



香港商船資訊

HONG KONG MERCHANT SHIPPING INFORMATION NOTE

A fatal accident happened outside the accommodation block under adverse weather

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

Summary

A fatal accident happened on board a Hong Kong registered container vessel (*the vessel*) when she was en route to the destination port of Kaohsiung, Taiwan. On the day of the accident, while *the vessel* was approaching the destination, the weather became worse and caused *the vessel* to roll and pitch heavily. An Electro-technical Officer (ETO) was found lying unconsciously outside the accommodation block near the gangway on the port side of the main deck. He was later airlifted to a local hospital in Kaohsiung for medical treatment but was declared dead 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. On the day of the accident, *the vessel* was en route from Laem Chabang port, Thailand to the destination port of Kaohsiung, Taiwan (*the destination port*). The weather became worse in the morning and caused *the vessel* to roll and pitch heavily. Under the rough weather, the ETO, without obtaining permission from the Master, conducted a routine inspection of the compressor machine room (*the room*) of the provision store. *The room* was located on the port side of the accommodation block with an access door on the main deck. At approximately the same time, the bosun found that the life raft on the port side of the accommodation A-deck shifted from its bestowed position after being hit by heavy swells. The bosun then went to secure the life raft after obtaining permission from the Master. After that, he found the ETO lying unconsciously on the port side of the main deck near the gangway with shallow breathing. His arms and legs were found injured with blood on his ear, nose and head.

2. The ETO was transferred to the ship's hospital, and first aid was applied to him under shore medical treatment instructions. Afterwards, the ETO was sent by helicopter to a local hospital at *the destination port* for medical treatment. Unfortunately, the ETO was declared dead on the same day at the hospital. The cause of death was intracerebral bleeding, which resulted from a traumatic brain injury caused by hits by a foreign object.

3. The investigation identified that the contributory factors leading to the incident were that the shipboard toolbox meeting failed to follow the requirements of the "Code of Safe Working Practices for Merchant Seafarers" (*the Code*) to identify the hazards and associated risks of the routine inspection of *the room*; the ETO failed to follow the instruction of the toolbox meeting of not to go outside the accommodation block to inspect *the room* under adverse weather unless permission is given by the Master; the ETO failed to follow the requirements of *the Code* and shipboard "Safety Management Manual" (*SMM*) when working in adverse weather; the shipboard training for the ETO on the *SMM* procedures, especially the familiarisation with the procedure for "Work on Deck in Heavy Weather" was ineffective; and the ETO lacked safety awareness on working outside accommodation block in adverse weather.

Lessons Learnt

4. 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 (d) as shown below:

- (a) prior to the commencement of work, strictly follow the requirements of *the Code* to identify the hazards and associated risks for all involved work in a toolbox meeting;
- (b) strictly follow the requirements of *the Code* and shipboard *SMM* on working outside accommodation block in adverse weather;
- (c) ensure shipboard training on the *SMM* procedures be conducted effectively, especially the familiarisation with the procedure for working on deck in heavy weather; and
- (d) enhance safety awareness of the crew onboard on working outside accommodation block in adverse weather.

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

20 June 2023