properly arrange the layout of the mooring lines during berthing operation and avoid using short length mooring lines;
 - (c) enhance crew members' safety awareness to the risk of the snap-back zone of mooring lines during mooring operation;
 - (d) ensure the mooring operation to be carried out under a safe working culture, including maintaining good communication among crew members and issuing timely mutual warning against unsafe acts when necessary;
 - (e) ensure provision of effective training to crew members for safe mooring operation, including proper risk assessment, toolbox meeting and good working practices on board; and
 - (f) ensure that crew members strictly follow *the Code* and shipboard procedures to manage shipboard mooring lines, and conduct effective risk assessment and training for safe mooring operation.

