



香 港 商 船 資 訊

HONG KONG MERCHANT SHIPPING INFORMATION NOTE

Fatal accident during operating of pilot ladder winch

To : Shipowners, Ship Managers, Ship Operators, Masters, Officers and crew on board Hong Kong registered ships

Summary

A sailor on board a Hong Kong registered container vessel was killed while he was operating the pilot ladder winch. This Note is to draw the attention of shipowners, ship managers, ship operators, Masters, officers and crew on board Hong Kong registered ships on the important lessons learnt from this accident.

The Incident

1. A sailor on board a Hong Kong registered container vessel was killed while he was operating the pilot ladder winch. At the time of the accident, the weather was cold and with strong wind. The sailor wore thick winter clothes while working on deck.
2. Investigation into the accident revealed that while the sailor was operating the pilot ladder winch to hoist the ladder, he was accidentally dragged / pulled into the reel after being entangled by the reeling pilot ladder. He sustained fatal injury and was certified dead. The report of investigation can be downloaded from Marine Department website at the following link : http://www.mardep.gov.hk/en/publication/pdf/mai091213_f.pdf
3. The main contributory factors leading to the accident are:
 - a) the sailor was not aware of the dangers of a reeling pilot ladder and to avoid himself from coming close to it;
 - b) the directional control valve for controlling the winch could not return to the neutral position for stopping the air motor as the valve was not of the self-return to neutral type; and
 - c) the potential risks associated with operating the pilot ladder winches on board were not fully appraised by the Master and the relevant crew of the vessel.

4. The other safety factors contributed to the accident are:
- a) the sailor, who was a new seaman with limited working experience on ship, was not properly supervised by senior crewmembers on board and was allowed to work alone at the time of the accident;
 - b) there were no warning signs for crewmembers about the dangers in the operation of pilot ladder winches, nor were there any such markings as “NO ENTER” zone in vicinity of the machines;
 - c) excessive grease had been accumulated inside the valve body of the directional control valve; and
 - d) the areas around the pilot ladder winches might be tight for crewmember to work within and posing dangers to them while operating the pilot ladder winches.

Lessons learnt

5. The following are important lessons learnt from this accident:
- a) The safety of crew in operating the pilot ladder winch should be assessed, particularly when the winch is driven by air motor controlled by non-self-return type directional valve. In this regard, the shipowners of Hong Kong registered ship is encouraged to consider using self-return or fail-safe type directional control valves in similar type of pilot ladder systems.
 - b) The safety measures and precautions in relating to the operation of pilot ladder winches for preventing operators from injury should be strictly followed;
 - c) The machinery and its control system should be properly maintained; and
 - d) Adequate and relevant training should be provided for operators; and if the operator is a new crewmember, proper supervision and monitoring should be given by officers or other experienced crewmembers.
6. The attention of Shipowners, Ship Managers, Ship Operators, Masters, Officers and crew on board ships is drawn to the important lessons learnt from this accident.