



## 香港商船資訊 HONG KONG MERCHANT SHIPPING INFORMATION NOTE

### A fatal accident happened on board during cleaning of a fuel oil tank

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

#### *Summary*

A fatal accident happened on board a Hong Kong registered multi-purpose dry cargo vessel (*the vessel*) during cleaning of a fuel oil tank (*the FOT*) in Egyptian waters. The foreman of a shore cleaning team (*the foreman*) rushed to *the FOT* to rescue an injured worker inside. Although the injured worker was rescued successfully, *the foreman* went missing inside *the FOT*. *The foreman* was finally rescued from *the FOT*, but was confirmed 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. *The vessel* was anchored at the Suez anchorage. A team of shore workers was employed to clean *the FOT* and then repair the ruptured bulkhead of *the FOT*, which was damaged during the cargo loading operation at the last port. Following the toolbox meeting between the ship crew and the shore cleaning team, the cleaning operation commenced and continued intermittently. In the early hours of the fourth day of the cleaning operation, two shore workers rushed out of *the FOT* and reported that a fellow worker had been injured inside *the FOT*. Upon being notified of the incident, *the foreman* immediately entered *the FOT* in haste, carrying a flashlight and wearing a breathing apparatus mask. Under the ship crew's effort, the injured worker was successfully rescued from *the FOT* about three hours later. He later regained consciousness. However, *the foreman* could not be found inside *the FOT* until around five hours after he had entered it. He was eventually found and rescued from the lower platform of *the FOT*, but showed no vital signs.

2. The investigation revealed that the main contributory factors leading to the accident were that the ship crew, the safety engineer of the shore cleaning team and *the foreman* failed to strictly follow the safety requirements for enclosed space entry and did not carry out a detailed risk assessment for the cleaning operation in accordance with the shipboard safety management

system (SMS); communication between the ship crew and the shore cleaning team, or among the team members themselves during the cleaning operation was ineffective; and both *the foreman* and the shore workers demonstrated a lack of safety awareness and underestimated the risks and potential hazards associated with enclosed space entry.

### **Lessons Learnt**

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

- (a) strictly follow the requirements of shipboard SMS to ensure that all persons on board comply with the safety requirements and procedures for enclosed space entry;
- (b) strictly follow the requirements of shipboard SMS to conduct a detailed risk assessment on board for cleaning operation inside enclosed space;
- (c) enhance effective communication between ship crew and shore workers; and
- (d) closely supervise operations carried out by shore workers on board and take immediate action to ensure safety if any dangerous situation is observed.

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

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4 September 2025