UK P&I CLUB

Ship Type: All Trade Area: Worldwide

Bulletin 530 - 06/07 - Fatal Elevator Shaft Incident - Worldwide

The Australian Transport Safety Bureau (ATSB) has published a safety investigation report on an incident where an engineer died in an elevator shaft as he attempted to solve a fault with the elevator. The ATSB also issued recommendations and safety advisory notices, as outlined below.

Members are encouraged to download and forward, with this bulletin, the ATSB safety report to their ships that have elevators on board. The report can be downloaded from the following internet page:

http://www.atsb.gov.au/publications/investigation_reports/2007/MAIR/mair235.aspx

The incident occurred after the electrical technician stepped into the elevator shaft and the second deck elevator landing doors were allowed to close behind him. When the doors closed, the landing door safety circuit was completed. The elevator control system then reset itself and, shortly afterwards, the elevator responded to a landing call. The elevator car moved upwards until its movement was obstructed by the electrical technician. The resultant damage to the elevator car allowed the car doors to open slightly, causing the elevator to stop.

From the evidence available, the ATSB concluded the following contributing safety factors:

1. The ship's elevator instruction manuals did not provide the crew with sufficiently detailed and unambiguous safety guidance.
2. The ship's safety management system risk minimising strategies, including the permit to work system and the risk assessment process, were not implemented before the electrical technician started working on the elevator second deck landing door switches.
3. The electrical technician, the second engineer and the third engineer were either not aware of, or did not consider, all of the hazards associated with working in the ship's elevator shaft.
4. The ship's crew were not supplied with sufficient guidance or instruction that would have assisted them in determining which tasks required a formal risk assessment.
5. Appropriate safeguards were not put in place to ensure that the elevator car could not inadvertently move while the electrical technician was working in the elevator shaft.

- The ATSB recommends that the elevator manufacturer takes action to address point 1 above.

- With regards to points 2 and 3 above, the ATSB (through Marine Safety Advisory Notices MS20070005 and MS20070006) advises ship owners, operators and masters to consider the implications of this safety issue and to take action when it is considered appropriate.

Source of information: Australian Transport Safety Bureau
www.atsb.gov.au