सत्यमेव जयते
भारत सरकार / GOVERNMENT OF INDIA
पत्तन, पोत परिवहन और जलमार्ग मंत्रालय
MINISTRY OF PORTS, SHIPPING AND WATERWAYS
नौवहन महानिदेशालय, मुंबई
DIRECTORATE GENERAL OF SHIPPING, MUMBAI

F. No.25-19011/6/2020-NT-DGS

Date: 03.11.2023

Casualty Circular - 02 of 2020

Sub.:Loss of life of a crew member due to falling overboard while working on deck

Summary of Incident:

On 21 May 2020, from 09:50 hrs to 11:00 hrs carried out dredging operation at the Paradip port channel. Thereafter, as part of normal operations, at around 11:20 hrs both the dredging suction tube/pipe were secured on the aft tube stand, and vessel commenced proceeding to dumping ground which was about 5 nm away from the port breakwater. Thereafter, both the dredging tubes were secured on board and power to the system was switched off, and Junior Officer (JO) who was also the tube operator was asked to go on deck to clear the debris from the both dredger suction tube heads. JO along with Deck Tindel, NCV Training Officer, and Helmsman (SHM) came down to deck to first clear the port drag head and then the starboard drag head. While starboard drag head was cleared, on port side a stone of about 1 m was found stuck which was cleared from the drag head onto deck, there after it was being pushed out using rope whose one end was held by SHM and other by Deck Tindel, while NCV Training Officer was pushing the stone out by legs. At this time the vessel was about 1.5 nm from the dumping ground with a speed of about 8 to 9 kts, and weather was calm with wind speed about 5 to 10 kts, it was at this time a freak wave was encountered which resulted in water on deck to about knee height, due to which caused the three personnel working on deck to fall, thereafter, as the water drained it was observed that the SHM was missing. JO immediately informed the bridge stating that the SHM has is overboard. Master immediately reduced the vessels speed, announced emergency stations, ordered preparation of starboard lifeboat and request Port control for assistance. In the meantime a body was seen floating with face down, after picking up, the SHM was found unconscious, first aid was given, CPR was administered and then transferred to hospital by port launch, where SHM was declared dead.

Causal Factors:

1. In adequate supervision while performing high risk tasks
2. In adequate risk assessment for tasks being conducted
3. In adequate communication and monitoring of bridge team in regard to persons working on deck
4. In adequate compliance with the company's safety management system procedures

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Action Taken:

1. Master raised emergency alarm, mustered crew and prepared rescue boat .
2. Lookout commence to locate the crew member who had fallen overboard
3. Crew member fallen overboard was recovered, given first aid and was transferred to port hospital

Lessons Learnt:

1. Bridge team is to monitor team working on deck especially close to the ship side and ensure adequate lee is to be maintained at all times.
2. Proper risk assessments is to be done for all high risk jobs, where all hazards are to be identified and required controls are to be put in place prior commencement of the job
3. Proper supervision is to be provided at all times

03/11/2023

(Capt. Harinder Singh)
Nautical Surveyor cum DDG (Tech.)

To,
All stakeholders through DGS website.