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:23.02.2024

Casualty Circular - 01 of 2024

Sub.: Annual Report – 2023 By the DG Communication Centre on the Incidents Reported – reg.

The international shipping industry is pivotal to the global economy by carrying about 80% of world trade by volume and the smooth running of the industry depends on a workforce of more than 1.6 million seafarers worldwide.

2. Recognizing that a proper analysis of marine casualties and incidents can lead to greater awareness of casualty causation and result in remedial measures, including better training, for the purpose of enhancing safety of life at sea and protection of the marine environment, the Directorate General of Shipping has developed an online repository for reporting and collecting the incident data at DG COMM Centre.

3. DG COMM Centre maintains an online casualty reporting module for all types of reported marine casualties and other casualties on board Indian vessels worldwide, to Indian seafarers on-board Indian and non-Indian vessels, and to other non-Indian vessels sailing within the Indian waters.

4. The detailed breakdown of incidents, their summaries, and lessons learned are provided in Annexure I for reference and continuous improvement. This annual report aims to serves as a valuable tool for stakeholders to understand, address, and prevent maritime incidents, fostering a safer maritime environment globally.

23/02/2024

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

To,
All stakeholders through DGS website.

9वीं मंज़िल, बीटा बिल्डिंग, आई थिंक टेक्नो कैम्पस, कांजुर गाँव रोड, कांजुरमार्ग (पूर्व) मुंबई- 400042
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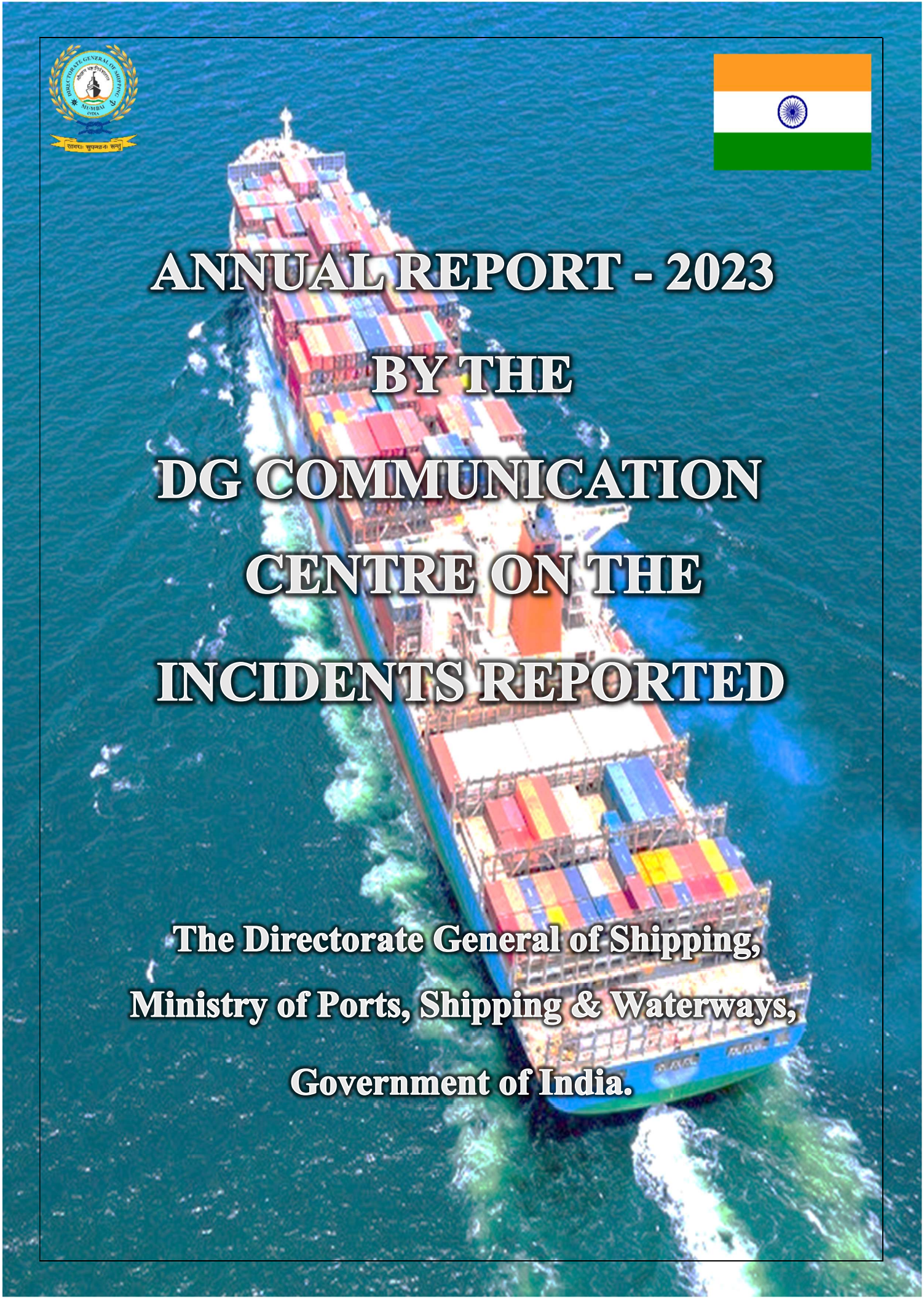

ANNUAL REPORT - 2023

BY THE

DG COMMUNICATION

CENTRE ON THE

INCIDENTS REPORTED

The Directorate General of Shipping,

Ministry of Ports, Shipping & Waterways,

Government of India.

Marine Accidents Statistics and Report

The international shipping industry is pivotal to the global economy by carrying about 80% of world trade by volume and the smooth running of the industry depends on a workforce of more than 1.6 million seafarers worldwide. In modern organisations, people are seen as the most valuable asset. This is certainly the case in shipping, and as such, crewing management is regarded to be crucial in their business operations by shipping companies.

Today, ships' seaworthiness, navigation and safety and the protection of the marine environment rank very highly among shipping political issues. Yet, the available published statistical data concerning marine casualties relate mostly to 'total losses'. Obviously, total losses are just the tip of a gigantic iceberg of marine incidents and a far more complete analysis of the causes, circumstances and consequences of all the major casualties recorded world-wide appears to be a prerequisite to the study of measures intended to improve the safety and cleanliness of shipping operations. Despite the continuous development of science and technology, maritime accidents still cause serious casualties and property losses, as well as pollution and ecological damage to the marine environment.

