Ref : DMA/AIFI/97/**C 1001**
Date: 09/03/2019

Dear Captain
Good Day,

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A bulk carrier was anchored prior delivery to a shipowner. Before delivery, the shipowner requested bunker supply to the ship, so a bunker barge got alongside on port side of vessel and started bunker supply at late afternoon hours. The bunkering plan included the following fuel specifications:

1. 450 M/T of heavy fuel oil
2. 30 M/T of diesel oil.

At the time of bunkering, all H.F.O. tanks of the ship, except for F.O. settling and service tanks, were empty and had been inspected prior vessels delivery.

The team to perform the bunkering operation on board involved the following individuals:

1. Chief Engineer – over all in charge
2. 2nd Engineer Bunkering officer / tank valve handling
3. Engine AB – safety personnel on deck (Hose handling and coupling)
4. Stand by SOPEP team (2 seafarers)

Chief engineer and 2nd engineer reviewed the bunkering plan which provided that 450M/T of H.F.O. should be transferred in No.2 H.F.O. tanks (P&S) evenly. Personnel on board connected the bunker hose to the ship's bunker manifold and started the bunkering operation.

In the middle of bunkering, after about half an hour, a ship's safety patrol found that fuel oil spouted out of the air vent of No.3 H.F.O. tank located on upper deck, and the bunkering operation was stopped immediately. Some quantity of fuel oil spilled into the sea.

Causes of accident

The plan included the provision to transfer the 450 tons of HFO to No2 P&S tank equally (Total available space 927 m^3). However, during preparation 2nd engineer due to mistake opened the bunker tank valve of No.3 H.F.O. tank(P) (capacity 110.6m3) instead of valve of No.2 H.F.O. tank(P). The bunkered fuel oil filled up the No 3 tank and having no other way out started to overflow from air vent.

Response to accident

Established emergency procedures (SMS & SOPEP) activated and oil spilled collected and removed from vessels deck. The No 3 (P) Tank emptied to required level. Coast Guard activated sea cleaning procedures.

Lessons learned

The vessel followed the SMS established bunkering preparation procedure. Thus, the bunkering plan was issued and discussed between team members involved during pre-bunkering meeting while members were aware of their role and responsibilities. However, the accident did occur because the over all in charge officer (C/E) had not supervised the procedure nor had verified the actions taken by crew members. As a result, a single point of failure occurred in this case that led to the accident.

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You are requested to confirm receipt , discuss the contents in the next consolidated meeting on board and keep a copy in DA-11 file.

Best Regards,
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