The Swedish Club

MONTHLY SAFETY SCENARIO

OCTOBER 2023

Fall into the cargo hold during cargo operation

The container vessel was alongside and cargo operations had begun. It was an early morning in winter and there were patches of ice on the deck and on the cargo hatch covers. The starboard outboard cargo hatch cover for hold 5 had been removed and placed on the quay. A couple of containers were then loaded into the cargo hold. After this a number of other holds were to be loaded before coming back to hold 5 and so the hold was left partially open.

A few hours after loading had started, a terminal supervisor came on board the vessel and reported that crew members had walked on a partly open cargo hatch while a container was hanging above. The OOW said he would discuss this with the crew at the next safety meeting.

At 06.00 there was a change of watch. Two AB's monitored the cargo operation and the OOW was in the ship's office. At around 07.00 AB1 informed the OOW that cargo operation had begun in hold 4 and advised that he wanted to examine cargo hold 5 to see that everything was in order and that there was no cargo damage. Between each cargo hold there was a protected walkway and to access the cargo hatch cover it was necessary to climb up a short ladder from the main deck. The guardrails on either side of the walkway were fitted with safety barriers, which could be lifted to gain access.

To get a better look into the cargo hold AB1 opened up the safety barriers and walked onto the cargo hatch cover, which was partially removed. When AB1 was close to the edge he slipped on some ice and fell into the hold.

About 15 minutes later AB2 meet the OOW by the gangway and asked if the OOW had seen AB1. He replied that he had not seen AB1 for about 15 minutes. Both men began

to search for their missing crew member and after ten minutes they found him lying at the bottom of cargo hold 5, just beneath the open hatch cover.

The OOW told the stevedores to call for an ambulance. The port's ambulance soon arrived soon at the scene and the Master informed vessel traffic service. About ten minutes later the crew had assembled a team who entered the cargo hold and they found that AB1 had no pulse. Five minutes later the ambulance paramedics entered the cargo hold. They tried to revive AB1 but were unsuccessful. He was later pronounced dead.

There were no temporary guardrails on board the vessels that could be fitted to hatch covers and it was impossible to secure any fall prevention harness. AB1 was wearing all the required personal protective equipment.

The vessel's SMS had addressed the risks of falling into an open hold and working on deck under icy conditions, but the particular risks from walking on a partially open hatch cover had not been considered.

Questions

When discussing this case please consider that the actions taken at the time made sense for all involved. Do not only judge but also ask why you think these actions were taken and could this happen on your vessel?

1. What were the immediate causes of this accident?
2. Is there a risk that this kind of accident could happen on our vessel?
3. How could this accident have been prevented?
4. What sections of our SMS would have been breached, if any?
5. Is our SMS sufficient to prevent this kind of accident?
6. If procedures were breached why do you think this was the case?
7. What are the procedures if someone walks on the cargo hatch covers during a cargo operation?
8. Do we have a risk assessment on board that addresses these risks?
9. How is the risk of falling into a cargo hold addressed in our SMS and risk assessment?
10. If a hatch cover is partially removed does our risk assessment address this?
11. If not, should this be implemented and how should it be implemented?
12. Do we have guardrails that fit if a cargo hatch cover is partially open?
13. What are the procedures for walking under anything suspended in the air?
14. Do we correct an identified issue with any safety equipment or breach of safety procedures immediately?