Recognising that a proper analysis of marine casualties and incidents can lead to greater awareness of casualty causation and result in remedial measures, including better training, for the purpose of enhancing safety of life at sea and protection of the marine environment, the Directorate General of Shipping has developed an online repository for reporting and collecting the incident data at DG COMM.

The DG Communication Centre (DG Comm Centre) established by the office of the Directorate General of Shipping, Mumbai maintains an online casualty reporting module for all types of reported marine casualties and other casualties on board Indian vessels worldwide, to Indian seafarers on-board Indian and non-Indian vessels, and to other non-Indian vessels sailing within the Indian waters.

Safety is a critical growth factor in any industry especially in shipping which is widely acknowledged as a risky and dangerous. In relation to this statement, equipping seafarers with the appropriate shipboard safety knowledge ensures that they are aware of the importance of keeping themselves and other people safe.

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Introduction

The Directorate General of Shipping, Mumbai, is pleased to present the annual report of the Directorate General Communication Centre (DG Comm Centre) for the year 2023. The DG Comm Centre was established in the year 2004 to facilitate the emergency response and reporting services in cases of Marine Casualty, Safety and Security and has played a pivotal role in the recent years as not only has the strength of Indian seafarers increased but also the increase in number of ships calling Indian ports. The DG Comm Centre has significantly established a seamless communication system for effective coordination among various departments and stakeholders, fostering interdepartmental collaboration, and ensuring swift responses during emergency situations. The Directorate General of shipping remains focused on improving safety at sea, information dissemination to the relevant stakeholders at the earliest and act as a catalyst for the response mechanism set up in cases of Marine Casualty.

In the pursuit of maritime excellence, the DG Communication Centre, established under the aegis of the Directorate General of Shipping, Mumbai, plays a pivotal role in fortifying the security, safety, and response mechanisms within the Indian maritime domain. This annual report serves as a testament to the centre's unwavering commitment to its objectives, highlighting key functions and achievements in the past year.

a. Security:

Adhering to the stringent standards set by the International Ship & Port Facility Security Code (ISPS), the DG Communication Centre diligently conducts periodic testing of Ship Security Alert System (SSAS) equipment. The centre serves as a linchpin for coordinating SSAS drills on board, ensuring preparedness for any security eventuality. Importantly, it acts as a central hub for receiving critical information on security incidents such as hijacking, piracy, armed robbery/theft, terrorism, and cases of stowaways and refugees on both Indian and foreign-registered vessels manned by Indian nationals. Our adherence to Standard Operating Procedures (SOPs) is unwavering, ensuring swift and effective dissemination of information in accordance with international and domestic protocols.

b. Safety:

In the realm of safety, the DG Communication Centre takes proactive measures to enhance maritime safety. By forwarding weather reports received from the Indian Meteorological Department (IMD) during cyclones, the centre contributes significantly to safeguarding

vessels, ports, and coastal areas. The meticulous recording of casualties, piracy incidents, accidents, and deaths on Indian ships and vessels manned by Indian crews serves as a crucial database for trend analysis and future prevention. The deployment coordination of Emergency Towing Vessels (ETV) on the East and West coasts of India, as per instructions from the Directorate General of Shipping (DGS), further underscores our commitment to ensuring the safety of maritime operations around the Indian coast.

c. Marine Casualty:

The DG Communication Centre's role in managing marine casualties is pivotal. Upon receiving requests from concerned Agencies and Authorities, DGS issues instructions, for deployment of Emergency Towing Vessels (ETV) through DG Comm Centre. Further, DG Comm Centre communicates vital casualty information to ships within the affected areas through Maritime Rescue Coordination Centers (MRCC) or the Indian Coast Guard (ICG). This showcases our dedication to regulatory compliance and effective communication during maritime emergencies.

As we reflect on the accomplishments of the past year, the DG Communication Centre remains resolute in its pursuit of maritime excellence. The commitment to security, safety, and effective response to marine casualties is unwavering, contributing to the overall robustness of the Indian maritime sector. Looking ahead, it remains dedicated to continuous improvement and innovation, ensuring that the seas under our watch are secure, safe, and resilient against unforeseen challenges.

d. Security & Safety Issues:

There has been an increase in incidents of piracy and armed robberies in the last quarter of the year 2023. The incident serves as critical case studies in understanding the evolving nature of maritime security threats. The calculated tactics employed by armed perpetrators highlights the ongoing challenges faced by vessels in high-risk areas. These incidents emphasise the imperative for continuous vigilance, strengthened security protocols, and collaborative efforts among international maritime stakeholders to ensure the safety and security of vessels navigating through these critical maritime regions.

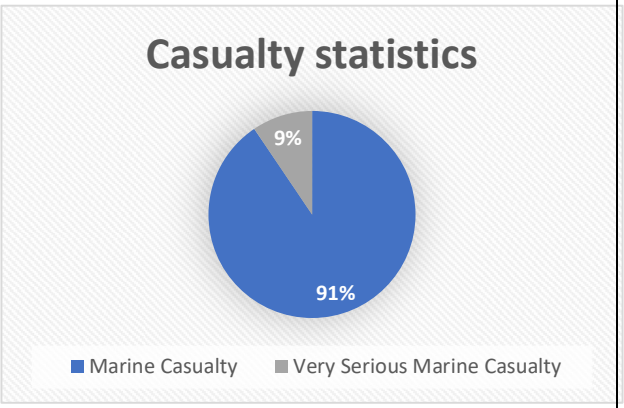
The stellar role of DG COMM in various recent incidents like ‘Chem Pluto’, STRINDA, ‘Swan Atlantic’, ‘Genco Picardy’ has been widely acknowledged by the Indian agencies and various stakeholders.

Analysis of Data

Data has been analysed for Marine casualty and very serious Marine casualty[1]. All in total 74 incidents were reported for the period 01st January to 31st December 2023 which were classified as per the above stated categories, which resulted in 08 deaths and 48 injuries.

