



香港商船資訊

HONG KONG MERCHANT SHIPPING INFORMATION NOTE

A fatal accident happened at a hanging platform inside a cargo hold

To : Shipowners, Ship Managers, Ship Operators, Masters, Officers and Crew

Summary

A fatal accident happened when a Hong Kong registered bulk carrier anchored at Bunbury anchorage, Australia awaiting cargo loading. While an able seafarer deck (AB), together with other crew members, was preparing to repair the leaked hydraulic oil pipe underneath the cross deck in the cargo hold, he fell from the hold cleaning platform (the platform) onto the tank top of a cargo hold, resulting in his death on the same day. This Note draws the attention of shipowners, ship managers, ship operators, masters, officers, and crew to the lessons learnt from this accident.

The Incident

1. A fatal accident happened when a Hong Kong registered bulk carrier anchored at Bunbury anchorage, Australia awaiting cargo loading. The AB, together with the Chief Engineer, Fourth Engineer, and two other able seafarers deck, was assigned to assist the repair work of the leaked hydraulic oil pipe under the lead of the Master. The repair work was conducted at the aft bulkhead of a cargo hold underneath the cross deck behind the hatch coaming. The crew members used the ship crane to lift the platform in order to get closer to the hydraulic oil pipe for the repair work. When the platform was lifted to the height of the hydraulic oil pipe, the Chief Engineer leaned his body out of the railing of the platform with the intention of securing the platform to the aft bulkhead. However, the platform tipped over suddenly, causing the AB, who was at the other end of the platform, to lose his balance and fall over the railing of the platform. Although the AB was wearing a safety harness with a lanyard, he failed to fasten his lanyard to a strong point. Eventually, the AB fell from a height of about 10 metres onto the tank top of the cargo hold, resulting in his death on the same day.

2. The investigation revealed that the securing arrangement of the platform carrying the working team was altered several times to allow for proximity to the position of the repair work,

which led to the instability of the platform and its toppling over in the end. The main contributory factors to the accident were: the risk assessment for accessing the hydraulic oil pipe by using the platform had not been carried out properly, neither the work was safely planned nor having adequate control measures in place; the permit-to-work for working at height was issued without satisfying the requirements of the Code of Safe Working Practices for the Merchant Seafarers (the Code) and the shipboard safety management system (SMS); and the toolbox talk with the working team failed to satisfy the requirements of the Code and the shipboard SMS.

Lessons Learnt

3. In order to avoid the recurrence of similar accidents in the future, all masters, officers, and crew members should note items (a) and (b) while ship management company should note item (c).

- (a) enhance safety awareness of working at height;
- (b) strictly follow the requirements of the Code and the shipboard SMS: -
 - (i) when carrying out toolbox talk before the work commences;
 - (ii) to conduct risk assessment before issuing permit-to-work, particularly working at height, to ensure a safe work plan with adequate control measures in place; and
- (c) review the company procedures of the permit-to-work system and ensure that the vessel abides by the relevant requirements of the shipboard SMS.

4. The attention of shipowners, ship managers, ship operators, masters, officers, and crew is drawn to the lessons learnt above.

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