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HONG KONG MERCHANT SHIPPING INFORMATION NOTE

A fall from height accident of a shore technician while connecting power to reefer containers on deck

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

Summary

A fatal fall from height accident happened on board a Hong Kong registered container carrier (*the vessel*) at the port of Guayaquil, Ecuador during cargo operations. A shore technician, who was working alone to connect *the vessel*'s power supply to reefer containers loaded on the deck, was found lying unconsciously on the top of a container inside the hold adjacent to those reefer containers (*the hold*) and later 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* berthed at the port of Guayaquil, Ecuador for discharging and loading containers. After completion of cargo discharge, *the vessel* commenced loading containers, including reefer containers. Eight shore technicians boarded *the vessel* to connect shipboard power supply to the reefer containers loaded on board in various locations. One of the technicians (*the technician*) worked alone on the catwalk on deck between the reefer containers and *the hold.* While *the technician* picked the cable out of its storage box with an extended cable picker for reefer containers at the second tiers or above, he unfortunately fell to *the hold* from its opened centre hatch cover (*the hatch cover*). The technician was found lying unconsciously on the top of a twenty-foot container inside *the hold* about 13 meters below the opening. The master immediately reported the accident to the management company and local agent upon receiving the report. The shore rescue team arrived at the scene to examine *the technician* and declared his death afterwards.

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2. The investigation identified that the contributory factors leading to the accident were that *the technician* lacked safety awareness of the risk of falling from height while working alone near *the hatch cover*; the crew failed to follow the requirements of the shipboard safety management system (SMS) to ensure *the technician* wearing appropriate personal protective equipment (PPE) during cargo operation.

3. The investigation also found that the communication between shore personnel and the crew was ineffective, i.e. no safety meeting before work, no safety instructions of wearing appropriate personnel protective equipment (PPE) during work, no risk assessment and no control measures taken for working aloft, no actions taken to close *the hatch cover* as soon as the cargo operation stopped in accordance with the requirements of the "Code of Safe Working Practices for Merchant Seafarers" (*the Code*); and that the communication between shore technicians and their company was also ineffective, i.e. no safety instructions and no supervision for the work of the shore technicians on board during the cargo operation.

Lessons Learnt

4. In order to avoid recurrence of similar accidents in the future, the ship management company, all masters, officers, and crew members should:

(a) enhance safety awareness of the risk of falling from height while working near the opening of a hatch cover;

(b) strictly follow the requirements of the shipboard SMS to ensure that the shore technicians use appropriate PPE during cargo operations including wearing a safety harness with a lifeline or other arresting device when working aloft; and

(c) enhance the communication between shore personnel and the crew on board to:

i) carry out a safety meeting before cargo operations, including providing safety instructions for wearing appropriate PPE, and conducting risk assessment with control measures for working aloft; and

ii) strictly follow the requirements of *the Code* to close the hatch cover immediately as soon as cargo operation stops.

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

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