Further, the incidents data has been analysed for

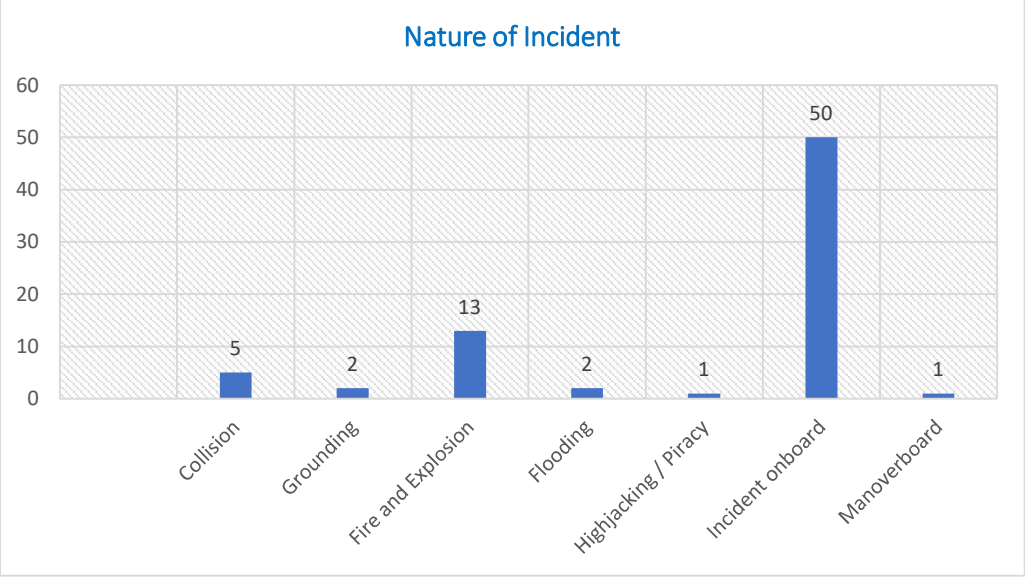
1. The nature of incident and its consequences
2. Flag state
3. Vessel Type and
4. Location of the incident



Nature of the Incident

a. Collision

In the year 2023 there were five reported incidents of collision which were all classified as a Marine casualty and did not result in death or injury of any personnel on these ships or any pollution. Of the five incidents reported two were on Indian flagged vessels in Indian waters and the remaining three were outside Indian waters.



[1] RESOLUTION MSC.255(84) – Definition as per Casualty Investigation Code

b. Fire and Explosion

There were 13 reported incidents of fire and explosion during this period which resulted in 05 deaths and 04 injuries. Of the reported incidents three incidents were classified as 'very serious' and accounted for the 05 deaths and 04 injuries. Notable amongst these were Oil tanker which reported explosion on main deck resulting in loss of three seafarers in Malaysian waters, a tanker which reported explosion on main deck in Chennai resulting in loss of 01 life and 03 injuries and fire on board a car carrier in North Sea resulting in loss of one life wherein the ship was abandoned. Of the thirteen incidents reported, seven happened in Indian waters.

Of the thirteen (13) incidents reported seven (07) happened in Indian waters[2].

Figure 1: Fire and explosion on tanker in malaysian waters and fire on a car carrier in North Sea

Chemical tankers and Oil tankers accounted for seven (07) incidents of the total.

[2] Waters up to Indian EEZ

c. Grounding

There were two incidents of reported grounding which did not result in any injury or death and neither did these incidents resulted in substantial damage to the vessel and were categorized as 'marine casualty'. Both the vessels were flagged in India , while one grounding happened in Indian waters on a inter island passenger vessel, the other reported incident was of bulk carrier outside Indian waters.

d. Flooding

There were two incidents of reported flooding which did not result in any injury or death and neither did these incidents resulted in substantial damage to the vessel and were categorized as 'marine casualty'. Both the vessels were Tugs and flagged in India.

e. Incidents on board

Majority of the incidents reported which contributed towards the casualty data were 'other incidents' on board which were incidental to the various shipboard operations, such as working at lathe machine, oil splashing from purifier, enclose space entry, etc. These incidents accounted for almost 67% of the total incidents reported which resulted in death of eight (08) and injury to forty seven (47) seafarers.

Following are the list of the incidents reported as 'very serious marine incidents'

(i) One fatality was reported while the crew member had gone on the forecastle to investigate ingress of water in forepeak and resulting heavy seas fatally injured the Chief Officer resulting in his death and injuries to three other crew members.

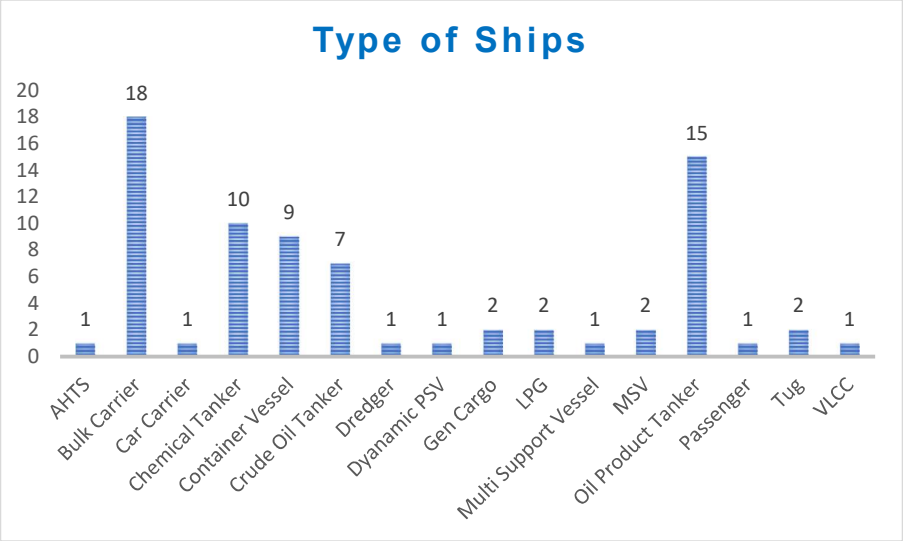
(ii) Four fatalities were reported due to entry in enclosed spaces where the atmosphere was not conducive and in one instance the person entering in the enclosed space had an underlying coronary issues and succumbed to the complications once out of the enclosed space.

