



香港商船資訊

HONG KONG MERCHANT SHIPPING INFORMATION NOTE

A fatal accident happened on board during the repair of an outlet valve of the exhaust gas boiler

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

Summary

A fatal accident happened on board a Hong Kong registered container carrier when the vessel was berthed alongside for cargo operation in Vancouver, Canada. The Fitter assisted the Third Engineer (3/E) in repairing the outlet valve (*valve*) of the exhaust gas boiler (EGB). When the bonnet cover was placed on the *valve* casing, hot water suddenly gushed out of the bonnet joint of the *valve* and scalded the Fitter underneath seriously resulting in his death about one month later. 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 on board a Hong Kong registered container carrier when the vessel was berthed alongside for cargo operation in Vancouver, Canada. The Fitter was working with the 3/E on the leaking *valve* of the EGB which was de-pressurised but was still full of hot water and steam. The isolation valve between the EGB and the auxiliary boiler, which was maintained at 4 bar pressure, was shut. After re-conditioning the *valve* by replacing the joint gasket of its bonnet cover, the 3/E used a rope to lower down the bonnet cover of the *valve* with the assistance of the Fitter who stood below the *valve* casing whilst holding another rope lashed to the bonnet stem. When the bonnet cover was placed on the *valve* casing, hot water suddenly gushed out of the bonnet joint of the repaired *valve* and scalded the Fitter underneath. The Fitter was sent to a local hospital on the same day, but he died in the hospital about one month later.

2. The investigation revealed that the engine crew members failed to follow the Code of Safe Working Practices for Merchant Seafarers to dissipate or isolate the thermal energy in the EGB together with the attached pipe resulting in hot water gushing out and scalding the Fitter.

3. The investigation also identified that the engine crew members failed to strictly follow the risk assessment report to carry out the required control measures of the repair work; and that they did not have sufficient safety awareness to apply good craftsmanship to control the potential fatal hazards when handling repair work.

Lessons Learnt

4. In order to avoid recurrence of similar accidents in the future, all masters, officers, and crew of vessels should:

- (a) draw the attention of all masters, officers and crew members to the findings of the investigation; and
- (b) enhance training on board to improve crew members' safety awareness of the potential hazards of working on hot fluid systems.

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

Marine Department
Multi-lateral Policy Division

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