



香港商船資訊

HONG KONG MERCHANT SHIPPING INFORMATION NOTE

A fatal accident happened on board while inspecting the cargo hold lime-coating work

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

Summary

A fatal accident happened on board a Hong Kong registered bulk carrier when she was en route to Port Hedland, Australia to load a cargo of salt in bulk. At the time of incident, the Chief Officer (C/O) was on the main deck checking the condition of the lime-coating of the cargo hold. When he placed his body underneath the partially opened folding type hatch cover to take photos, the hydraulic operated hatch cover suddenly closed, crushing the C/O to death on the spot. 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 Hong Kong registered bulk carrier (*the vessel*) was en route to Port Hedland, Australia to load a cargo of salt in bulk. During the voyage, the crew of *the vessel* were engaged with the main deck cleaning work and the cargo hold lime-coating work, while the C/O was coordinating the lime-coating operation on the main deck. When the C/O placed his body underneath the partially opened folding type hatch cover to check the condition of the cargo hold and take photos, the hydraulic oil hose of the hatch cover operating system ruptured, resulting in the sudden closure of the hydraulic operated hatch cover. As a result, the C/O was crushed to death by the hatch cover on the spot.

2. The investigation revealed that the main contributory factors to the accident were that there was a lack of safety awareness by the C/O on operating the hatch cover, and he did not hold a valid permit to work aloft as required; the crew failed to carry out maintenance of the hydraulic operating system in compliance with the requirements of the shipboard manual, namely “Operating and Maintenance Manual for the Hydraulic Operated Folding Hatch Cover”

(*the Manual*); the shipboard Safety Management System (SMS) failed to identify the hydraulic system as an item that required maintenance in order to comply with the requirements of *the Manual*; and the crew failed to follow the requirements of “Code of Safe Working Practices for Merchant Seafarers” (*the Code*) and *the Manual* when operating the hatch cover.

Lessons Learnt

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

- (a) to enhance safety awareness and training onboard in operating the hatch cover including effective risk assessment, and the requirement for a valid permit to work aloft;
- (b) to strictly follow the requirements of *the Manual* to carry out maintenance of the hydraulic operating system of the hatch cover;
- (c) to strictly follow the requirements of *the Code* and the shipboard hydraulic operated folding hatch cover operating manual to operate the hatch cover; and
- (d) to consider revising the shipboard SMS to ensure the hydraulic operating system of the hatch cover is included in the shipboard maintenance manual. Besides, to conduct an internal audit on the vessel to ensure that the crew strictly follow the requirements of the shipboard maintenance manual when carrying out the aforementioned system maintenance onboard.

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

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