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 - 01 of 2023

## Sub.: Loss of life of Second Officer on board Dredger Vessel

**Summary of Incident:**

The vessel was carrying out the dredging operation in the port till very recently, and as part of the routine maintenance required after continuous dredge operations it was brought to jetty at port for routine maintenance work and inspection.

On 13.06.2023, in good weather, while the vessel was at port/berth, second officer and GP rating upon instructions of the chief officer proceeded to hopper for inspection in the floating pontoon. The floating pontoon was lowered into hopper with the help of moving crane on deck, and chief officer was supervising the inspection work from main cleck. The hopper was having water of about three meter depth, which could not be emptied. The floating pontoon was moved in water using two lines one at forward and one at aft part of the pontoon. After about 30 minutes of inspection at around 1135 hrs, due to instability of floating pontoon, the pontoon tilted to one side and toppled. This resulted in GP rating falling off, who swam to hopper pipe at the middle of the hopper. However, second officer who was wearing life vest and a safety harness which was hooked to the railing of the pontoon, got trapped and could not came out of the capsized heavy floating pontoon. GP rating tried to pull off the second officer but could not do so as his safety harness was tied to the pontoon railing.

At 11.37 hrs ship's general emergency alarm was sounded and announcement made on the ship's PA system, and all crew was mustered near the hopper. Meanwhile, some crew members went down into hopper through ladder with a knife they cut the safety harness of the second officer, and take him out of the pontoon. Upon retrieving the second officer, it was tried to remove the water from his stomach and CPR was given, at the same time port control was informed for ambulance. The ambulance and rescue team arrived at 1150 hrs and second officer was shifted to hospital, where he was declared brought dead.

**Causal Factors:**

1. Use of non approved and non certified equipment (ship made pontoon for inspection)
2. Lack of stability of floating pontoon. Pontoon not tested for stability.
4. Inadequate risk assessment and failure to identify potential hazards.
5. Failure to follow Safe Working Practice for Merchant Seaman.
6. Failure to follow and maintain hopper tank entry procedures
7. No standby person was available nearby which caused delay in rescue operation.

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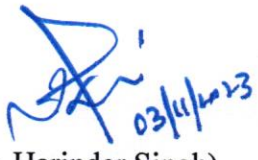
**Lessons Learnt:**

1. To consider implementing a tool box meeting prior to carrying out any work on hopper tank in order to make all involved aware of the potential hazards.
2. To develop and review SMS procedures for specific tasks onboard in order to ensure that all risks are well covered and that the procedures being followed.
3. Risk assessment procedure for maintenance and repairs in hopper tank to be reviewed and to take steps to ensure that the actions as per the check list are diligently followed.
4. Safe Working Practice to be followed while working in potentially hazardous area.
5. Company circular may be issued to all vessels under their management for using only tested, approved and certified pontoons for inspection of hopper.
6. Additional onboard safety training may be given to crew for working in hopper.




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

To,
All stakeholders through DGS website.