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香 港 商 船 資 訊

HONG KONG MERCHANT SHIPPING INFORMATION NOTE

Fatal accident of an electrician officer while working alone on a shipboard elevator

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

Summary

A Hong Kong registered bulk carrier anchored at Qingdao, China. An electrician officer (*ETO*) was found unconscious, lying on top of the shipboard elevator cage. Afterwards, the *ETO* was removed from the top of the elevator cage for medical treatment but was declared dead eventually by the shore medical officer. 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 Qingdao, China, waiting for berthing instruction. The duty oiler informed *the ETO* that the common alarm of the elevator was activated. *The ETO* replied that he would check the elevator the next day. However, the *ETO* subsequently changed his decision after dinner and worked alone on the cage top of the elevator during his non-working hours without informing other crew members. Later, the duty engine trainee discovered some blood came out from the entrance door of the elevator (*the entrance door*) on the upper deck and immediately reported the situation to the third engineer. The third engineer then reported the incident to the chief engineer and the master.

2. The engine room crew removed *the entrance door* and found *the ETO* was unconscious, lying on the top of the elevator cage bleeding from his nose and mouth. Afterwards, *the vessel* shifted to the inner anchorage of Qingdao to seek shore medical treatment for *the ETO*. Unfortunately, *the ETO* was declared dead after the examination by the shore medical officer.

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3. The investigation identified the contributory factors leading to the accident were that the crew members failed to follow the cautions on inspection or maintenance stated in the Operation Manual for Elevator provided by the manufacturer and the requirements of the Code of Safe Working Practices for Merchant Seafarers (*the Code*) in carrying out work on the elevator in a safe manner on board; failed to conduct a risk assessment and follow the permit-to-work system before commencing the work on the elevator; lacked sufficient safety awareness in the work on the elevator and effective communication in executing their duties; and underestimated the inherent risk of hazards associated with work on the elevator.

4. The investigation also found that the shipboard Safety Management System (*SMS*) failed to follow the requirements of *the Code* to identify work on elevator, including work requiring access to its trunk, as one of the main risks on board.

Lessons Learnt

5. In order to avoid recurrence of similar accidents in the future, the ship management companies, all masters, officers, and crew members should note the following items (a) to (c) while ship management companies should also note item (d):

(a) to strictly follow the requirements of the shipboard Operation Manual for Elevator and *the Code* in carrying out the work on an elevator in a safe manner on board;

(b) to ensure that the risk assessment is completed and the permit-to-work system is followed before commencing the work on an elevator;

(c) to enhance the safety awareness and safety culture on board to ensure that crew members have sufficient safety awareness in the work on an elevator; and

(d) to revise the shipboard *SMS* to identify work on an elevator, including work requiring access to its trunk, as one of the main risks on board and conduct an internal audit on the vessel to ensure that crew members strictly follow the safety requirements when carrying out work on an elevator.

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

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