SYNOPSIS

On 21 April 2010 the chief engineer on board the UK registered container ship *Ever Excel* was killed when he became trapped between the top of the ship's passenger lift and the edge of the lift shaft.

Ever Excel was alongside in Kaohsiung, Taiwan, undergoing a preliminary environmental compliance inspection, which required that the pit of the lift shaft be checked for oil residues. The second engineer was unable to open the lift shaft doors to gain access to the lift pit and the chief engineer intervened to resolve the problem. Without stating his intentions, the chief engineer entered the lift car, climbed through an escape hatch to reach the top of the lift car, and closed the hatch behind him.

The second engineer reset the lift controls, incorrectly assuming that the chief engineer had taken manual control of the lift from on top of the lift car. The chief engineer had not, and the lift was returned to its normal automatic operating mode. The lift moved upwards at its usual operating speed and trapped the chief engineer against the door sill of the deck above, asphyxiating him. It is not known exactly what the chief engineer intended to do, but it is likely that he was looking at the back of the lift shaft doors to establish how the locking mechanism worked.

The investigation found that all the safety barriers that could have prevented the accident had been ignored, reset, or circumvented. The risks associated with lift maintenance and inspection had not been considered.

This was the third fatal accident in an 8-month period on board ships operated by Evergreen Marine UK Limited (EMU). One crewman was killed on *Ever Elite* and another on board *Ever Smile* in occupational accidents. EMU sent specific instructions and procedures to the ships immediately following the accidents; however, the underlying safety issues were not addressed.

The investigation found that, although EMU's safety management system was compliant with the international standard, there were serious failings in its implementation. Few risk assessments were completed, safe systems of work had not been established and work permits were not used appropriately. Communication between crew and shore management was ineffective, and underlying problems were not identified.

The MCA has assisted EMU in developing its system of risk assessment and operating procedures. EMU has subsequently developed additional training in safety awareness and lift maintenance, and has sent further instructions to its ships on safe working.

A recommendation has been made to the highest levels of EMU's management to recommit to establishing a "just safety culture" within a robust safety management system.