MARINE DEPARTMENT NOTICE NO. 174/2024

(Marine Industrial Safety)

Fatal marine industrial accident during cargo operations

The Incident

A fatal marine industrial accident happened on board a sea-going bulk carrier (*the vessel*) during cargo discharging operations at the Pun Shan Shek Anchorage, Hong Kong. At the time of the accident, a locally licensed dumb lighter (*the lighter*) was moored to the port side of *the vessel*, and the steel bars from the cargo hold of *the vessel* were lifted onto *the lighter* via *the lighter*'s crane (*the crane*). When *the crane* operator lifted the steel bars in the cargo hold to a height of about six to seven metres, *the lighter* was suddenly rolled by heavy sea swells, which led to the swaying of steel bars on *the crane*. At that time, a slinger noticed that a rectangular wooden dunnage sandwiched between the steel bars had protruded out as a result of the swaying. He immediately shouted to alert others working in the cargo hold to beware of the wooden dunnage that might fall. When the lifted steel bars were ascended to the height of the hatch, the swaying became much more intense, causing the wooden dunnage to fall. The wooden dunnage accidentally hit the head of a signaller in the cargo hold. After the accident, a rescue helicopter transferred the injured signaller to hospital for medical treatment. Unfortunately, the signaller was confirmed dead on the same day.

2. The investigation revealed that the contributory factors leading to the accident were that the works supervisor did not follow the requirement of the Shipping and Port Control (Works) Regulation (Cap. 313X of the Laws of Hong Kong) (*the Regulation*) to ensure the safety of the signaller during the discharge operations; and the signaller also did not follow the requirement of the "Code of Practice - Using Protective Clothing and Equipment for Works on Vessels" (*Code of Practice*) issued by the Marine Department to wear a safety helmet during the discharge operations.

3. The investigation also revealed that the signaller lacked safety awareness as he failed to observe the lifted steel bars at all times and keep a safe distance from their travelling path; the slingers and the works supervisor also did not realise that the signaller was in an unsafe position and failed to alert him accordingly and stop the operation.

Lessons Learnt

4. To avoid similar incidents in the future, ship management companies, shipmasters, persons in charge of works, works supervisors and cargo operators should:

(a) comply with the requirements of *the Regulation* that works supervisors shall ensure the safety of cargo operators during cargo operations;

(b) comply with the requirements of the *Code of Practice* that cargo operators shall wear safety helmets during cargo operations; and

(c) enhance the safety awareness on cargo operations and ensure the safety of cargo operators during cargo operations by observing the lifted cargo at all times and keeping a safe distance from its travelling path; and alert each other and immediately stop the operation in situations where safety is at stake.

Mr. S.F. WONG
Director of Marine

Marine Department
Government of the HKSAR
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