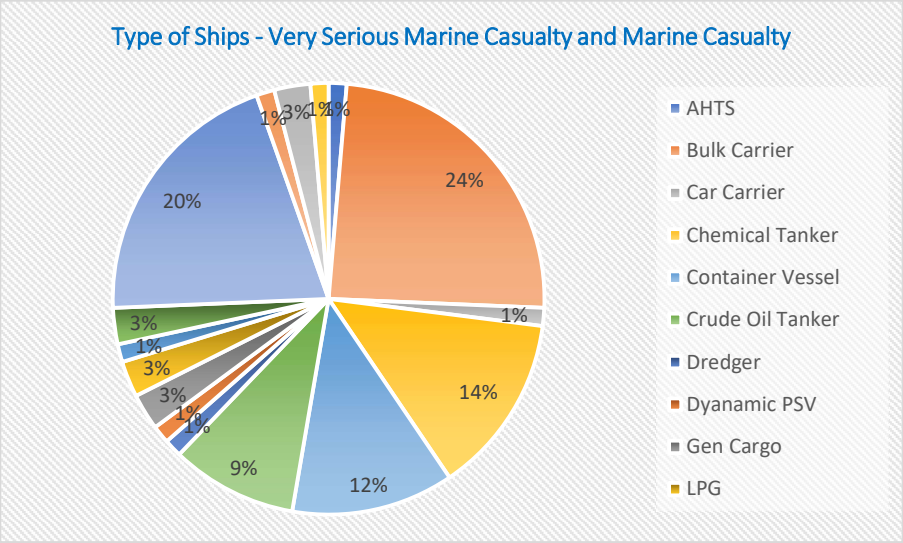
(iii) The other three instances of very serious marine casualty arose from 'failure of crane', drowning in hopper space of a dredger during routine maintenance.

Of the reported incidents in this category, 92% of the incidents happened outside Indian waters with 94% of the incidents reported from foreign flagged vessels.

Type of Vessels

Maximum number of incidents were reported from the bulk carriers, followed by Oil product tanker, container vessels, Chemical tankers and crude oil tankers





Flag of the vessels reporting incidents

Maximum number of incidents were reported from the ships registered with Indian flag, followed by Marshall Island and then by Hong Kong, Liberia and Panama with 10 incidents each

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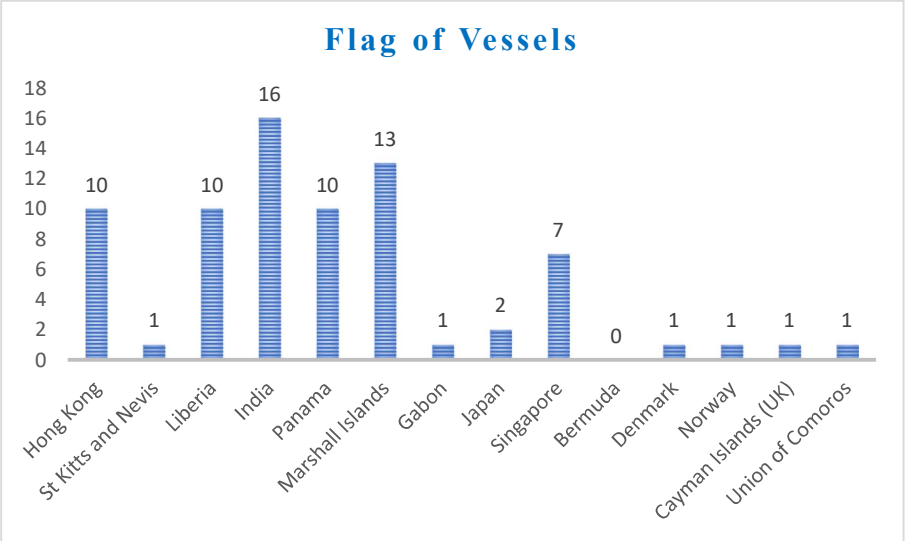
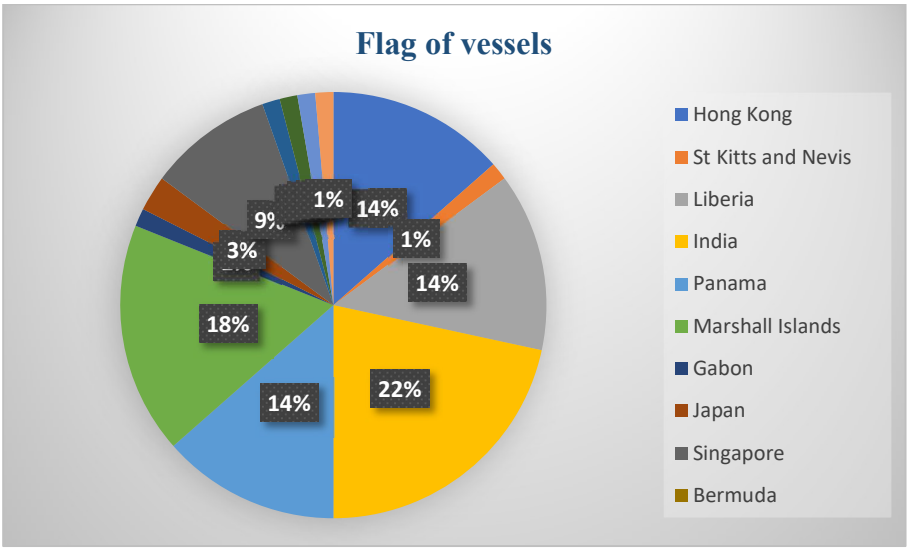
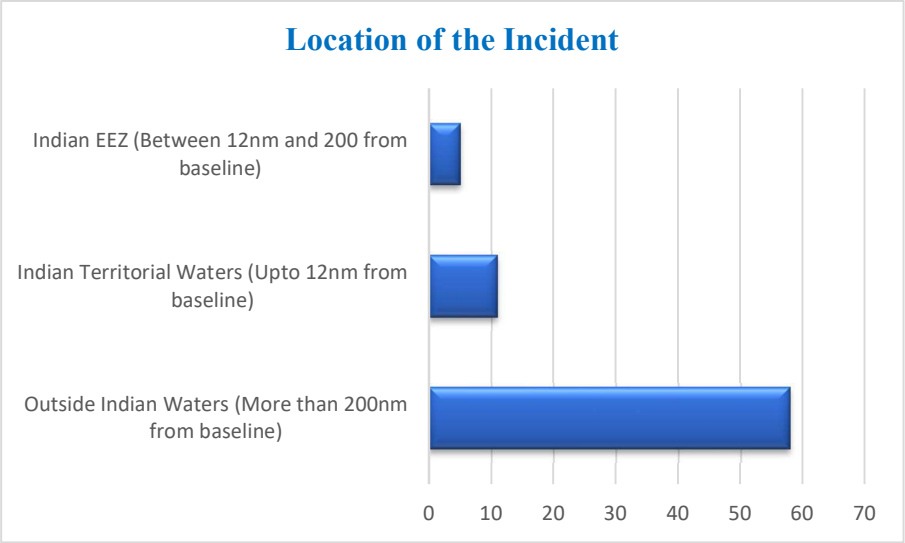


