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香 港 商 船 資 訊

HONG KONG MERCHANT SHIPPING INFORMATION NOTE

# A fatal accident happened during work carried out near the main engine flywheel

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

***Summary***

A fatal accident happened on board a Hong Kong registered bulk carrier when it was anchoring at Astoria anchorage, Columbia River, USA. One Fitter was found seriously injured, lying unconsciously on the engine room (E/R) tank top between the main engine flywheel and the main lubrication oil pump with a paint bucket and a roller at his side. He was later certified dead. 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 (the vessel) anchored at the Astoria anchorage, Columbia River, USA awaiting berthing instruction for loading wheat in bulk. In order to verify the running conditions of the main engine after switching to the low sulphur marine gasoil, the main engine of the vessel was tested under the engine control room (ECR) control mode upon agreement from the Chief Engineer (C/E) and approval from the duty officer on the bridge. After the completion of the test, the First Engineer (1/E) made a telephone call to the Fitter's cabin informing him to arrange the cleaning of the E/R as instructed by the C/E, but nobody answered. The 1/E then searched the E/R for the Fitter and found him seriously injured, lying unconsciously on the E/R tank top between the main engine flywheel and the main lubrication oil pump with a paint bucket and a roller at his side. Afterwards, the Fitter was sent ashore for emergency medical treatment, but unfortunately, the shore doctor declared him dead on the same day.

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2. The investigation identified that the contributory factors leading to this accident were that the crew failed to follow the requirements of the “Shipboard Safe Working Instruction” of the shipboard Safety Management System (SMS) to arrange a toolbox meeting to identify the hazards involved and put them under control before starting work; the Fitter lacked safety awareness underestimating the risk of working adjacent to the main engine flywheel; and the crew lacked effective communication for the main engine test versus the work adjacent to the flywheel of the main engine .

**Lessons Learnt**

3. In order to avoid the recurrence of similar accidents in the future, the ship management company, all masters, officers, and crew should:

(a) enhance safety awareness and safety culture onboard to ensure a risk assessment to be conducted before commencing work to determine the potential hazards;

(b) strictly follow the requirements of the “Shipboard Safe Working Instruction” of the shipboard SMS, especially for the routine maintenance work of the E/R; and

(c) enhance the communication among the crew before conducting key operations such as main engine test, maintenance or repairs work adjacent to moving machinery, etc.

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

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