Class A Accident Report

# Shinano Reefer Stevedore Fatality

At the Port Napier on 19 January 2005

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# REPORT NO: 05 3644

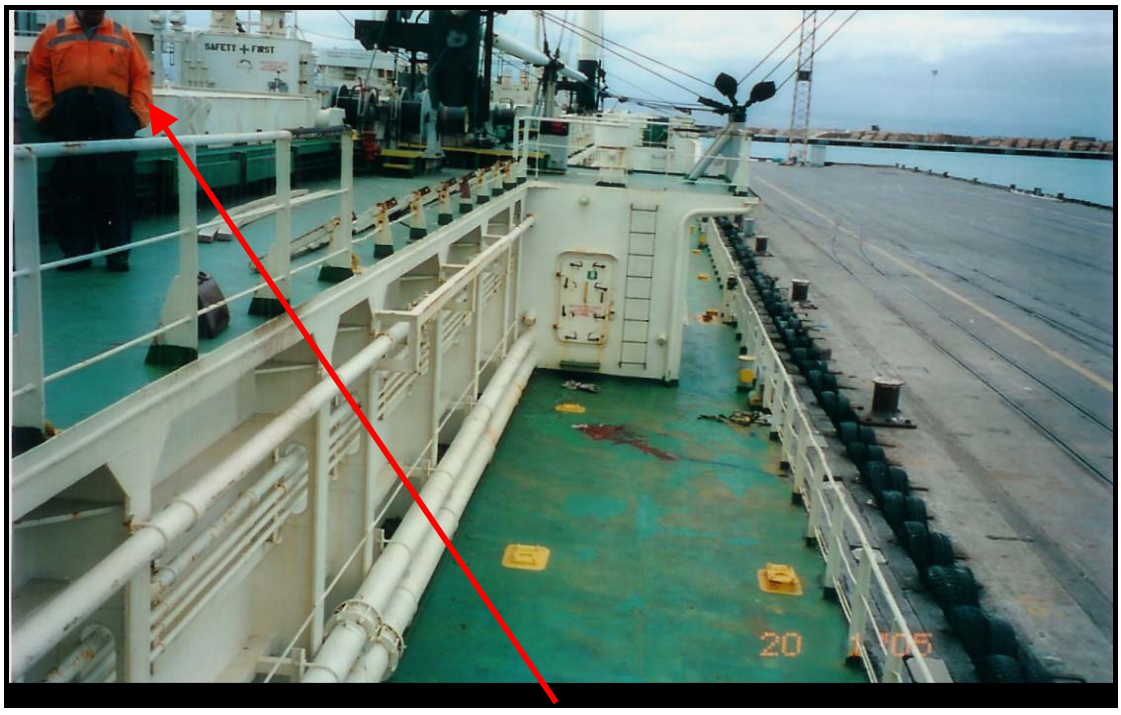
## *SHINANO REEFER* – STEVEDORE FATALITY

At approximately 1600 hours on 19 January 2005, at the Port of Napier, cargo operations had been completed and the ship's crew were securing numbers 3 and 4 cargo holds.

The Hawkes Bay Stevedoring Ltd (HBSS) Stevedores had completed loading and were walking down the deck to disembark the vessel.

Two Stevedores, (the Winchman and Hatchman) were walking along the hatch deck when one turned and saw the Hatchman falling to his left down to the deck below *(See Photograph)*. He and a number of other Stevedores from shore side rushed to the scene and gave first aid while an ambulance was called.

The Stevedore was bleeding profusely from a head wound. Shortly after, he was removed by ambulance but died in transit to hospital.




**PHOTOGRAPH OF HATCH DECK (MAN IN ORANGE) AND IMPACT AREA ON MAIN DECK BELOW.**

## Details of Vessel, Owner & Management, Classification, Navigational Equipment, Manning & Crew:

| | |
|---|---|
| **Name of Vessel:** | ***Shinano Reefer*** |
| **Vessel Type:** | Reefer |
| **Port of Registry:** | Panama |
| **Flag:** | Panama |
| **Built:** | 1993 |
| **Construction Material:** | Steel |
| **Length Overall (m):** | 134.02 |
| **Maximum Breadth (m):** | 20.80 |
| **Gross Tonnage:** | 7 307 |
| **Net Tonnage:** | 4 812 |
| **Propulsion:** | 6355 kW Diesel |
| **Accident Investigator:** | Domonic Venz |

