

Ref : DMA/AIFI/98/C 1062

Date: 29/09/2019

Dear Captain
Good Day,

Herewith we bring into your attention below incident report regarding Fatal incident in an enclosed space

Incident description

On a loaded bulk carrier, a bulkhead stool void space was due for periodical internal inspection. The chief officer instructed the bosun to open the main deck hatch to the vertical access trunk and to place a small ventilation fan over the opening. In the meantime, he completed a permit to work in his office and after about 20 minutes, joined the bosun at the access hatch. The C/O instructed the bosun to remove the fan and stand by the hatch while he entered to carry out the inspection. It was agreed that the C/O would check the atmosphere using his personal gas meter at each ladder platform before descending down to the next level, maintaining communication by walkie-talkie. After the C/O reached the bottom of the ladder, he did not report and when he failed to respond to the bosun's calls, the bridge watch keeper was alerted. The bosun then entered the access trunk to render assistance to the C/O but upon reaching the bottom of the ladder, he became dizzy and collapsed. Other crew members performed a rescue using self-contained breathing apparatus and although the bosun regained consciousness, the C/O lost his life.

Analysis

The void space had not been opened for about 6 months and was not fitted with any natural ventilation. In these conditions, the oxygen content of the atmosphere became depleted over time due to the effects of corrosion. The low rated ventilator fan was inadequate for the job and in the short time it was operating, would have had little effect on the atmosphere in the lower part of the space. The preparations for entry into this enclosed space were not in accordance with the vessel's Safety Management System and SOLAS requirements. A risk assessment was not carried out and the Permit to Work not properly completed at the site of the task. Furthermore, the C/O placed too much reliance on his personal gas meter instead of checking the atmosphere at all levels remotely. Although well intentioned, the actions of the bosun in entering the space not only placed his own life in danger but critically hindered the chances of successfully rescuing the C/O.

Lessons Learnt

- Strictly follow documented shipboard procedures for enclosed space entry
- Be alert to the ways in which all enclosed spaces on board your ship can become dangerous
- If in any doubt, speak up and stop the job until all safety concerns have been eradicated

- Resist the instinct to rush in any help a casualty. Always raise the alarm and perform a team rescue in accordance with drilled procedures
- Remember, enclosed spaces are dangerous until proven otherwise!

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

Best Regards,

Ali Mohtasham

Accident Investigations & Fleet Inspections

ROD Ship Management Co.

Dept. Tel No. : 0098-21-26100357-8

Dept. Fax No. : 0098-21-26125081

Direct Tel No. : 0098-21-2384 3553

Please reply to dma@sealeaders.com

(Note: This e-mail has been sent as BCC <blind carbon copy to : All R.O.D.-SMC Vessels, to eliminate the lengthy list that would result if this e-mail is printed)