



# 香 港 商 船 資 訊

## HONG KONG MERCHANT SHIPPING INFORMATION NOTE

### **A seaman fell to his death into a cargo hold**

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

#### *Summary*

A seaman (the victim) stepped on hatch-cover-pulling chains in order to view the interior of a cargo hold. The chains were suddenly tightened up due to the closing of hatch covers. He lost his balance and fell into the cargo hold. This information note draws the attention of Ship owners, Ship Managers, Ship Operators, Masters, Officers and Crew to the lessons learnt from this accident.

#### **The Accident**

1. When a Hong Kong registered bulk carrier was in an anchorage, the crewmembers on board were divided into three teams to cleanse the cargo holds. The victim and his teammate had finished cleansing a cargo hold and hence returned onto the main deck. The victim proceeded to the hatch coaming of another cargo hold to check if there were any crewmembers inside.
2. The victim stepped on hatch-cover-pulling chains in order to view the interior of the cargo hold. Without knowing the above, the chief engineer operated the hydraulic motor to pull the chains for closing the hatch covers. The victim was forced to bounce up as the chains under his feet got tightened up. He lost his balance and fell into the cargo hold.
3. Investigation into the accident revealed the contributory factors as follows:
  - a) the safety awareness of the victim was low. He stood on the chains to view the interior of the cargo hold was a dangerous act that caused the accident of his falling into the cargo hold when the chains driving system was operated;
  - b) the chief engineer, who operated the chains driving system, did not ensure nobody working/standing near the hatch before operating the system; and
  - c) the chief engineer, who was the highest ranked officer among the working teams, failed to organize the operation in accordance with the relevant company procedures.

## **Lessons Learnt**

4. It is important that officers and crew on board cargo ships that are fitted with cargo holds hatch covers operating system should be cautious and strictly follow the relevant shipboard safety operation procedures. It must be ensured that all crewmembers have stayed clear of any movable parts prior to the operation of the system, especially when the operator could not have an unobstructed view at the control console. As far as practicable, for improving the safety of crewmembers, it is advisable to install a visual and audible warning alarm to alert crewmembers during system operation and to fit protective guards to cover the movable parts of the system.

5. The attention of Shipowners, Ship Managers, Ship Operators, Masters and Officers and Crew is drawn to the lessons learnt above.

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25 September 2015