



## 香 港 商 船 資 訊

## HONG KONG MERCHANT SHIPPING INFORMATION NOTE

**A fatal accident of falling from the maintenance platform of a hose handling crane**

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

***Summary***

While an able seafarer (AB) was rigging a scaffolding to the maintenance platform of a hose handling crane, the platform suddenly collapsed. Although the AB had worn a safety harness and anchored it to the platform railing, the lanyard of the safety harness snapped and failed to prevent him from falling from the platform at a height of about 7.9 metres onto the main deck, 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 fatal falling accident happened on board a Hong Kong registered oil tanker (*the vessel*) during her voyage from Mina Al Ahmadi, Kuwait to Kawasaki, Japan via Galle, Sri Lanka and Singapore.

2. In the accident, the bosun and AB were assigned to rig a scaffolding to the maintenance platform which was bolted to the gusset plates at the boom of the port side hose handling crane (*the boom*) on the main deck. When the bosun and AB were working on the maintenance platform of *the boom* setting the scaffolding, the platform and the scaffolding suddenly collapsed at the same time. The bosun fell onto the platform railing and he climbed back to *the boom* safely. Although the AB had worn a safety harness and anchored it to the platform railing in the form of a choker hitch, the lanyard of the safety harness snapped and failed to prevent him from falling from the platform at a height of about 7.9 metres onto the main deck. The AB was declared dead later on the same day.

3. The investigation revealed that the securing bolts of the platform support were seriously corroded and failed to support the weight acting on it, resulting in the collapse of the platform. The investigation also identified the other contributory factors of poor risk assessment; poor supervision of scaffolding work being carried out by the crew without training record of scaffolding; non-compliance of the configuration of the scaffolding including the non-compliance of its structural steel rods with a generally recognized standard; insufficient safety instructions or guidelines for scaffolding work provided by the management company of *the vessel*; inappropriate maintenance of the safety harness; and insufficient training on using personal protective equipment.

### **Lessons Learnt**

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

- (a) the work at height is strictly conducted in accordance with the shipboard safety management system (SMS) and the Code of Safe Working Practices for Merchant Seafarers, in particular on risk assessment, planning and safety supervision; and
- (b) the implementation of the shipboard SMS is effective, in particular the maintenance of personal protective equipment and deck fittings.

5. The management company should consider revising the shipboard SMS documents to enhance:

- (a) working procedures, plans and instructions for scaffolding work and working aloft, including checklists as appropriate;
- (b) maintenance and inspection procedures as well as safety instructions for safety harness, including checklists as appropriate; and
- (c) training plans of scaffolding work and safe wearing of safety harness and safety helmet.

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

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