SAFETY RECOMMENDATION No: 51/2014

Text of Safety Recommendation:	
Provide clarification concerning the "Working Aloft/Overside Permit" procedure, so that the tasks for which the Permit is valid are recorded and described in detail and are well understood by every involved crew member.	
No of Safety Investigation Report:	07/2014: **FATAL FALL OF BOSUN FROM THE DECK CRANE OF B/C «PANORIA»** Flag Greece IMO: 9480930 *(See the full Report here.)*
Safety Recommendation addressed to:	Managers/Owners
Date of publication:	24/01/2017
Comments-Remarks:	

INFORMATION OF ACCIDENT

Type of vessel: Bulk Carrier
Year of built:02/2008

FATAL FALL OF BOSUN FROM THE DECK CRANE OF B/C «PANORIA»

Course of events:

On 30 November 2014, at approximately 22:30, the Greek flagged B/C *"Panoria"* berthed at Brownsville Texas, USA laden with steel slabs from Novorossiysk, Russia. The cargo discharge operations were scheduled for the following day morning hours using Panoria's deck cranes. Early morning hours, on 01 December 2014, the stevedores' superintendent, and shore safety personnel boarded on the vessel to review Panoria's cargo gear condition and documentation and permit the deck crane operation. During said cargo gear inspection some broken wires were observed at the load hoist wire of No.2 deck crane and operation permit could not be granted unless the hoist wire was replaced. Vessel's crew started the preparation for the replacement of the crane wire at around 10:30. They had one hour lunch break at 12:00 and continued with the replacement of the wire at 13:00. At approximately 15:25, the one end of the old wire was connected with the new wire and the crew started winding the old wire rope at low speed. However, the connecting piece of the two wires got snagged on a transverse (cross section) of the crane's jib. The Bosun who was standing at the crane's platform directly below the control cabin, walked out onto the crane's boom wearing a safety harness and moved towards the cross section to unsnag the connecting piece. When he reached to the cross section he attached his safety harness to the old wire that was being replaced. While he was

standing on the jib's cross section he lost his balance and fell from a height of 9.5 meters on the cargo hold's hatch cover. The safety harness did not prevent his fall as the old wire rope was not secured to any fixed point and was hanging free.

Vessel's berthing position at Brownsville, Texas, USA

The location were the Bosun fell on top of cargo hatch cover No.3

Emergency response actions

No one saw the exact movements of the Bosun while attempting to release the wire apart from one AB standing on the main deck, at the top of the cargo hold hatch cover No.3 who was the only crew member that witnessed the Bosun's fall from the crane boom. The AB reported immediately the accident to the Chief Officer who was inside the control cabin. The C/O reported immediately to the master and headed to the hospital room to bring the stretcher and the oxygen respirator. At the same time a port policeman noticed the incident from the shore and got on board. He instructed the crew not to move the Bosun until the arrival of the emergency services which already had being informed. Brownsville medical service team members got on board approximately after 20 minutes, however Bosun's condition was very serious and their efforts to keep him alive were unsuccessful. Shortly after the medical team's arrival on site the Bosun was pronounced dead. According to the post mortem report Bosun's death was caused by severe injuries on his head and his back.

Identified factors:

The safety Investigation and analysis highlighted the following main contributing and underlined factors that led to the marine casualty as presented in random order:

- the bosun's risk taking action to walk out on the crane boom without informing the C/O and without safety precautions, possibly driven by the desire to "get the job done" and a "can-do attitude" .
- the description of work recorded at the Work Aloft Permit was generic and it was not clarified that it was valid only for the usual and planned procedures.
- insufficient supervision and lack of effective reporting and communication between the work team members
- Absence of any wire rope's manufacturer documentation or any other valid document stating the discard criteria which contributed to the decision making for the replacement of the wire, following the request of stevedores inspection team.

- Inadequate safe working practices concerning the replacement of the wire rope.

Conclusions related to the SR:

The description of work stated at the Work Aloft Permit was generic and it was not clarified that it was valid only for the usual and planned procedures.