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HONG KONG MERCHANT SHIPPING INFORMATION NOTE

A fatal accident happened on board while preparing for discharging coal cargo at the anchorage

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

Summary

A fatal accident happened when a Hong Kong registered bulk carrier was preparing for discharging coal cargo at Navlakhi outer anchorage, India. When the bosun entered the cargo hold, through the access trunk, with the intention of climbing to the top of the cargo pile to unlink a grab from a ship crane, he slipped down to the edge of the cargo pile. In order to rescue the bosun, the carpenter and steward entered the cargo hold. However, their efforts were in vain, both the bosun and steward lost their lives in the incident. 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 anchored at Navlakhi outer anchorage, India to prepare for discharging coal cargo. The bosun entered the cargo hold, fully loaded with coal cargo with the hatch cover opened, intending to climb to the top of the cargo pile to unlink a grab from a ship crane. Unfortunately, after walking a few steps on the cargo pile, the bosun collapsed and slipped down to its edge where the oxygen level was insufficient to sustain life. In order to rescue the bosun, the carpenter and steward entered the cargo hold without wearing self-contained breathing apparatus, nevertheless they also fainted and rolled down to the edge of the cargo pile. All of them were rescued from the cargo hold and received first aid treatment before being evacuated to a local hospital for further treatment a few hours later. The carpenter recovered consciousness that night, but the bosun and the steward were declared dead on the same day.

2. The investigation revealed that the main contributory factors of the accident were the crew: lack of safety awareness and underestimated the risk of entering cargo hold carrying coal cargo; failed to carry out a risk assessment and follow the permit to work system before entering into enclosed space; failed to follow the safety procedures of the Code of Safe Working Practices for Merchant Seafarers and shipboard safety management system (SMS) when entering into enclosed spaces; ineffective training and drills on emergency rescue in enclosed spaces as well as ineffective safety training on the carriage of coal cargo.

Lessons Learnt

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

- (a) enhance safety awareness and safety culture on board to ensure the risk assessment and permit to work system to be followed before entering into enclosed spaces;
- (b) enhance the training on enclosed spaces entry and the potential fatal hazards of carriage of coal cargo; and
- (c) ensure crew members to strictly follow the safety requirements when entering enclosed spaces, familiarize and understand their duties under SMS in emergencies.

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

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