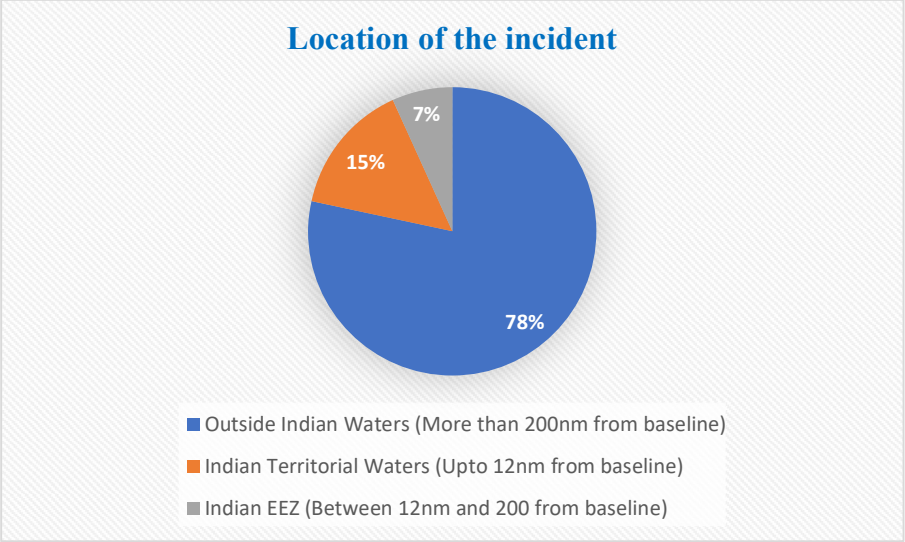


The numbers of incidents happening on Marshall Island, Hong Kong, Liberia and Panama are also indicative of the large number of Indian seafarers serving on these vessels and also must take cognizance that these flags are amongst the top five registries in the world.

Location of the incident

Maximum number of incidents were reported from the outside Indian waters with 58 incidents followed by incidents occurring in territorial waters followed by between Indian Territorial waters.





This is a continuous process, where we try to learn from various incidents happening in the maritime industry, with an endeavour to disseminate learnings to all stakeholders to avoid reoccurrence of incidents, thereby improving safety culture in the maritime industry as a whole.

List of various reported incidents including, summary of the incidents and lessons learnt from those, is attached as Annexure I.

Conclusion

In conclusion, the Annual Report for the year 2023 provides a comprehensive analysis of incidents reported. Over the specified period, a total of 74 incidents were documented, falling into categories such as Marine Casualty and Very Serious Marine Casualty. The detailed examination of data encompassed factors like the nature of incidents, flag state, vessel type, and location of occurrence. Notable incident categories included collision, fire and explosion, grounding, flooding, and incidents on board, with Bulk carriers, chemical tankers and oil tankers accounting for a significant portion. The report also highlights incidents categorized as 'very serious,' emphasizing the need for ongoing learning and dissemination of lessons to enhance safety culture within the maritime industry. The detailed breakdown of incidents, their summaries, and lessons learned are provided in Annexure I for reference and continuous improvement. This annual report serves as a valuable tool for stakeholders to understand, address, and prevent maritime incidents, fostering a safer maritime environment globally.

ANNEXURE - I

Sr. no	Incident Date	Ship Type	Incident Category	Severity of Incident	Brief summary of Incident	Brief summary of action taken	Lessons learnt
1.	04/01/2023	AHTS	Flooding	Marine Casualty	On 04/01/2023 around 0440 hours, the vessel reported that the steering gear compartment bilge high level alarm was activated & upon inspection the steering gear compartment was found flooded. During the inspection found all equipment up to upper gear box of azimuth system submerged & resulting each propulsion was lost. Pumping out the water started immediately and BT started for maneuvering purpose. At 0343 hrs, bilge alarm of steering compartment was activated in ECR. The alarm was acknowledged by duty engineer, but no action was taken. As per statement of duty engineer, attempt was made to enter steering compartment but same was aborted due to heavy weather. Chief Engineer and Wheelhouse were not informed about the alarm and subsequently no other action was taken.	Upon further investigation, it was noted that water ingress was due to open port side booby hatch of Steering Gear Compartment. The alarm indication of the port side booby hatch of the Steering Gear compartment was disabled by Ship's staff hence there was no indication in ECR for the open booby hatch. The company immediately informed DG com centre, DG shipping classification society, Indian coast guard for the same. Continuous monitoring of the vessel situation & condition on phone as well as mail was being done Salvage Tug was mobilized on 04.01.2023 but it could depart Mumbai port only on 05.01.2023 at about 0700 hrs due to logistical reasons. On 06.01.2023, Vessel's crew reported that there is considerable reduction in height of water level by continuous pumping out of water, the salvage tug reached location of the stricken vessel at 0115 hrs on 07.01.2023, connected towline of the vessel at 0212 hrs and started towing both the vessel and the barge. The position report was forwarded to MRCC every two hours and reached Mumbai harbor at 2200 hours on 11.01.2023.	a. Before departure to sea watertight integrity to be checked & ensure by ship staff that vessel is safe to sail high seas & log entry to be made of the inspection. b. Copy of inspection report to be sent to DPA / ADPA for verification & conformation to sail high seas. c. Following shall be ensured prior departure from port and at all times during the voyage: i. The alarm monitoring system of all watertight doors are activated. ii. All watertight doors/booby hatched are closed properly. iii. The inspection cover of the watertight compartment below the shark jaw/towing pin is properly secured. iv. There is no leakage of water from shark jaw/ towing pin into the steering room. v. All air vents of steering room are in proper condition.

