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香 港 商 船 資 訊

HONG KONG MERCHANT SHIPPING INFORMATION NOTE

Fatal accident of stevedores involving enclosed space entry

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

Summary

When a Hong Kong registered bulk carrier was loading logs at anchorage, two stevedores were found lying inside a fully loaded cargo hold and they were declared dead later. 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. At the time of the incident, a Hong Kong registered bulk carrier (*the vessel*) anchored at port Kupiano, Papua New Guinea, for loading of logs. A barge loaded with logs came alongside *the vessel*, and 16 stevedores boarded *the vessel* to assist in cargo loading at Nos. 4 and 5 cargo holds. Nos. 1, 2, and 3 cargo holds were fully loaded and closed a week ago. On the morning of the next day, the foreman of the stevedores (*the foreman*) gathered all stevedores to assign them with loading duties but two stevedores didn't show up. *The foreman* immediately requested the Chief Officer to assist in searching for the two missing stevedores on board *the vessel.*

2. During the search, a stevedore saw that the No. 2 cargo hold forward access hatch (*the access hatch*) was open and found the two missing stevedores lying on the logs inside the cargo hold. A rescue team was organised to pull the two unconscious stevedores out. Although first aid treatment was provided to them, they did not show any vital signs and were declared dead on the same day.

3. The investigation revealed that the main contributory factors causing the accident were lack of safety awareness and supervision of the stevedores; failure to follow safety requirements of enclosed space entry to the cargo hold for unknown reasons without authorization; failure to

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lock *the access hatch* to prevent unauthorised entry; and insufficient measures to control or monitor *the access hatch*.

4. The investigation also found out that *the vessel* failed to display proper marking on *the access hatch* as the entrance to a dangerous space.

Lessons Learnt

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

(a) enhance the communication with the stevedore company regarding the safe operation on board;

(b) enhance monitoring of the restricted areas and supervision of cargo handling in accordance with the International Ship and Port Facility Security Code; and

(c) follow the Code of Safe Working Practices for Merchant Seafarers by locking entrances to all unattended dangerous spaces against unauthorised entry and marking all entrances readily accessible to dangerous spaces as appropriate.

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

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