Casualty Circular No. 01 of 2010

NO:

Dated: 29.03.2010

Subject: Injury to crew while working in heavy weather..

1. **Narrative:**

Foreign flagged cellular container vessel loaded with 28009.1 MT of cargo was en-route from Singapore to Aden, Yemen during the month of July, 2009. The vessel was drawing draft of 12.10 meter (forward) and 12.60 meter (aft) with 100% propeller immersion.

1.1 Weather conditions were very rough the vessel was encountering heavy long swell from WSW direction with wind force 8 on Beaufort scale. Vessel was rolling and pitching heavily with occasional shipping heavily seas on forward deck.

1.2 On 5th July, 2009, while the vessel was around 450 miles off the port of Salalah, engine room informed bridge about water ingress alarm from forward bow thruster compartment. Subsequently it was decided that chief officer along with Bosun and two seamen would proceed to forward to investigate the water ingress alarm. On reaching the forecastle deck where the bow thruster compartment is located, it was noted that there was no ingress of water and therefore alarm in the engine room was false.

1.3 Chief officer also checked other compartments in the forward area and found that port side chain locker was filled with sea water and this water was leaking into fore peak store from bitter end manhole. Crew was instructed to pump out fore peak store water using portable pump. At the same time chief officer and Bosun went to the forecastle deck to investigate the spurling pipe and the reason for anchor banging on the shipside. It was observed that spurling pipe cover s had come off and the anchor was banging since the bow stopper had not been able to fit properly. Spurling pipe cover on port side was fixed properly with the help of cement. Having completed, the pumping out of water for the fore peak store and the fixing of spurling pipe cover, the crew informed the bridge that they were returning back to the accommodation.

1.4 However, from bay no-3, the crew decided to turn back to fore castle deck to check the anchor and to fix the hawse pipe covers. This decision to turn back was not informed to the bridge.

1.5 Soon there after, a huge wave shipped on the deck and the chief officer and two crew members were badly injured. Duty officer of the bridge heard noises on walkie-talkie and tried to contact the chief officer. Immediately thereafter, master was informed, emergency alarm raised and emergency party was mustered who brought the injured persons into the accommodation. The vessel was diverted to nearest port and injured persons were landed ashore for medical treatment.

2. **Observations**:

2.1 The vessel's course was altered to 20 Stbd to prevent heavy swell from port bow prior to dispatch of crew to forward. The crew went forward from the Stbd side which was the lee side.

2.2 After the work was completed and on receiving information from the crew that they were returning to the accommodation, the master left the bridge and went down to check the conditions of a trg. GS who was suffering from severe stomach pain and vomiting.

2.3 The decision of the chief officer to turn back to go to the forecastle deck to attend to the anchor and the hawse pipe was not communicated to the bridge. The vessel being an fully loaded container vessel, it would not have been possible for the duty officer to site crew members from the bridge.

3. Work procedure and maintenance

Following internal technical failures were observed which were due to poor onboard maintenance contributing to incident.

- The chain locker could not be pumped out in time of emergency.
- Portable pumps were used to pump out fore peak store.
- The sounding of port chain locker could not be taken as the sounding pipe was choked.
- The port chain locker leaked to forepeak store from bitter end manhole.
- Port anchor chain bow stopper did not rest properly to make firm grip on chain in secured position and resulted in anchor banging to hull of ship.
- Improper securing of port chain locker spurling pipe and not re-ensuring water tightness of same before entering Arabian Sea in SW monsoon season which resulted in water ingress.

4. Conclusion:

4.1 Risk assessment was not carried out for this critical operation and full impact of situation emerged crew only on reaching fore peak store.

4.2 Heavy weather precautions were not taken for SW monsoon prior to entering Arabian Sea and prior sending crew on forecastle deck on the day of incident.

4.3 Considering the nature of work and the work being performed in rough weather with potential for hazards due to seas shipping on deck and rolling pitching of vessel, alteration of the course was not adequate.

4.4 The shipboard management did not ensure the heavy weather safety precautions like rigging of safety lines on exposed decks, ensuring water tightness of spurling pipes prior entering Arabian Sea.

4.5 The course of the vessel was not altered to avoid heavy seas shipping on deck while the injured crew were being brought back to the accommodation.

4.6 The vessel was unable to pump out chain locker and forepeak store in emergency situation and violated SOLAS requirement of pumping out arrangements for dry spaces forward of collision bulk head.

5. All Masters and ship-owners are required to take note of this casualty circular and MSC.1/Circ. 1228 (Guidance on hazards in adverse weather conditions that may cause capsizing of vessels or heavy rolling with risk of damage) to avoid similar accidents on their ships.

6. This issues with the approval of Director General of Shipping.

Sd/-

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