



## 香港商船資訊

HONG KONG MERCHANT SHIPPING INFORMATION NOTE

**Fatal accident of an able seafarer deck falling onto the bottom of a cargo hold***To : Shipowners, Ship Managers, Ship Operators, Masters, Officers and Crew***Summary**

When a tween-deck pontoon cover of a cargo hold was lifted to prepare for loading, an able seafarer deck (AB) standing high on the main deck and in close proximity to the cargo hold hatch opening was pulled inboard by a control lanyard which was held in his hand and at the same time secured to the pontoon cover. Subsequently, the AB fell into the cargo hold through the hatch opening. This Note draws the attention of all shipowners, ship managers, ship operators, masters, officers and crew to the lessons learnt from this accident.

**The Incident**

1. In preparation for loading a cargo hold of a Hong Kong registered general cargo ship (the vessel), the tween-deck pontoon covers of the cargo hold had to be lifted in advance. An AB was tasked to hold a pontoon cover control lanyard in order to control the movement of the pontoon cover during lifting.
2. During the lifting operation, the AB was standing on top of a hoisting spreader, which was temporarily laid on the starboard main deck, being close to and level with the cargo hold hatch opening. When the first pontoon cover was lifted, the vessel rolled suddenly. Under the movement of the vessel and the suspended pontoon cover, the AB was moved inboard by force towards the cargo hold hatch opening. After hearing a yell and a thump sound, the other crew members found the AB lying on the bottom plate of the cargo hold. The AB was declared dead by the shore medical brigade on the same day.
3. The investigation revealed that the lifting operation carried out in an unsafe manner with poor supervision was the main contributory factor of the accident.
4. The investigation also identified that the AB probably lacked situation awareness and

failed in releasing the control lanyard or keeping his body clear of it, thus resulting in his fatal falling from height when he was subjected to a pulling force.

## **Lessons Learnt**

5. In order to avoid recurrence of similar accidents in future, the masters, officers and crew of vessels should:

- (a) always conduct a full risk assessment to identify potential risks including dangerous locations for personnel, implementation of control measures to minimise the risks before lifting, and keeping the lifting operation under constant supervision; and
- (b) heighten safety awareness to stay alert to the risk of falling from height in lifting operation, including releasing the control lanyard in time and keeping the body clear of the control lanyard.

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

**Marine Department**  
**Multi-lateral Policy Division**

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