Sr. no	Incident Date	Ship Type	Incident Category	Severity of Incident	Brief summary of Incident	Brief summary of action taken	Lessons learnt
					At about 0800 hrs, wheelhouse reported erratic behavior of pitch system of starboard azimuth thruster and emergency stop was pressed. Port main engine had already been shut down for regular maintenance. Attempts were made to clutch in both main engines to azimuth thrusters but same failed. Thereafter, ship's staff entered steering compartment and found ingress of seawater up to the level of about 1.5 meters.		
2.	17/01/2023	Chemical Tanker	Incident onboard - Personnel Related	Marine Casualty	17th of Jan 2023 – 3/E replaced a rotary wire brush during routine maintenance of equipment, with the intention to buff the boiler fuel oil pump suction strainer cover, which was held in the workshop bench vice. On fitting the new rotary wire brush into the pneumatic tool, he started the machine to buff the cover. Contrary to company instructions	Special Safety meeting was carried out by the Master with all the crew. During the safety meeting the incident along with the safety precautions required to be taken by the crew discussed. Compliance with planning assessment of risks and importance of toolbox talk highlighted. - Specific onboard training was carried out by the C/E for air driven grinder. Further, a ship specific training agenda focusing on the following was carried out:	Where tasks are carried out without adequate planning, assessments of risks, there is an increased probability of an incident/injury occurring. - Prior use of any power tool check the compatibility of equipment to the rotation head (in this case brush). The rotational speed as specified for the power tool, must be less than max rotational speed of the consumable fitted to the power tool (in this case a rotary wire brush). - Wearing the appropriate PPE for any job is mandatory. Type of PPE

Sr. no	Incident Date	Ship Type	Incident Category	Severity of Incident	Brief summary of Incident	Brief summary of action taken	Lessons learnt
					the crew member was not wearing full PPE. After a few seconds of use, a stray metal wire from the rotary wire brush penetrated his left eye. The 3/E stopped the pneumatic tool and immediately removed the stray wire with his hand and used the eye wash to clean the eye.	a) Compatibility checks for equipment, with particular reference for rotary machinery. b) Pre-checks and tests that need to be done prior to use of any rotary equipment. c) Period checks of rotary pneumatic tools to confirm that the test speed is as per the rated speed. d) Use of the correct PPE, appropriate for the task being carried out - Fleet wide - Learning from incidents - Highlighting the issues identified and prevent recurrence sent. - Follow-up training was delivered by attending Superintendent.	worn must relate with the hazards and control measure to be implemented as indicated in the Risk Assessment and PPE matrix. - Generic risk assessments available in the QMS are to be made ship specific and used.
3.	31/01/2023	Tug	Man Overboard	Marine Casualty	Tug along with Barge were at Port Khalid, UAE on 31-01-2023. At 2320 hrs on 31-01-2023 2nd Eng & duty AB informed Master of Man Overboard. Chief Officer was found unconscious in water. Rescue operation was carried out. On 01-02-2023 0100hrs C/O was disembarked on another vessel for taking ashore for medical assistance as he was found unconscious. Port control and DPA were informed.	C/O had expired. NOK was informed, and company is in touch with principal owner, as mortal remains under UAE police for investigation and principal owner following rules and completing the formalities. Mortal remains of Chief Officer pending to be repatriated to India on 20.02.2023	Man overboard is a potentially dangerous situation for a ship at sea, at anchorage or even alongside in port. Among the many threats that could undermine the accidents, man falling overboard is one of them. Unfortunately, according to a report, a high percentage of all overboard incidents end in death. It is therefore very important for the ship personnel to act immediately and execute the correct recovery methods so that the life of the person in water is not endangered. Some of the reasons why seafarers go overboard in the sea are: Accidents such as loosing footing on deck, being swept overboard by

Sr. no	Incident Date	Ship Type	Incident Category	Severity of Incident	Brief summary of Incident	Brief summary of action taken	Lessons learnt
							waves, being pulled by mooring ropes Falling from an accommodation or ladder climbing on ton to or sitting on the ship's railings Being under the influence of alcohol or drugs Working in low visibility or in rough sea conditions
4.	10/02/2022	Oil Product Tanker	Incident onboard	Marine Casualty	On 10/02/2023, while the vessel was drifting off Osaka Bay, the incident occurred while the fitter was working on the lathe machine for polishing the pump spindle. The fitter's gloves got stuck in the lathe machine and injured his right-hand little index finger. The cause appears to be the thread inside the gloves that cut his finger while the gloves were stuck. RMA was contacted and first aid medications were given as per RMA advice. The fitter was medevaced to a local hospital and the NOK was informed.	Radio medical (RMA) was contacted, and First aid medication was given. The dressing was done and medication was administered immediately. The pain subsided and the fitter was stable with vitals normal and monitored continuously on board. On 10/02/2023, at- 1605 LT- The fitter was medevaced and moved to a local shore hospital for further treatment. 1900 LT- He was hospitalized at Kindai University Hospital. He was surgically operated on in the hospital. NOK was contacted and informed about the finger injury and hospitalization of the fitter. Upon the requisite treatment at the shore hospital, he was repatriated to India. He was treated until fitness and he was later on fit for sea service. He was paid partial disability compensation, for the loss of part of	• Once relevant permits/checklists are completed same is to be cross-checked by management team members (top 4). • Work on pressurized systems should be properly organized and all the safety barriers must be established and cross-checked by another team member. • Risk assessment must be discussed prior to work during the toolbox meeting.

