



香 港 商 船 資 訊

HONG KONG MERCHANT SHIPPING INFORMATION NOTE

Stevedore fatality in the hold during loading of steel pipes

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

Summary

A fatal accident happened on board a Hong Kong registered bulk carrier when loading its cargo of steel pipes in various sizes at a pier. As a heavy steel pipe was lowered with a crane, its weight displaced the steel pipes below, leading to the stevedores in the hold being crushed as a result of losing their balance and falling. Eventually, one of the stevedores was dead, and the other one was seriously injured. 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 berthed at a pier to load its cargo of steel pipes in various sizes. During the crane operation, the stack of steel pipes below was displaced by lowering a heavy steel pipe. It caused the nearby stevedores to lose their balance and fall into the gaps between the steel pipes. Although the two injured workers were rushed into the port hospital for medical treatment, one of the stevedores responsible for unhooking the cargo was declared dead the day after the incident, and the other stevedore responsible for cargo securing was seriously injured.

2. The investigation revealed that the contributory factors of the accident were as follows:

(a) The stevedores had insufficient safety awareness and did not pay enough attention to foreseeable risks for lifting/lashing operation of heavy cargo, large stacking gaps, and easy-to-loosen cargo; they had insufficient ability to identify potential risks and had not taken effective preventive measures;

- (b) The stevedores did not have clearly defined job responsibilities and procedures for the heavy lifting operation. Lifting of cargoes and placement of dunnage were carried out at the same time;
- (c) The stowage and securing plan was imperfect, with no effective solutions for the cargo with complex specifications, large stowage gaps, and easy displacement. The loading Master failed to effectively monitor the loading quality, resulting in excessive cargo gaps and the potential risk of cargo loosening and displacement; and
- (d) The shore stevedore's service companies do not provide sufficient safety education and training for their stevedores, causing their low safety risk identification ability and weak safety awareness

Lessons Learnt

3. In order to avoid the recurrence of similar accidents in the future, the ship management should further optimise the selection of ship type for the cargo, improve the cargo stowage and securing plan, enhance the monitoring of the loading quality, and the onsite safety management of the cargo operation.
4. The attention of shipowners, ship managers, ship operators, masters, officers, and crew members is drawn to the lessons learnt above.

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