

Incidents involving accommodation ladders

Safety Flash Published on 1 February 2003 Generated on 28 January 2026 IMCA SF 02/03

IMCA has recently been provided with a document submitted to the International Maritime Organization's (IMO) Sub-Committee Ship Design & Equipment by the delegation from Canada which describes two incidents, one resulting in a fatality and the other in a serious injury. They are not particularly new, but still appear to be relevant.

The paper points out that, under the SOLAS Convention, only accommodation ladders used for pilot transfer are required to be inspected. Whatever the likelihood of them being inspected as part of any other survey, the Canadian delegation suggests that there is no defined set of rules relating specifically to accommodation ladders and that inspections can, therefore, be no more than perfunctory. The proposal is to amend SOLAS to cover this area. In the meantime, the two incidents submitted are reported below (details taken from Canada's proposal) and highlight the construction, maintenance and inspection faults which led to the incidents:

- Since 1999, Canada has investigated two accidents involving accommodation ladders which resulted in death and injury. The results of the investigations were that routine inspections and maintenance had failed to detect the deteriorated condition of the ladders and their fittings. The accidents were on a bulk carrier in 1999, where one person was seriously injured, and on a container ship in 2001, which resulted in a fatality;
- In the 1999 accident, six people were disembarking the bulk carrier onto a water taxi when the accommodation ladder's turntable separated from its upper platform. Two people were thrown from the ladder. One fell into the water, while the other fell onto the bow of the water taxi and sustained serious injuries;
- In the 2001 accident, the deck crew of the containership was raising the accommodation ladder to its stowage position when a pad eye welded to a supporting steel deck post broke in two. The sudden fracture of the pad eye violently released a steel snatch block that was shackled to it, which then struck a crew member, who died from his injuries.

Investigations of the two accidents resulted in a number of findings:

- In the 1999 accident, the construction of the accommodation ladder was found not to conform to its design specifications. Furthermore, the construction of the ladder's turntable did not allow for regular inspection, or for the lubrication of its central pivot pin. The condition of the pin had deteriorated to a point where it had seized in its housing. It was determined that the pin had fractured under the influence of external

applied forces, as the ladder was moved into the disembarking position. This permitted the ladder to separate from the turntable. The poor quality of the pin attachment welds also indicated that the turntable had not been fabricated professionally.

- In the 2001 accident, it was determined that the pad eye had been cracked in two places and that these cracks had been in existence for some time prior to the accident. The cracks had not been detected during planned maintenance and had slowly become enlarged, to the point where they could no longer take the applied load. The general condition of the accommodation ladder and its fittings was also poor: the band brake around the winch motor was found broken; the securing pin on the lock nut of the central pin of the turntable was missing; there was scale and corrosion built up around the lock nut, the pin, and also on some sheaves; the underside of the davit arm was heavily corroded in places; and the side plates of the sheaves attached to it bore signs of past contact with other external objects.

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