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HONG KONG MERCHANT SHIPPING INFORMATION NOTE

A fatal fall accident involving the lifting operation on the main deck

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

Summary

At the time of the accident, an able seafarer deck was assigned to assist in lifting out the garbage drum from a cargo hold by stopping the swaying of the garbage drum with a tag line secured to the hook of the ship crane. During the lifting operation, the able seafarer deck who stood on the main deck port side beside the hatch coaming was hauled by the tag line and fell onto the bottom of the cargo hold. The able seafarer deck was evacuated by a rescue helicopter to an onshore hospital for emergency medical treatment. Unfortunately, he was declared dead before arrival. 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 anchored at the Outside Port Limits anchorage of Kwangyang, South Korea for cargo hold cleaning while awaiting berthing instruction for cargo loading. An able seafarer deck was assigned to stand on the main deck port side beside the cargo hold longitudinal hatch coaming and assist in lifting out the garbage drum with copper concentrate from the cargo hold. He was holding a tag line secured to the hook of the ship crane to prevent any swaying motion of the hook when the garbage drum was being lifted out from the cargo hold. At the time of the accident, the garbage drum was lifted to about a metre above the hatch coaming, the crane driver, without noticing that the tag line of the able seafarer deck was in tension, slewed the ship crane to transfer the garbage drum to the main deck starboard side. The able seafarer deck suddenly shouted at that moment and was then hauled by the tag line and flown off sideways across the cargo hold to the starboard side. He bumped on the starboard side shell web frame of the cargo hold and dropped to the bottom. Despite being evacuated by a rescue helicopter to the shore hospital for emergency medical treatment, the able seafarer deck was declared dead before arriving there.

2. The investigation revealed that the main contributory factors causing the accident were that the risk assessment and planning of the lifting operation did not meet the requirements as stated in paragraph 19.9.1 of the Code of Safe Working Practices for Merchant Seafarers (*the Code*); effective communication among the lifting team members was not established; on-site supervision was inadequate; and training on lifting operation and safety awareness of the lifting team was inadequate.

Lessons Learnt

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

- (a) conduct lifting operation in accordance with *the Code*, in particular on risk assessment, planning, communication, and supervision; and
- (b) establish training plan to enhance personnel safety awareness, including wearing safety helmets properly and familiarisation of the lifting operation.

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

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