No. : 18/2013

香 港 商 船 資 訊

HONG KONG MERCHANT SHIPPING INFORMATION NOTE

Fatal accident caused by a moving elevator cage

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

Summary

The Assistant Electrical Officer on board a Hong Kong registered vessel was killed by the cage of the elevator when he was carrying out inspection alone on the cage top. This Information Note draws the attention of the ship owners, ship managers, ship operators, masters, officers and crew on the lessons learnt from the accident.

The Incident

1. The Hong Kong registered vessel was anchored while waiting for berth. In the morning on the date of the accident, the Assistant Electrical Officer (AEO) and the Fourth Engineer were assigned by the Second Engineer to check the cause of abnormal noise in the ship elevator, among other work during the day including assist launching drills of the port and starboard lifeboats.

2. After lunch break, they placed their informal repair notices on every elevator door and started to check the elevator by operating it manually at the cage top. The work was aborted without any findings after approximately 15 minutes as they had to proceed to the port lifeboat station for the boat drill. After the drill, only the AEO returned back to the elevator to continue checking the machine as the Fourth Engineer was occupied with other work from the drill. Unfortunately, the AEO was soon found stuck in the gap between the cage and the bulkhead. He was rescued out of the cage but was certified dead later.

3. The investigation into the accident revealed that the AEO, who was working alone and without seeking for help, might have changed-over the MANUAL/AUTO switch located at the cage top to AUTO hoping that someone would press the call buttons from other decks to let the elevator move at a normal speed to expedite the checking process for the abnormal noise. At the time of the accident, he was at the front side of the cage. With the sudden move of the elevator, he lost his balance and fell into the gap between the cage and the bulkhead. He was dragged up until the cage finally stopped in between A-deck and B-deck.

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4. The main contributing factors to the accident are the Safety Measures for crew to work on ship elevator issued by the company were not strictly followed and that the Safety Measures were prepared without sufficiently appraising the associated risks.

Lessons Learnt

5. To avoid recurrence of similar accident, it is important that all risks associated with working on ship elevator should be fully assessed and the relevant procedures be reviewed regularly. All ship's personnel engaged in the work should strictly follow the safety procedures.

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

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13 June 2013