Australian Government
Australian Transport Safety Bureau

Serious injury of a crew member on board *Mell Selarang*

Port of Townsville, Queensland | 20 August 2013

Investigation

ATSB Transport Safety Report
Marine Occurrence Investigation
302-MO-2013-009
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Addendum

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What happened

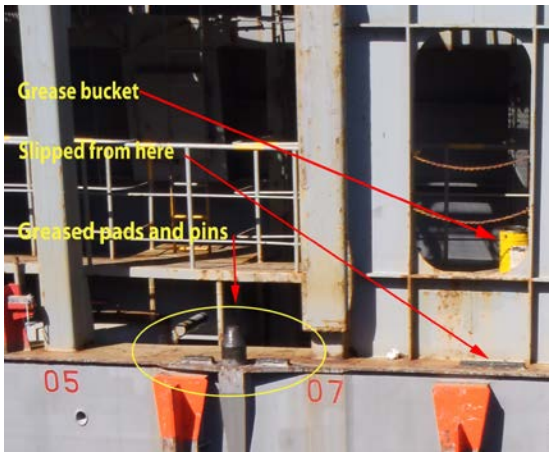
At about 0755[1] on 19 August 2013, the 175 m container ship *Mell Selarang* (Figure 1) berthed at number three berth (AUTSV 3) in the Port of Townsville, Queensland. Shortly after, the stevedores started cargo operations.

Figure 1: *Mell Selarang*

Source: Aristotle P Refugio, Philippine Ship Spotter's Society

Cargo operations continued into 20 August and, at about 0752, the stevedores stopped work for a change of shift. In the quiet period between the two shifts, one of the ship's seamen decided to grease the hatch landing pads (Figure 2) around the open cargo hold. The chief mate and the boatswain (bosun) were not advised of the work and permission had not been obtained.

Figure 2: Cargo hatch coaming



Source: Australian Maritme Safety Authority

Figure 3: Open cargo hold

Source: Drinmore Marine Surveyors and Consultants

At about 0820, the new shift of stevedores boarded the ship and began to make their way into the cargo hold. At this time, the seaman was moving around the hatch coaming greasing the hatch lid landing pads when he slipped and fell, landing about 8.5 m below on the top of a container in the cargo hold (Figure 3).

One of the stevedores in the cargo hold heard the seaman land on a container and then moan. The stevedore looked up and could see the seaman half on, half off a container. He called out to another stevedore, who was still on the main deck, to raise the alarm and then went to assist the seaman. The stevedore on deck notified the terminal management and they initiated the terminal's emergency response plan.

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[1] All times referred to in this report are local time, Coordinated Universal Time (UTC) + 10 hours.

At about 0823, the ship's crew were alerted and shortly after, the ship's first aid party arrived at the scene. They noted that the seaman was wearing work shoes, overalls and a hard hat was lying close by. He was not wearing a safety harness.

At about 0845, an ambulance arrived on the wharf. The paramedics were taken on board the ship to assess the seaman's condition. At about 0910, he was lifted ashore by crane and transferred to the ambulance. At about 0918, the ambulance departed the wharf.

The seaman was taken to the local hospital where he was admitted and provided with medical attention. On 26 August, he was discharged from the hospital and repatriated home.

Working on deck

The chief officer had informed the bosun that no work on deck was to take place while the ship was in Townsville due to the stevedore's restrictions while they were working cargo. However, this information had not been passed on to the seamen.

Greasing the hatch landing pads

The hatch landing pads could only be greased when the hatch lid was not in position. Normally, this task was carried out using an extended handle roller, which allowed the work to be performed from the walkway. As a result, the crew were not exposed to the risk of falling from the hatch coamings.

Working aloft

According to the ship's safety management system, the seaman was required to complete a Working at Heights Permit and carry out a complementary risk analysis before he climbed onto the hatch coaming. Had he done so, he would have identified the permit requirement to wear a safety harness when working at height. Furthermore, he would have alerted the authorising officer of his intentions.

Training and familiarisation

In 2008, the seaman qualified as an able bodied seaman (AB) in the Philippines. He had previously worked on board *Mell Selarang*'s sister ship and, before joining *Mell Selarang*, had completed the ship management company's Quality Systems Manual induction.

On 1 August 2013, the day the seaman joined *Mell Selarang*, he completed the 'Familiarity with Safety Equipment and Procedures' form. In the following week he also completed the 'Familiarisation with Deck / Cargo System' form.

ATSB comment

The seaman decided on the spur of the moment to grease the hatch pads. Choosing to grease the hatch landing pads during the period between stevedore shifts indicated that he may have identified the hazard of containers moving past his position.

