STEAMSHIP MUTUAL

Risk Alert

Working at height in and around cargo holds

Introduction

A recent Club review of crew injury and death claims highlights the dangers of falling from height when working in cargo holds. In the 2010-2012 underwriting years there were two such fatalities and investigations showed they should both have been avoidable.

There are many reasons why crew need to enter cargo holds. For instance, on general cargo ships it may be necessary to inspect the cargo lashings or test the hold bilges. However, on bulk carriers all residues from a previous cargo will need to be removed before the next loading and so in an empty hold the height from the hatch coaming to tank top can be large.

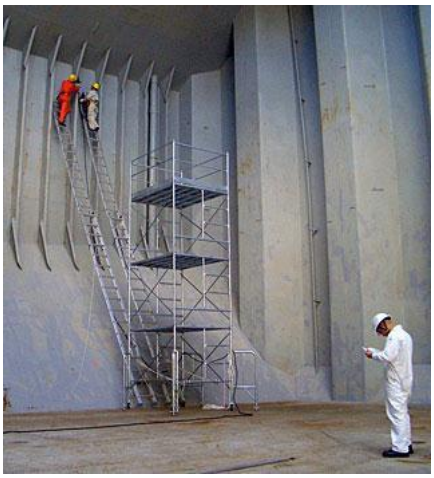
Recommendations

Vessel crews should remember that when working at height it may not be possible to give their full attention to the job they are doing and at the same time guard themselves against falling. This means that proper precautions should always be taken to ensure personal safety and so the Club recommends referring to the Code of Safe Working Practises for Merchant seamen (COSWP). In particular:

1) Ensure the work is properly planned, including carrying out a risk assessment, appropriately supervised and carried out in as safe a manner as practicable.

2) Only done by experienced people or, if not, then be accompanied by an experienced person.

3) Only done by people wearing a safety harness with lifeline or other such arresting device at all times. Lifelines are to be attached to a strong point above to reduce the fall height. The equipment should be tested periodically and checked before being used.



4) Rigging a safety net where necessary and appropriate.

5) Take care to avoid risks to anyone working or moving below. Handle tools with care and particularly when hands are cold or greasy and where the tools themselves might be greasy.

Case study 1:

In 2010 a 'Panamax' bulk carrier was in ballast off the Australian coast when a deck fitter and an ordinary seaman were repairing the hold access ladder platform handrails. This work, carried out with portable lights when the hatch covers were closed, involved removing the damaged sections of handrails and welding replacement sections.

After removing a damaged section from the middle platform the two men stopped for a lunch break and afterwards returned to the hold to fit the new section. The fitter entered the hold first and descended to the middle platform after which the ordinary seaman, who was still on deck preparing to lower the tools down, lost sight of the

fitter. Shortly afterwards the fitter fell from the middle platform to the tank top. Despite a prompt medical deviation the fitter died from his injuries before he could be evacuated.

An investigation showed that even though the fitter was wearing a safety helmet and harness the helmet was not fitting tightly and the harness lifeline was not hooked on to a strong point. It appears that the fitter did not connect the safety harness before stepping off the ladder on to the platform. In the semi-darkness he fell from the platform where the handrail had been removed before the lunch break.

Case Study 2:

The deck crew of a 'Capesize' bulk carrier were all involved in hold cleaning while on a deep sea passage in the Indian Ocean. The weather was good with the vessel rolling only 2° or 3°. Several crew were sweeping cargo residues, some were shovelling it into buckets and the Bosun was on deck operating the hold cleaning davit and winch.

Work was proceeding well until, after removing one lift from the hold and preparing to lower the empty bucket back down again, the winch wire jammed in the sheave at the davit head.
Rather than keep the davit over the deck and use a portable ladder to reach the sheave the Bosun placed the davit over the hatch coaming and then climbed on the coaming. The Bosun did not use a safety harness and, unfortunately, lost his balance and fell about 25 metres to the tank top where he died.

Even though he was an experienced seafarer the Bosun chose not to take even the simplest precautions. Perhaps he thought he would only be on the coaming for a few seconds; perhaps bringing the portable ladder would have taken a few minutes; perhaps the safety harness was in a deck store near the accommodation. Whatever the reason the outcome did not justify any of them.

Further information

For further information, please check the below websites:

http://www.dft.gov.uk/mca/cos wp2010.pdf

http://www.dft.gov.uk/mca/mg n410.pdf

For further information on this or other Loss Prevention topics please contact the Loss Prevention Department, Steamship Insurance Management Services Ltd.

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