

Report from the Division for Investigation of Maritime Accidents

## Occupational Accident on ANN ROUSING on 28 August 2008.

### Factual information

ANN ROUSING (c/s OYIP2, IMO 9037903) is a general cargo vessel. The vessel has one large boxed cargo hold. The cargo hatch is a two-piece folding hatch. One piece folding forward and the other one aft (see figure 1). The vessel is built in 1991 and measures 2326 GT / 2752 TDW. Length overall is 84.90 m, breadth 12.92 m and maximum draught 4.44 m. The vessel is registered in the Danish International Ships register, DIS



The crew consists of master, chief officer, 1 engineer, 3 ordinary seamen (OS) and 1 cook.

The occupational accident happened when the vessel was preparing for sea after having loaded iron rods in El Ferrol, Spain. Two of the ordinary seamen were working together in starboard side forward. One was closing the hatch, the other one raising the rail. At one stage the two OS'es changed tasks. Shortly after this the OS now closing the hatch, injured his right hand when the wheel on the forward hatch drove over the hand causing an open fracture.

## **Narrative**

*The following narrative is based on an interview with the master conducted during the Investigation Divisions visit on board the vessel and a telephone interview with the injured OS conducted after the OS' arrival back home in Poland.*

*In the following section all times are local times (UTC – 2 hours).*

ANN ROUSINGS arrived to El Ferrol at 07:30 in the morning of the 28 August 2008. The last port of call had been Bayonne (France) and the voyage had taken approximately 39 hours. The weather had been very good on the voyage. Loading started at 1400 and was completed at 1940.

While preparing for sea, the two OS'es were working close together on deck in the starboard passageway forward. OS 1 was raising the rails that routinely had been lowered during loading. OS 2 was closing the forward hatch. At one stage OS 1 had problems in raising one of the stanchions, and asked his colleague if he could help. They agreed to change tasks, and OS 2 took over the raising of the rails while OS 1 continued the closing of the hatch. To close the hatch OS 1 put a foot on the lever and his right hand on the hatch coaming. At some stage during the closing of the hatch, OS 1 turned towards OS 2 to see how he was doing. While turned towards OS 2 he continued to close the hatch and he still had his hand on the hatch coaming. OS 1 suddenly felt the hatch wheel hitting his hand. He stopped closing the hatch and succeeded in removing his hand. He then ran aft towards the accommodation.

