MA2017-8

MARINE ACCIDENT
INVESTIGATION REPORT

August 31, 2017

The objective of the investigation conducted by the Japan Transport Safety Board in accordance with the Act for Establishment of the Japan Transport Safety Board is to determine the causes of an accident and damage incidental to such an accident, thereby preventing future accidents and reducing damage. It is not the purpose of the investigation to apportion blame or liability.

Kazuhiro Nakahashi
Chairman
Japan Transport Safety Board

Note:

This report is a translation of the Japanese original investigation report. The text in Japanese shall prevail in the interpretation of the report.

Marine Accident Investigation Report

July 13, 2017
Adopted by the Japan Transport Safety Board
Member Kuniaki Syoji
Member Satoshi Kosuda
Member Mina Nemoto

Accident type	Injury of worker
Date and time	09:45 on April 7, 2016 (local time, UTC+9 hours)
Location	Honmoku Pier D5 Wharf, Yokohama City, Kanagawa Prefecture Near 236° true, 520 m from Yokohama Honmoku Breakwater Lighthouse (Approximate position 35°26.4' N, 139°41.1' E)
Summary of the accident	On the container ship MOL DEVOTION, during loading of containers, one worker was injured by falling into the cargo hold.
Process and progress of the investigation	The Japan Transport Safety Board appointed an investigator-in-charge from Yokohama Office and 1 other investigator to investigate this accident on April 8, 2016. Comments on the draft report were invited from parties relevant to the cause of the accident. Comments on the draft report were invited from the flag State of MOL DEVOTION.
Factual information	
Vessel type and name, gross tonnage	Container ship, MOL DEVOTION (Republic of the Marshall Islands), 39,906 tons
Vessel number, owner	9352420 (IMO number), Clan Navigation Ltd.
L×B×D, hull material	260.00 m × 32.25 m × 19.30 m, steel
Engine, output, date of launch	Diesel engine, 36,560kW, August 2008 (construction)
Crew information	Master (citizen of the Republic of the Union of Myanmar) Male 48 years old Endorsement attesting the recognition of certificate under STCW regulation I/10, Master (issued by the Republic of the Marshall Islands) Date of issue: May 7, 2015 (valid until Dec.31, 2016) Worker A, male, 51 years old Worker B, male, 53 years old
Death/injury etc.	Serious injury, one person (Worker B)
Damage to vessel	None
Weather and sea conditions	Weather conditions: weather condition: rain, wind direction: north, wind speed 2, Visibility: good Sea conditions: ocean surface: calm

Events leading to the accident	On the ship, with its Master and 24 others (all citizens of the Republic of the Union of Myanmar) aboard, stevedoring containers began at Honmoku Pier D5 Wharf at about 8:30 on April 7, 2016. The stevedoring work was performed by workers employed by a port and harbor transportation company. Worker A was the general supervisor, and Worker B and 6 others were performing the work. On the ship, the stevedoring work in Hold No. 1 ended at about 9:20, then at about 9:40, Worker B and one other worker started to place the portside hatch cover of the No. 2 Hold on the wharf, while the other five workers were lashing Hold No. 1. Worker B unlatched the Chain of the passageway hatch (below, "the Chain"), which is used to prevent falling, installed transversely at a height of about 1m above the upper deck in order to place the hatch cover on the land, and with one other worker, moved to the portside while watching the crane shift the hatch cover to the land. At about 09:45, when the ship started to load containers on the portside of Hold No. 2 and a container had been lowered about 5m from the same hold opening, Worker B, noticing that he had forgotten to attach the Chain, approached the passageway hatch intending to attach it, tripped in the passageway and fell into Hold No. 2 from the passageway hatch. Worker A stopped the stevedoring and directed other workers to take action to rescue Worker B because Worker B did not move. Worker B was transported to a hospital in an ambulance, was diagnosed as having suffered multiple fractures to his face etc. was admitted to the hospital and was treated as an inpatient for about 4 months. (Refer to Attachment 1: Rough sketch of the location of the accident, Photo 1: View of the area around the portside Hold No. 2, Photo 2: View of the passageway, Photo 3: View of the location of the fall.)
Other matters	At the port and harbor transportation company, when moving a hatch cover, the Chain was unlatched in advance so that the Chain does not interfere the movement of a hatch cover, and then restored the Chain after the hatch cover has been moved. Worker B was wearing rain wear in addition to his helmet and safety shoes because it was raining, and was also wearing a life jacket and safety belt, but he felt that it was difficult to move in the rain wear. Worker B fell about 8m into Hold No. 2 from the passageway hatch.
Findings	
Involvement of crew etc.	Yes
Involvement of hull, engine etc.	No