While he was showing initiative, the task was not appropriately planned and all of the associated risks were not identified and mitigated. Furthermore, the fall hazard was magnified by the application of grease to areas of the hatch coaming that he would be walking over.

Good communication requires the flow of information in both directions of a management structure. This is particularly important on board a ship where a number of independent work groups can be engaged in multiple tasks.

Safety action

Whether or not the ATSB identifies safety issues in the course of an investigation, relevant organisations may proactively initiate safety action in order to reduce their safety risk. The ATSB has been advised of the following proactive safety action in response to this occurrence.

Jahre-Wallem AS - Ship Manager

As a result of this occurrence, Jahre-Wallem has advised the ATSB that they are taking the following safety actions:

- Upgrading its training matrix (JW-64), to include a series of accident prevention, risk assessment and accident investigation courses that will be completed by all crew rather than just the officers. Cross referencing to the VOD/Seagull training courses and references to the STCW / Syllabus have also been added.
- Revising the wording in its safety familiarisation checklist (JW-175) to include safety harnesses under the section 'PPE' (personal protective equipment). A tick off section will also be included in the 'Welcome On Board Instructions' to cover this information.
- Revising/adding more clarity and instruction to its 'Welcome On Board Instructions'. Tick off boxes have also been included in sections 03 (Familiarisation), 14 (PPE), 16 (Permit to Work) to highlight the importance of the information that is needed to be passed on during the induction process.

Safety message

This incident highlights the fact that seemingly simple tasks that are undertaken with the best of intentions often have the planning and risk assessment stages inadvertently overlooked. This is particularly the case when the task is undertaken when an unexpected and opportune moment arises to complete the task.

The ATSB SafetyWatch highlights the broad safety concerns that come out of our investigation findings and from the occurrence data reported to us by industry. One of the current safety concerns is marine work practices www.atsb.gov.au/safetywatch/marine-work-practices.aspx.

General details

Mell Selarang

Name	Mell Selarang
IMO number	9401673
Call sign	C6AA7
Flag	Bahamas
Classification society	Det Norske Veritas
Ship type	Dedicated container with two 45 tonne SWL cranes
Builder	Guangzhou Wenchong Shipyard Co Ltd, China
Year built	2009
Owner(s)	TDS Containerships V AS
Ship Manager	Thor Dahl Management AS
Technical Manager	Jahre-Wallem AS
Operators:	Marianna Express Lines Ltd
Number of crew	18
Gross tonnage	18,326 t
Deadweight	23,332 t
Draught	10.92 m
Length overall	175.46 m
Moulded breadth	27.40 m

Moulded depth	14.43 m
Main engine(s)	MAN-B&W 7S60MC-C
Total power	16,660 kW at105 rpm
Speed	20.6 knots
Damage:	Nil

Occurrence details

Date and time:	20 August 2013 – At about 0825
Occurrence category:	Incident
Primary occurrence type:	Serious injury
Location:	Port of Townsville – Berth AUTSV 3

About the ATSB

The Australian Transport Safety Bureau (ATSB) is an independent Commonwealth Government statutory agency. The ATSB is governed by a Commission and is entirely separate from transport regulators, policy makers and service providers. The ATSB's function is to improve safety and public confidence in the aviation, marine and rail modes of transport through excellence in: independent investigation of transport accidents and other safety occurrences; safety data recording, analysis and research; and fostering safety awareness, knowledge and action.

The ATSB is responsible for investigating accidents and other transport safety matters involving civil aviation, marine and rail operations in Australia that fall within Commonwealth jurisdiction, as well as participating in overseas investigations involving Australian registered aircraft and ships. A primary concern is the safety of commercial transport, with particular regard to fare-paying passenger operations.

The ATSB performs its functions in accordance with the provisions of the *Transport Safety Investigation Act 2003* and Regulations and, where applicable, relevant international agreements.

The object of a safety investigation is to identify and reduce safety-related risk. ATSB investigations determine and communicate the safety factors related to the transport safety matter being investigated.

It is not a function of the ATSB to apportion blame or determine liability. At the same time, an investigation report must include factual material of sufficient weight to support the analysis and findings. At all times the ATSB endeavours to balance the use of material that could imply adverse comment with the need to properly explain what happened, and why, in a fair and unbiased manner.

About this report

Decisions regarding whether to conduct an investigation, and the scope of an investigation, are based on many factors, including the level of safety benefit likely to be obtained from an investigation. For this occurrence, a limited-scope, fact-gathering investigation was conducted in order to produce a short summary report, and allow for greater industry awareness of potential safety issues and possible safety actions.

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