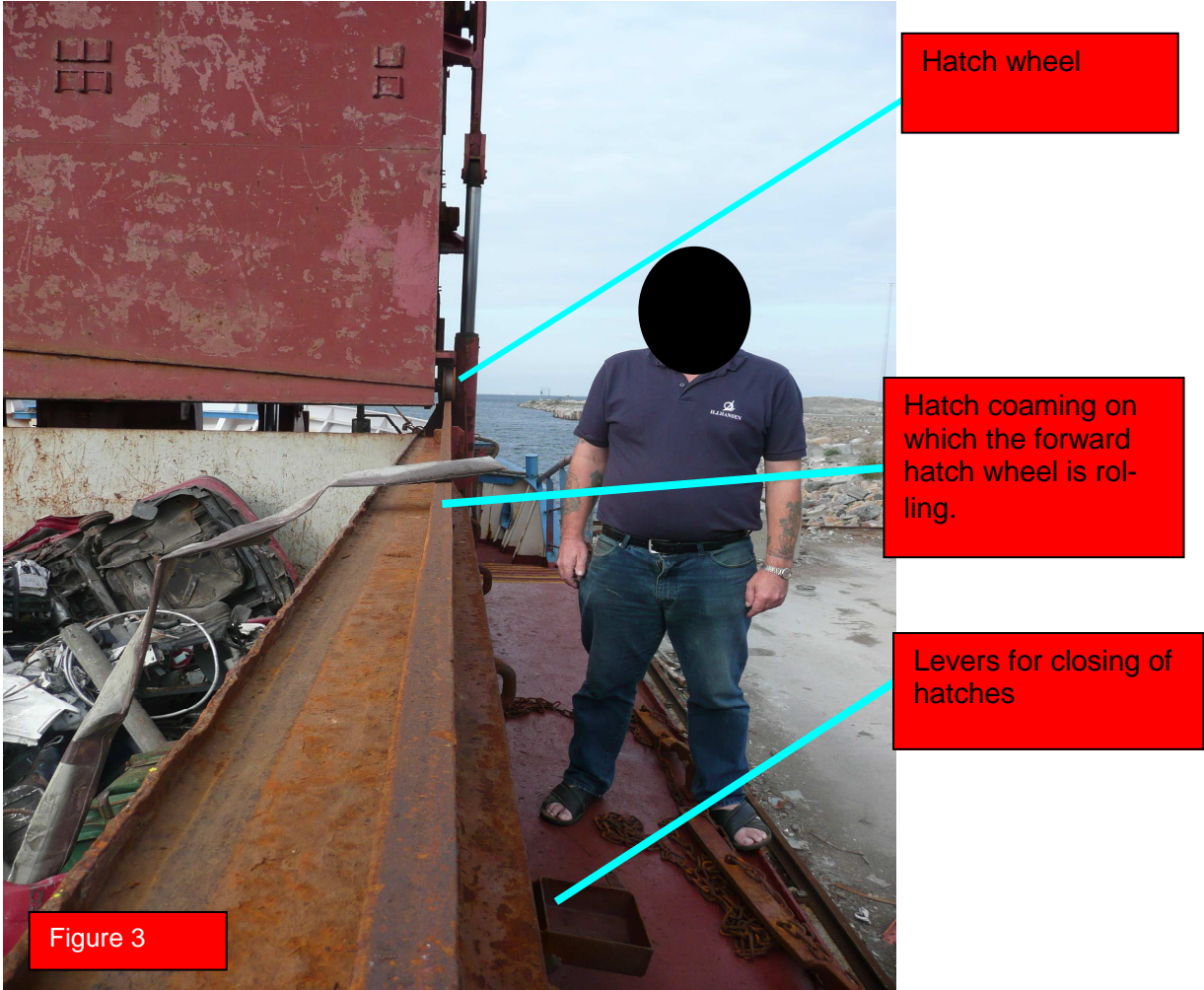
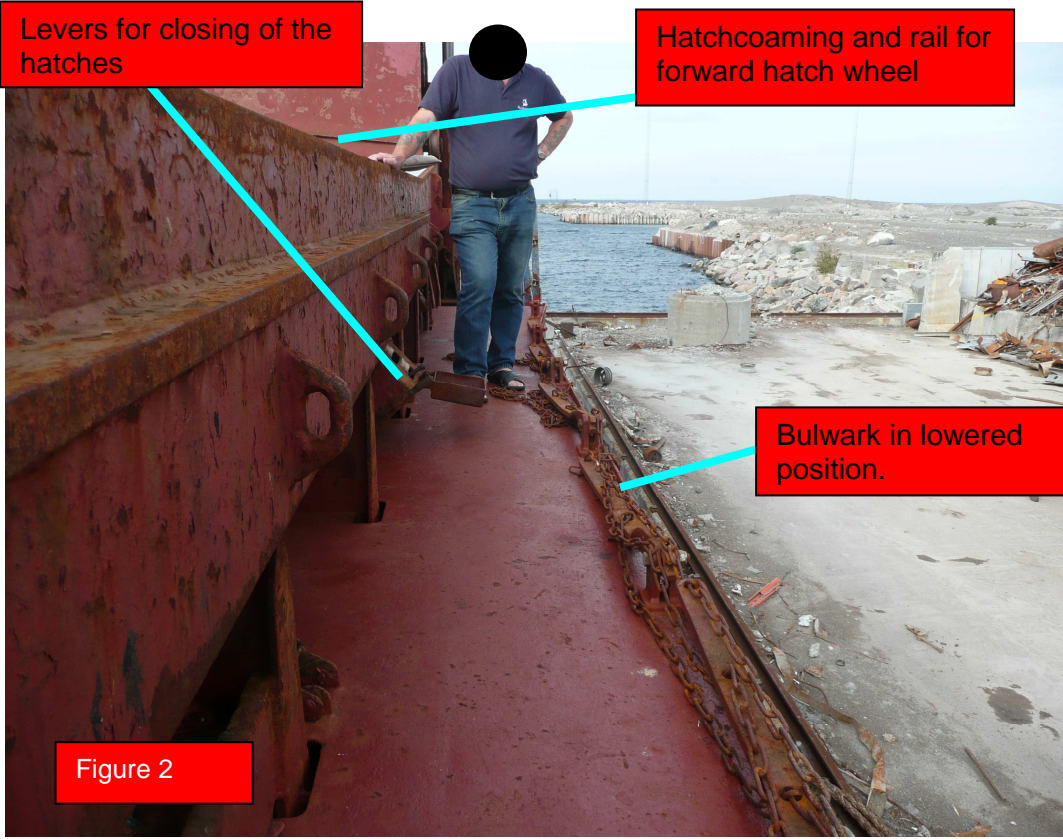
Outside the accommodation, the injured OS met the master. Seeing the injuries, the master immediately called for an ambulance, which arrived after approximately 15 minutes. The chief officer accompanied the injured OS to the hospital.