Sr. no	Incident Date	Ship Type	Incident Category	Severity of Incident	Brief summary of Incident	Brief summary of action taken	Lessons learnt
						his right index finger as per IBF NUSI CBA.	
5.	24/02/2023	Container Vessel	Incident onboard - Personnel Related	Marine Casualty	Injury on board- Fall from 4 meters height while climbing down from a vertical ladder in the cargo hold. On 09/02/2023, when the vessel was enroute from Coronel, Chile to Hongkong. At 1110 SMT, OS proceeded to check the bilge alarm in Cargo Hold no. 1 from aft vertical ladder. OS took the lead and Cadet followed him. Cadet held a torch in his left-hand wrist whilst climbing down the vertical ladder and in the process of climbing down the ladder from the first platform to the second he lost balance as he let off his right hand to climb down the ladder holding the ladder with the left hand and torch around his wrist and fell from a height of about 4M to second platform seriously injuring his left elbow/arm.	10/02/2023- the NOK was informed and the cadet spoke with his family as advised by the Fleet personnel manager. Preparations were made to medevac the cadet from the nearest port 11/02/2023- after informing charterers, and agents in Papeete along with JRCC Tahiti & registering the vessel with the JRCC, the vessel deviated to Papeete-Tahiti for disembarkation of cadet.From 12/02/2023 to 14/02/2023- daily updates of the vitals of the injured cadet were given to 3Cube Medicare, JRCC Tahiti, Charterers, and owners; and the treatment of the cadet continued. On 14/02/2023- the crew was briefed and prepared for Helivac operations and JRCC Tahiti was updated onthe rendezvous position and the injured cadet was prepared for Helivac. 1745 LT- the vessel arrived rendezvous position and confirmed Helivac from the port bridge wing 1802 LT- the Helivac personnel landed on the vessel	Working at Height COSWP: Section 17.3.6- Personnel negotiating a ladder should use both hands and not attempt to carry tools or equipment in their hands. When working, three points of contact with the ladder should be maintained (both feet and a handhold). For hands-free operation, it is strongly recommended that the crew should either use an LED headlamp on the Safety helmet he wears or carry a Safety Torch embedded with a strap used for slinging around the shoulder.

Sr. no	Incident Date	Ship Type	Incident Category	Severity of Incident	Brief summary of Incident	Brief summary of action taken	Lessons learnt
						1816 LT- the injured cadet was winched up in the helicopter, along with his baggage. 1818 LT- the rescue personnel also winched in and the helicopter cleared the vessel to resume passage. The vessel resumed passage to Hongkong and all the parties were informed about the successful Helivac of the injured cadet. After Helivac, the injured cadet was admitted to a hospital in Papeete, Tahiti. He underwent a surgery on dislocated left elbow, after which he was repatriated back to his home port. Further medication and physiotherapy were ongoing.	
6.	25/02/2023	Bulk Carrier	Personnel Related	Marine Casualty	During voyage from Adelaide Australia to Singapore 25/02/2023 at 1845LT, the right hand thumb finger of AB got crushed in between WT Door and door compression bar while closing accommodation upper deck WT Door on the portside. Due to this his right thumb was injured with lacerated cut and heavy bleeding and suspected fracture. Crew member tried closing the	Immediately vessel sought Medical Advice from Company Doctor and CIRM Telemedical Advisory and gave him First Aid/ Treatment as per Doctor's advice. Vessel also contacted Nearest Port Esperance, Australia for Medical Evacuation. At 2300 Lt/25th Feb 2023, Vessel was diverted to Esperance port with Maximum Speed. Crew was disembarked on 26th Feb 2023 and admitted at the Esperance Regional Hospital. AB was admitted to Fiona Stanley	1) Crew should be extremely careful and attentive when opening/closing watertight doors. Notice to be posted on W/T doors, Caution "Prone to get injured if the W/T door is not handled with care. Crew were advised to keep all door closed when vessel is underway and be vigilant to make sure that Watertight doors are properly secured when it is open for use. 2) The importance of the proper weather assessment while working on deck is to be discussed and this has to be made aware to all the crew

Sr. no	Incident Date	Ship Type	Incident Category	Severity of Incident	Brief summary of Incident	Brief summary of action taken	Lessons learnt
					watertight door with one hand instead of using both hands without realizing that the vessel was slightly rolling. This resulted in the bone of thumb getting crushed.	Hospital for further treatment and then was sent from Esperance to Perth by a Flight for repatriation.	members. It is to be borne in mind that watertight doors are heavy and hence close with great force. Hence never to keep the hand near the frame of the door where the door will close. 3) Lack of situational awareness while opening/closing watertight doors may cause serious accidents. A case study is to be prepared and during the pre-joining crew safety briefing, this case is to be discussed and the crew is to be made aware of the consequences of bypassing safety. 4) This incident report and the investigation report was circulated to other fleet vessels to avoid such incidents. 5) All crew members have to be made aware that no shortcuts are to be made and use proper safe working procedures such as using both hands, Positioning the body correctly before carrying out the job etc to be observed to avoid such incidents.
7.	28/02/2023	Crude Oil Tanker	Fire & Explosion	Marine Casualty	Smoke in the pump room. On 27/02/2023, the vessel berthed at Vadinar SPM at and commenced cargo unloading at 1848LT.	The ship's crew tried to enter the pump room to investigate the cause of incident; however, due to thick smoke and poor visibility, the crew could not enter the pump room.	1. COPT parameters to be closely monitored during discharge operation.

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					During the course of cargo discharging, on 28/02/2023 at around 0530LT, COP # 1 RPM suddenly shot up to 2500rpm and got tripped and smoke was observed coming out of the pump room. Cargo unloading was immediately stopped. The ship's emergency team swung into action and simultaneously, the shore contingency team was constituted and manned at the designated Contingency room of the Shipping house. A line of communication and close monitoring of the situation was established and confirmed between the ship and shore office.	Therefore, the pump room was sealed after switching off the blowers and closing the vent flaps. Boundary cooling started from the engine room COPT platform and bulkhead temperature was continuously monitored. Meanwhile, the SBM Cargo hose was disconnected for casting off the vessel in the event of any kind of emergency arising out of the above situation. It was observed that the pump room bulkhead temperature gradually came down from 200 degrees at 0700LT to 59 degrees at 1200LT on 28/02/2023. CO & 2EO entered the pump room with SCBA sets to assess the situation inside the compartment. At 1740 hrs, it was confirmed that there was no fire or source of ignition and after checking thoroughly, Pump room ventilation was started. The vessel staff carried out the damage assessment and preliminary incident investigation. A detailed investigation was done once the pump room condition improved and became suitable for man-entry. The terminal decided to cast off the vessel from SPM for safety reasons and the vessel was later safely anchored at the designated Vadinar anchorage area. Boundary cooling	2. All Lights/Electrical fittings in the pump room are to be checked regularly. 3. Fire patrol rounds must be performed effectively. 4. Test and checks on critical equipment including fire detection system, alarms, trips and various interlocks should be performed routinely. 5. Emergency drills to be carried out in realistic manner and should be as close as possible to actual Emergency situation.

