



## 香港商船資訊

## HONG KONG MERCHANT SHIPPING INFORMATION NOTE

**A fatal accident happened on board while cleaning a cargo hold**

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

**Summary**

A fatal accident happened on board a Hong Kong registered bulk carrier when she was en route to Guiuan, Philippines to load a cargo of nickel ore in bulk. At the time of the incident, the bosun climbed up a portable ladder to clean the upper part of the lower slope of the starboard side cargo hold, the bosun suddenly fell from the ladder onto the tank top of the cargo hold and died as a result of it. 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*) was en route from Lanshan Port, China (*the discharge port*) to Guiuan, Philippines to load a cargo of nickel ore in bulk. As affected by the COVID-19 pandemic, no stevedore was assigned to *the discharging port* for the removal of cargo residue inside the cargo holds. As such, the crew of *the vessel* were assigned to do so after departure. At the time of the accident, the bosun and one deck cadet (*the D/C*) were going to clean the upper part of the lower slope of the starboard side No. 1 cargo hold (*the hold*) with the aid of a portable ladder (*the ladder*). When the bosun was climbing up *the ladder* to clean *the hold*, *the D/C* was providing assistance by holding onto the ladder, the bosun then suddenly fell from *the ladder* onto the tank top of *the hold* with his safety helmet flown off. The bosun was then transferred to the hospital of *the vessel* for emergency treatments under the medical guidance of the International SOS (Beijing). Afterwards, *the vessel* was steered back to *the discharge port*, and the bosun was sent to a local hospital for treatment. Unfortunately, the bosun was declared dead at the hospital on the day of the accident.

2. The investigation identified that the contributory factors leading to the incident were that the deck crew were lack of shipboard training on cargo hold cleaning, including working at height; the Chief Officer did not hold a toolbox meeting before the cargo hold cleaning and not supervise the cargo hold cleaning on-site as a supervisor under the shipboard Safety Management

System (SMS); the approval of a permit to work at height and risk assessment for the cargo hold cleaning onboard were not carried out effectively; and the crew did not follow the requirements of the “Code of Safe Working Practices for Merchant Seafarers” (*the Code*) on the use of portable ladders and securing of lifelines connected to safety harnesses when working at height.

### **Lessons Learnt**

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

- (a) enhance shipboard training in cargo hold cleaning by conducting an effective risk assessment including the approval of a permit to work at height for the cargo hold cleaning;
- (b) ensure a toolbox meeting is held before cargo hold cleaning, with a designated officer supervising the cargo hold cleaning on-site in accordance with the requirements of the shipboard SMS;
- (c) strictly follow the requirements of *the Code* on the use of portable ladders and proper securing of lifelines connected to safety harnesses when working at height; and
- (d) ensure the crew strictly follow the company’s instructions and the requirements of the shipboard SMS.

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

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7 February 2023