At the hospital it was established, that the OS had suffered an open fracture in his right hand. This was treated without complications, and the OS arrived back home in Poland 6 days after the injury. It is not expected that the OS will have any permanent after-effects caused by the injury.

## **Operating the hatch**

The hatch coaming and the rail on which the hatch wheels are rolling (figures 2 and 3 below) are approximately 1 (one) meter above deck level. The levers for the opening and closing of the hatches are positioned in a box approximately 30-40 cm above the deck.

If the operator let go of the lever during operation, the lever will automatically return to its neutral position, and the hatch will stop and remain in its actual position. There have been no recent malfunctions or repairs on the hatch system or related hydraulics. Following the accident, when operating the hatches, no changes to its normal operation has been noted.



## **Instruction**

The injured OS had previously been on board ANN ROUSING for one contract lasting 4 weeks. This was during the vessels stay at a Polish shipyard ultimo 2006/primo 2007 where the vessels cargo hold was being strengthened. On the day of the occupational accident the OS had been on board for 10 days.

On board ANN ROUSING working place instructions has been made regarding the different tasks on board. In these instructions the correct procedure for the task, risk involved, necessary protection equipment etc are described. For "Hatch Operation" the procedure for closing the hatch describes that one person should be operating the lever closing the hatch, while another is stand-by at one of the emergency stops forward or aft. On the day of the accident the described procedure was not followed, and the hatch was closed by one person only, while the other crewmember was conducting a separate task. In the "Hatch operation" instruction is also noted the risks when conducting this task:

*"...Injuries of hands if You are holding to the hatch coaming while operating..."*

According to the procedure when new deck-crew members are signing on the vessel, the on signer together with the chief officer must go through an introduction to his tasks on board. This is done according to the checklist "Task Introduction – Deck Crew". Included in this checklist is the item "Deck cranes/derricks and hatches". For the injured OS this checklist was completed and signed for. Following the accident the chief officer confirmed to the Master that the OS had been instructed in the operation of the hatches.

Instructions in the vessels working place instructions and how these are used is not included in the "Task Introduction – Deck Crew"-checklist for new crewmembers. The injured OS explains, that he has been instructed to read all the existing written work place instructions.

## **Conclusion**

The accident and the related injury was caused by:

- The injured OS had placed his right hand on the hatch coaming for support while standing on one foot operating the lever with the other.
- The position of the lever operating the hatch was inappropriate, because it allowed the operator to put a hand on the hatch coaming while closing the hatch.
- Written work place instruction was not followed. According to the instruction, a crewmember should have been standing by at the emergency stop.
- There was not sufficient control ensuring that written work place instruction was followed.

## Recommendations

- The Investigation Division recommends that the ship owner changes the position of the levers operating the hatches to ensure that it is not possible to put a hand on the hatch coaming while operating the hatches. Alternatively installs screening arrangements at all controlstations for operating the hatches, ensuring that the operator can not operate the levers and at the same time reach the hatch coaming with a hand.
- The investigation division recommends that the shipowner revises the checklist "Task Introduction – Deck Crew" by adding the item 'working environment / workplace instructions', thus ensuring that new crewmembers are introduced to this system and its use.

26 September 2008

The Division for Investigation of Maritime Accidents