



## 香港商船資訊

## HONG KONG MERCHANT SHIPPING INFORMATION NOTE

**A fatal accident happened on board during cargo hold cleaning**

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

**Summary**

A fatal accident happened on board a Hong Kong registered bulk carrier (*the vessel*) when she was en route to Balikpapan, Indonesia. At the time of the accident, an able-bodied seaman (*the AB*) was standing on a grating of the athwartships forward Permanent Means of Access (PMA) platform (*the fore platform*) of the cargo hold No. 6 (*the hold*) to wash the forward upper part of *the hold*. Unfortunately, the grating where *the AB* was standing suddenly detached from its support frame. Consequently, *the AB* lost his balance and fell onto the tank top of *the hold*, resulting in his death. 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 Weda, Indonesia, to Balikpapan, Indonesia for loading coal. The deck crew of *the vessel* was divided into three groups led by the Bosun to wash *the hold* by using fire hoses with seawater (*the hold cleaning*). Before *the hold cleaning*, the Chief Officer (the C/O) conducted a toolbox meeting which included issues on risk assessment for *the hold cleaning*, briefing on safety control measures when working aloft, and issue of a permit for working aloft by the Master.

2. At the time of the accident, *the AB* and another able-bodied seaman, as members of Group 3, were on *the fore platform* washing the forward upper part of *the hold*. When *the AB* walked to the port side of *the hold* on *the fore platform* with a pressurised fire hose, the grating where *the AB* was standing suddenly detached from its support frame. As a result, *the AB* lost his balance and fell onto the tank top from a height of about 15.8 meters together with the detached grating. The Bosun immediately reported the accident to the C/O and the Master. The Master then assembled the rescue team to provide first aid to *the AB* and altered the ship's course to Kota Manado, Indonesia to seek emergency medical assistance from shore. Afterwards, *the AB* was

transferred to a local hospital by a patrol boat of the Indonesian Coast Guard for further medical treatment. Unfortunately, he was certified dead on the same day.

3. The investigation identified that the contributory factors of the accident were that the crew failed to (i) follow the requirements of the shipboard Safety Management System (SMS) to carry out an effective risk assessment on board before *the hold cleaning*, including identifying the dislocation risk of the grating of *the fore platform*; (ii) wear a safety belt when working aloft during *the hold cleaning*; (iii) supervise on the spot *the hold cleaning* work aloft; (iv) carry out proper maintenance of *the fore platform* in *the hold*; (v) identify the defective *fore platform* in the last detailed inspection of *the hold*; and (vi) check the condition of *the fore platform* in *the hold* before entering *the hold* for cleaning. The accident also revealed that the shipboard training for the crew on working aloft was ineffective.

### **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:

- (a) strictly follow the shipboard SMS to carry out an effective risk assessment before cargo hold cleaning and identify dislocation risks of gratings of PMA platforms;
- (b) ensure the crew to wear safety belts when working aloft;
- (c) enhance on-the-spot supervision by the person in charge during cargo hold cleaning;
- (d) ensure PMA platforms and their gratings are properly maintained and inspected;
- (e) ensure that the conditions of PMA platforms and their gratings have been checked before entering cargo holds for cleaning and maintenance; and
- (f) enhance shipboard training for the crew on working aloft and their safety awareness on the use of safety belts.

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

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