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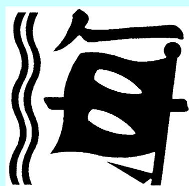

香 港 商 船 資 訊

HONG KONG MERCHANT SHIPPING INFORMATION NOTE

# A fatal fall accident happened on board while washing the hatch coaming

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


## *Summary*

When a Hong Kong registered bulk carrier was en route in ballast condition from Xiamen, China to her loading port of Abbot Point, Australia, a fatal fall accident happened. An able seafarer deck (AB) fell to the bottom of the cargo hold while he was washing its hatch coaming. 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 bulk carrier was en route in ballast condition from Xiamen, China to her loading port of Abbot Point, Australia. During the voyage, the AB was alone while washing the aft end hatch coaming of a cargo hold on the cross deck by using a fire hose. He accidentally stepped into an opening which was kept open for passing the fire hose to the cargo hold below for cleaning. Unfortunately, he fell to the bottom of the cargo hold from a height of over 19 metres. Although an emergency rescue team was organized immediately and first aid treatment was applied to the AB, he was declared dead on board later.

2. The investigation revealed that the AB lost the situation awareness without staying alert to slips, trips, and falls during working. The opening was not fenced off to avoid inadvertent falling of people, which led to the accident eventually. The investigation also found that the toolbox talk had not been carried out thoroughly according to the shipboard Safety Management System, thus contributing to the death of the AB.

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**Lessons Learnt**

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

(a) guardrails are erected, or apparent warning signs are displayed around manholes and other deck accesses when they are left open;

(b) appropriate control measures are implemented corresponding to risk assessment results, such as item (a) above to be clearly spelt out in the relevant work as listed in the shipboard Safety Management System, and the officer who signs the form for the toolbox talk should be responsible for carrying out the talk directly to the team; and

(c) the toolbox talk is carried out thoroughly to ensure the work plans, safety and hazards involved are clearly understood in accordance with the requirements of the shipboard Safety Management System.

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

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