Involvement of weather or sea conditions	No
Analysis of matters that were clarified	It is probable that during container stevedoring work on the ship at Honmoku Pier D5 Wharf, Worker B approached the passageway hatch intending to attach the Chain, then tripped in the passageway, resulting in him falling into the hold from the open passageway hatch and suffering injuries. It is somewhat likely that worker B tripped in the passageway partly because it was difficult to move wearing the rain wear.
Probable causes	It is probable that this accident occurred because, during container stevedoring work on the ship at Honmoku Pier D5 Wharf, Worker B approached the passageway hatch intending to attach the Chain, then tripped in the passageway, resulting in him falling into the hold from the open passageway hatch.
Actions taken	After this accident, the port and harbor transportation company revised its work standards related to the use of safety belts at places where there is a danger of falling and informed its entire company of the revised standards in order to prevent accidents. The following are considered measures which would help prevent a recurrence of any similar accidents. ▪ Being sure to always be wearing a safety belt when approaching a location where a passageway fall prevention use chain has been unlatched. ▪ When wearing rain wear, performing work extremely carefully because it is difficult to move wearing rain wear.

Attachment 1 Rough sketch of the location of the accident

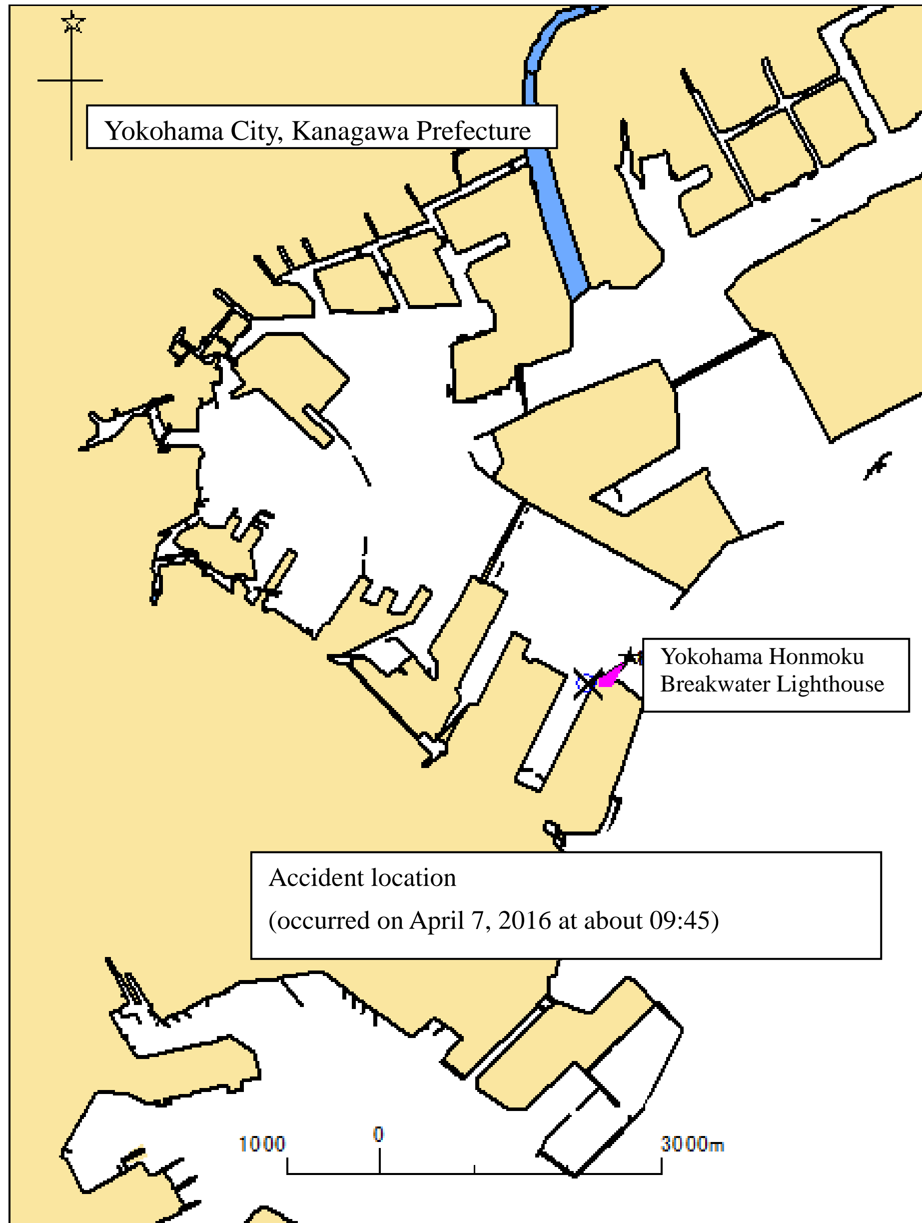

Photo 1 View of the area around the portside Hold No. 2

Photo 2 View of the passageway

Photo 3 View of the location of the fall