Fatal fall of a crew from tween deck onto cargo hold bottom

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

Summary

When a Hong Kong registered general cargo ship was sailing at sea, the bosun of the vessel fell from tween deck onto the cargo hold bottom 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. A Hong Kong registered general cargo ship was en route to her loading port. At the time of the incident, the chief officer and the No.1 mechanic were inspecting the watertightness of the cargo hatch covers in darkness at the aft tween deck of No. 1 cargo hold. They suddenly heard a “pop” sound from the front of the cargo hold. Through the torchlight, they saw the bosun lying on the bottom of the cargo hold. Without notifying his colleagues, the bosun entered the cargo hold alone from the forward access and fell through the opening where the tween deck hatch panels were removed for maintenance. An emergency team was summoned to the scene but in vain to save the bosun.

2. The investigation revealed that the contributing factors to the accident are as follows:

   (a) none of the basic safety requirements/procedures under the ship management company’s safety management system in relation to the enclosed spaces entry and the work on hatch covers or panels had been followed;

   (b) the crew lacked personal safety awareness and was unfamiliar with the procedures of entry into enclosed spaces. They did not follow the requirements of the ship management company’s “permit to work” system when entering the fully covered cargo hold. Furthermore, the bosun entered the forward part of the No. 1 cargo hold alone without wearing his safety helmet properly, preparing portable lighting and notifying his colleagues; and
(c) the crew did not carry out any measures to keep persons away from tween deck opening when any hatch panel was removed.

Lessons Learnt

3. In order to avoid recurrence of a similar accident in future, masters, officers and crew of vessels should:
   
   (a) conduct a full risk assessment before entry into enclosed spaces and issue entry permit in accordance with the requirements of the safety management system;
   
   (b) provide adequate lighting for entering into and working in enclosed spaces;
   
   (c) restrict entry into tween deck spaces when some of their hatch panels have been removed. If it is really necessary to work in such spaces, safety measures must be in place before work begins; and
   
   (d) arrange relevant safety training in order to enhance the personal safety awareness and familiarities of the crew with the safety management system.

4. Ship management companies should conduct internal audits on their fleet to ensure that the crew on board strictly follow the entry into enclosed spaces procedures.

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

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