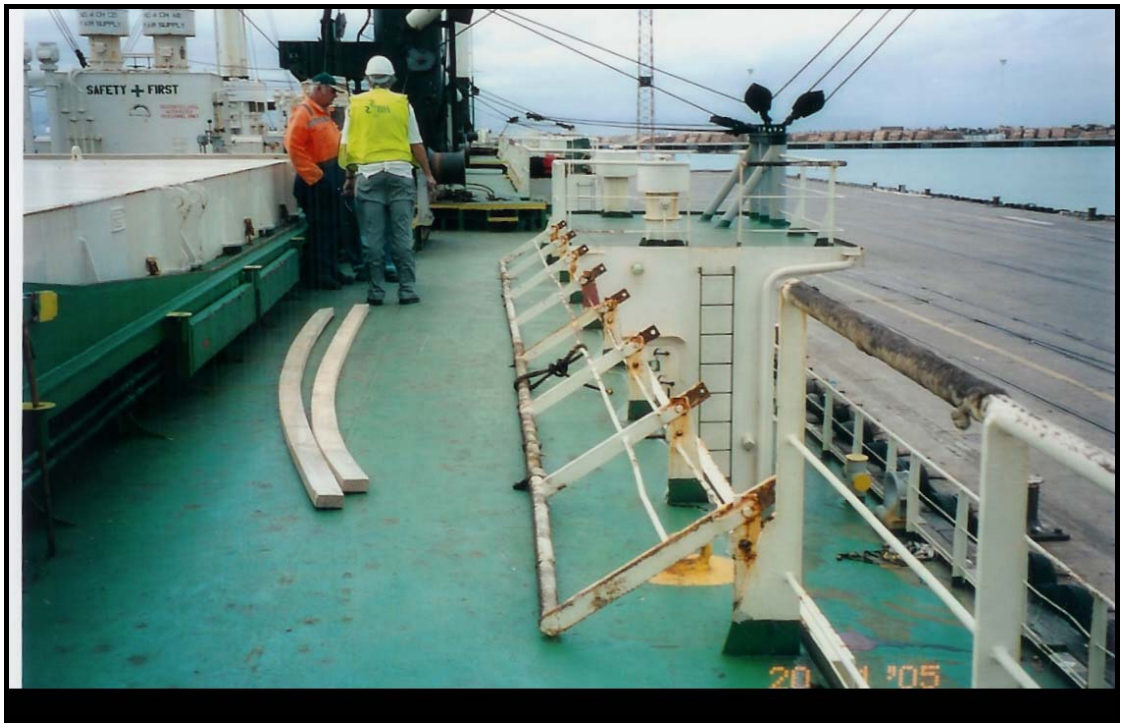
- **Owner Details**
  Altair Lines S.A Panama

- **Charterer**
  Kyokuyo Shipping Co Ltd Tokyo Japan.

- **Employer Details**
  Hawkes Bay Stevedoring Services is a wholly owned subsidiary of Southern Cross Stevedores Ltd.

- **Employee Details**
  The Hatchman was to be 65 the day after the accident. He had worked for 40 years on the waterfront, with 15 years of those with Hawkes Bay Stevedoring Services. He was a vastly experienced Stevedore, and had worked this type of vessel many times before, as had all of the Stevedores rostered on that day.

- **Hazard Identification Details**
  The vessel is equipped with a 'hatch deck' that runs above the main deck near the top of the hatch coaming.




**PHOTOGRAPH OF HATCH DECK WITH LOWERED SAFETY RAIL.**

The vessel also has a fold down safety rail as part of its design; this allows the cargo runner from the union purchase derricks to pass over it and into the holds.

HBSS and all of the Stevedores working that day have worked this ship design many times before. The rail is lowered and raised by the vessel's crew before and after cargo operations. It had not been identified as a specific hazard by HBSS but was widely known by all the Stevedores.

HBSS has A Health and Safety manual dated July 2004. Contained in section 5 *Policy on the wearing of personal safety equipment,* it is stated under Head Protection, Hard hats will be worn at all times in areas where hazard identification and/or management deem it necessary.

The Manager of HBSS stated that at the time of the accident, the Hatchman had finished work and there wasn't any overhead work. HBSS do not have a firm policy as to what point hard hats will or will not be taken off.

## NARRATIVE

On the week starting 10 January 2005, the Hatchman worked 5 eight hour shifts through the week. On the week commencing 17 January, he had this day off. On 18 January, he worked from 1600 to 2400 hours.

At 0800 hours, on 19 January, he started work loading a reefer vessel in Napier. He was assigned to the hatch deck to work as a Hatchman liasing between the winchman, the man in the hold and the Stevedores on the wharf.

All the Stevedores had a ¼ hour break at 1000 hours, ½ hour at 1200 hours and ¼ hour at 1400 hours.

As the shift approached knockoff time of 1600 hours, loading of cargo was almost completed and it was decided to continue and finish loading.

Shortly after 1600 hours, loading of cargo was completed and the vessel's crew were closing the hatches. The HBSS Stevedores working on board had finished their work and were making their way off the vessel and back to HBSS's base.

The Hatchman and Winchman were walking along the hatch deck with the Winchman slightly ahead. The Winchman turned and saw the Hatchman off balance and falling to his left down to the main deck, 3 metres below. He rushed down to the main deck and was met there by other Stevedores from the wharf. They gave first aid and an ambulance was called.

The Hatchman was bleeding from his mouth and nose and had started breathing again.

Shortly after this he was attended by ambulance paramedics and removed to hospital but died in transit.

## FINDINGS

The Hatchman was not wearing his helmet at the time of the fall. As he had finished work, he was not required to do so, under the HBSS Health and Safety manual.

The fold down safety rail had yet to be raised after loading was completed.

The Hatchman was seen to overbalance and fall over the edge of the hatch deck. The Winchman who was the nearest eyewitness is not sure whether he lost balance or tripped over the lowered safety rail.

The Hatchman was seen to fall without his hands in a defensive position and, as he landed, his head struck the deck with no apparent involvement of his arms.

The Hatchman and Winchman were in a relaxed mode having finished loading and the shift. It was the Hatchman's 65th birthday party the next day, and he was due to retire at the end of January 2005.

The hatch deck safety rail is lowered to prevent the derricks luffing out too far and therefore putting excessive load on the wires.

## SAFETY RECOMMENDATIONS

1. That Southern Cross Stevedores Ltd (SCS) critically review their Health and Safety manual to include the need to always wear all personal safety equipment including safety helmet until well clear of any work area and clear of the vessel and surrounding areas.

2. That SCS also direct all of their subsidiaries to identify and list the fold down safety rail as a hazard.

3. That where possible, the hatch deck safety rail remain in the raised position and cargo operations are managed in such a way as to minimise the luff of the outboard derrick.