KISH P&I CLUB

# KISH P & I LOSS PREVENTION CIRCULAR KPI-LP-51-2012
## (An accident while handling bunker hose & Lessons to be Learnt)

**Brief description of the accident:**

On a bulk carrier in Bandar Abbas anchorage; the vessel was receiving bunkers. The bunker hose was taken up by ropes not by the crane - probably as it was marine diesel transfer hose & relatively light - the operation ended & the hose was to be sent down.
While lowering the hose the attached rope entangled an oiler who was handling it with two other crew members – ***he was standing in the bight of the rope***- and dragged him down from a height of about 10 metres.
Before the incident; the hose was being lowered slowly but the flange got stuck on a deck obstruction & the oiler tried to free it; after this attempt the hose slipped away taking the oiler along.
The oiler fell on head on the bunker barge deck. He suffered severe head trauma & hospitalized since; the condition is rather stable now but the after-effects of the trauma are yet to be revealed.

**►Results of the investigation:**

1- The oiler who had the accident; stood in the bight of a rope. He was seemingly unaware of the dangers involved while handling the ropes.

2- He was a first timer; joined 11 days before & this was his first ship. It can be concluded the initial training had not been sufficient; the on board familiarization was not effective & the task attribution had not been appropriately thought of.
The primary training concerning the rope handling is of utmost importance. Passing initial safety courses should have included this amongst many other vital points.

3- The investigation revealed that there had not been any timely risk assessment for this operation on board. Bringing up & lowering a rather awkward shape pipe & attached flange may involve risks in addition to those of bunkering process which in itself is a totally different operation.

4- It is a good point to mention that as many engine staff might not be very much acquainted with handling ropes or things alike; the deck crew must be at hand for such operations & having deck duty officer & the chief officer as signatories of the bunker check-list is there to necessitate the presence & supervision at this sort of operations. The other ratings such as the engine crew must have been familiar with handling ropes but still the responsibility lies with the deck staff. Snubbing a running line is a very tricky matter & the people should be old hands to be let to involve.

5- Although the Personal Protective Equipments were used properly in this case but as a general remark; their use is being emphasized here.
If the PPE were not used the consequences of such an accident could have surely been more noticeable.

6- The team management on board has not been considerate of the fact that the oiler is an absolute beginner. Although the chief engineer stated that he has instructed the subordinates to give simple jobs to the fresh oiler; but this requirement had not been followed. The supervision on the operation has been incomplete in the way that the ship board operations were partially done in a haphazard way.

7- The number of people heaving up the bunker hose was 7 but while lowering it; only 4 people were present. This is a sign for lack of resource management. The job which ends well is a job well done, as the saying goes.

8- There were signs that inadequate communication amongst people involved in the operation, played a role due to language barriers. Some officers & crew were from Ukraine & India. The oiler who had the accident was not possessing effective oral communication for lack of English language ability.

### ►*Lessons to be Learnt:*

***1- A risk assessment must foresee this sort of incidents.***
***2- Proper resource & team management could avoid the occurrence.***
***3- Lack of training must be taken into account even if the person involved has certificates for passing the due courses. Basic points & initial familiarizations should be dealt with serious caution & attention to details.***
***4- Possibility of lack of experience should be borne in mind while assigning duties to various personnel.***
***5- Lifting and lowering operations should better be supervised & handled by the deck & more experienced staff.***
***6- The communication & language barriers may aggravate many situations.***