Fatel fall from floating crane

Casualty Circular No.NT-CAS(8)/2003

No. CAS 9-NT- (34)/2002 Dated 29th October,2003

Sub: Fatel fall from floating crane

1. Narrative :

1.1 A floating crane of length 46 mts., G.T. 1507 propelled by two nos. Schottles with motor capacity 300 KW and registered under the Coasting Vessels Act, 1838 was operating in the port of Marmugao to load vessels at outer anchorage. None of her crew were having Certificates of Competency. On completion of her loading duties, this floating crane was to be towed by a tug to Ravdanda.

1.2 The floating crane was made fast alongside the ship during loading operations. At about 2130 hrs, on completion her loading duties, the floating crane commenced casting off from the mother vessel. The crew was instructed to prepare the chain bridle for towing floating crane to Revdanda. While the crew members were preparing the bridle, the stern rope of the tug parted. The crew was instructed to refasten the mooring rope of the tug. However, one crew member continued to work in the forward starboard side of the crane to prepare the bridle chain for towage.

1.3 At about 2200 hrs, while the crews were returning after refastening the tug line, they saw one of the crew member still trying to pull the chain of the bridle with a rope while on the crane. Suddenly, the rope slipped from his hand and he lost his balance. He staggered and fell backwards into the waters. His pataka / turban loosened and his long hair covered his face. He was seen to be struggling to set his hair and his turban in place. The crew members immediately raised the alarm by shouting. Thereafter, ropes and lifebuoy were also thrown in the water. Seeing that the fallen crew was drifting between the crane and the tug, mooring ropes of the tug were slackened so that a gap appeared between the tug and floating crane. The crew was seen to be drifting between the tug and the crane. He finally came up behind the stern of the tug . At this time , three crew members jumped into the water to rescue him. They were able to recover him and put him in the service launch, which had come to take the crew of floating crane

1.4 First aid was given in the same launch and thereafter he was transferred from the service launch to the tug which immediately cast-off and proceeded to the port of Marmugao.

1.5 While in the tug, attempts were made to remove water from the stomach of the crew and mouth-to-mouth resuscitation was also attempted. The victim was subsequently transferred into the pilot boat of Marmugoa Port Trust which had been mobilized for the rescue which eventually, brought him to the jetty. A doctor was waiting who examined him and pronounced him dead on arrival.

2. Causes of Casualty:

2.1 The railing provided on the floating crane was of the dis-mantling type. The normal practice was to operate the crane without rigging the railing. Therefore, at the time of accident, railing was not rigged.

2.2 Rope used for pulling the chain slipped from the victim's hand causing him to loose balance and fall over-board. Since accident occurred at night during rough weather, he died due to drowning even though immediate steps were taken to rescue him.

2.3 Life jackets / work vests were not provided to the crew while working on the floating crane.

2.4 All persons having long hair should have the same well secured when working in areas when there is risk of falling over-board.

3. Lessons Learnt:

3.1 Personnel working at a height may not be able to give their full attention to the job and at the same time guard themselves against falling. Proper precautions should therefore always be taken to ensure personal safety when work has to be done aloft or when working outboard. It must be remembered that the movement of a ship in a seaway and extreme weather conditions even when alongside, will add to the hazards involved in work of this type. A stage or ladder should also be utilized when work is to be done beyond normal reach.

3.2 Attention of shipowners, managers, operators and masters is invited to ensure that personnel working aloft (above 2 mts.) should wear safety harness. Personnel working aloft should wear a safety harness with lifeline or other arresting device at all times. A safety line should be rigged where necessary and appropriate. Additionally, where work is done overside, buoyancy garments / lifejackets should be worn and a lifebuoy with sufficient line attached should be kept ready for immediate use. Personnel should be under observation from a person on deck.

4. This issues with the approval of Nautical Adviser to the Govt. of India.

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