Circular 207 / 2019

To: Vessel Owners, Managers, Masters, Officers, Deputy Registrars and Other Interested Parties

Subject: Lessons Learnt - Marine Casualty investigation result - Occupational accident - fall of person to a lower deck.

Date: 27th June 2019

Dear Captains and Managers,

This information is published to inform all Cook Islands Vessels and Owners of the general circumstances of a recent marine accidents and to draw out the lessons learnt.

Summary of Events:
On May 2018, the involved Cook Islands vessel departed from Antalya at 23.05 hours local time in ballast condition, proceeding at the sea speed of about 10,5 knots to her next port of call Mersin (Turkey). Sometime after departure, during the night navigation, one AB had a fatal fall into the cargo hold. Although there were no eyewitnesses to the accident, according to the evidences collected, the accident occurred at or shortly after midnight and was discovered by the other crew members about one hour later. By that time, the vessel was steaming in the Turkish domestic waters. Upon receipt of the accident notice, the Master immediately reversed the course to Antalya, contacted the Maritime Authorities reporting the accident and requesting medical assistance. Meanwhile, first aid to the injured was given by the crew. A Coast Guard fast rescue boat with a medical team and a helicopter were sent from Turkey's MRCC and met the vessel in her way back but, upon medical team boarding, the **injured AB had already passed away.**

Investigation Result and Root Causes analysis:
The investigation identified that:

- A hatch cover section was voluntarily left opened, while the vessel was navigating at night. Relevant safety procedures omitted.
- Proper fences, signals and warnings, for protecting the opened hatch cover section, were not envisaged.
- No warning posters reminding to use deck walkways and not to walk on the hatch cover were posted at the aft deck.
- The injured did not have a torch/flashlight with him to illuminate his steps.
- The injured did not have a radio handset with him to maintain radio contact with the officer on watch on the bridge.
- The injured was moving at night-time on deck, alone; no special procedures to verify his position and condition have been provided or activated.
- The injured rescue and first aid operations were started about one hour after the accident.
- The emergency signals, to alert crew and engine room, were not activated by the OOW and Master.

- At the gantry crane driving position a poster showing the crane operation/use instructions was missing.
- At the time of the accident, the manning of bridge was not properly maintained.

Action Taken:
During the course of the investigation and through discussions with the investigation team, where applicable, the following safety actions were recommended by Maritime Cook Islands to Vessel's Managers:

1. People operating on decks during night time must be authorized and must keep frequent contacts via portable radio handset with the Officer on duty. In/out time must be recorded in the logbook.
2. Each crew member working on decks and enclosed spaces must be provided with a portable radio handset.
3. Each crew member working in dark environment must be provided with flash light, in addition to the applicable PPE.
4. For deck movements during navigation, side walkways have to be used only. Walking on top the hatch covers must be restricted.
5. At the access to the main deck, warning posts for safe movements on deck have to be installed.
6. Hatch covers should be closed at sea, unless absolutely essential; whenever the cargo hold hatches are required to be opened or left opened at sea, such in special circumstances, (i.e. for the purpose of hold cleaning and preparation) a risk assessment must be completed, and relevant safety barriers must be put in place.
7. The risk assessment should include, but should not be limited to, the monitoring of weather conditions, the maximum number of hatches to be open at any given time, the installation of proper fences, signals, warning and adequate lighting.
8. In any case, hatches must not be opened when the ship is moving due to adverse sea state conditions and must not remain open overnight.
9. Open hatch covers left unattended must be avoided.
10. A detailed procedure for Gantry crane operation is requested to be included in ISM manual and relevant instructions to be posted near Gantry crane control panel.
11. Circular related to the "lesson learned" issued by DPA is requested.

The circulation of the same safety action to all managed vessel was requested as well.

Conclusion:
We would like to urge all vessel Masters, Managers and Owners to implement the above listed safety recommendations and operative procedures all time on board MCI vessels.