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						continued along with monitoring of bulkhead temperature. It was found that bulkhead temperatures were subsiding gradually and smoke was also reducing considerably. Internal and external communication of the incident was carried out with the Port, Terminal, Head office, charterers, class, insurance, and Flag Administration as per the requirement.	
8.	02/03/2023	Container vessel	Incident onboard - Personnel Related	Marine Casualty	During Mooring operation at Aliaga (Turkey) Bosun attempted to put one of the Forward Spring lines into the Dead man roller fairlead guide, while the rope was running out by gravity. The Rope jumped over the guide and roller and struck the OS on his right side .He was immediately rested. He continued routine work from next day. Few days later he complained of discomfort and chest pain	Remote medical assistance was taken. The recommended pain killers and analgesic gel were administered to OS . Over the next few days his pain continued on & off. 3Cube recommended X ray at next port call Pireaus . The X ray showed his left thoracic chest cade were found fractures at 5 places. He was hospitalized and later brought back home after initial treatment and fit to fly. He is presently fit for Duty.	1. Mooring operations is one of the most high-risk operations onboard containers vessels 2. Lack of situational awareness during mooring / unmooring operations is leading cause of mooring -related accidents. 3. Poor Communication and unsafe acts follow situational awareness as other leading causes. 4. The high number of mooring / unmooring during numerous port calls tends to make crew and officers overconfident and complacent. 5. Risk assessment must be discussed prior work during the toolbox meeting.
9.	05/03/2023	Crude Oil Tanker	Incident onboard -	Marine Casualty	Injury -2nd Degree Burns on thighs	Immediate first aid was administered to the burn area by running cold water on the affected area and later burn	• Ensure that proper testing and checks are conducted during equipment overhaul and replacement

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			Personnel Related		On 04/03/2023 around 1920 LT, the vessel was at sea when the 2nd engineer accompanied by the Chief Engineer reported on the bridge that the 2nd engineer had suffered a burn injury while working on the boiler water circulating pump. New spares for Boiler water circulating pump No. 2 were received, at Houston on 21/02/2023 and it was planned to replace the mechanical seal. On 03/03/2023, the Boiler water circulating pump was isolated. The pump was removed, shifted to the workshop, and overhauled. New mechanical seal with shaft renewed. The pump was fitted back on 04/03/2023. Inlet outlet valves were opened and the mechanical seal was found to be leaking. Inlet and outlet valves to Boiler water circulating pump No. 2 were closed and the plan was to slack the	cream was applied. 2nd engineer was advised to take rest and anti-pain medication was administered. Radio medical advice was sought from the company doctor. The vitals of the 2nd engineer were checked and found normal. The same was informed when seeking RMA and the medications prescribed by the doctor were administered to the patient.	to identify any potential issues before starting operations. • Maintain a safe distance and wear appropriate personal protective equipment when working on equipment that may contain hot or pressurized fluids. • Implement safety protocols and procedures for depressurizing and handling potentially hazardous equipment to minimize risks to personnel. • Regularly review and reinforce safety training for all crew members to enhance awareness of potential hazards and safe work practices.

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					mechanical seal cover and re-tighten it. To work on the mechanical seal cover, the 2nd engineer wanted to depressurize the Mechanical seal leak offline. He slackened the coupling to release pressure; the line was intact and did not move from the valve on the cooler. Thinking there was no pressure in the pipe 2nd engineer decided to remove the coupling entirely and moved the pipe, suddenly the hot water trapped in the cooler sprayed onto his legs as he was working very close to the pipe due to the congested location causing 2nd-degree burns.		
10.	11/03/2023	Crude Oil Tanker	Incident onboard - Personnel Related	Marine Casualty	Injury to the shoulder of AB. On 11/03/2023, the vessel was at No.1 Algoa anchorage, Port Elizabeth. At 1000 LT, when picking up stores and provisions from service launch by port quarter provision crane, the head block wire guide steel	The incident was reported by the Chief officer to the bridge at the same time. On examination, a small but deep wound was observed with blood oozing out. First aid was administered to stop the bleeding and the wound was dressed. Marine superintendent, agent, and MHR informed.	• All shipboard cranes are to be thoroughly visually inspected. Particular attention is to be paid to the non-load-bearing components as they escape scrutiny during crane load tests. • Close-up inspection required on the lifting appliances including the non-load bearing parts of all lifting appliances. Ship staff were urged to

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					preventer rod of the crane which prevents the runner wire from jumping out of the sheaves, dislodged and fell on the AB causing injury on his right shoulder.	At 1216 LT, the injured AB disembarked on the service launch which had brought the provisions along with the agent & off-signers. At 1853 LT, the vessel was informed by email from the agent that the AB was declared unfit for sea service by the doctor and after necessary treatment would be repatriated to India. Lab tests and x-rays were taken ashore, and type 1 AC joint dislocation was observed. At 2000 LT, personal belongings and all documents of AB were landed in service launch. After repatriation, AB reported at the Maritime Medical Consultancy clinic in Kolkata, India on 16/03/2023. Type 1 injury was diagnosed on the right A-C joint. He was reviewed on 17/03/2023 and asked to report for review after 6 weeks (1st week of May 2023). He was declared Unfit for sea service.	report without delay to the Department heads if any part of the lifting appliances were found not in good order or condition to take adequate measures to avert an incident in the future. • Inspection of the head block wire guide steel preventer rod of the crane must be included in the PMS as applicable. All cranes are to be thoroughly inspected and similar items not available must be included in the PMS in order not to miss out during inspections.
11.	15/03/2023	VLCC	Incident onboard-Personnel Related	Marine Casualty	Injury to right-hand middle finger. On 15/03/2023, Engine Cadet while wiping some spilled water in the changing room inadvertently placed his hand on the door frame and due to the sudden rolling of the vessel the door	The chief officer and 2nd officer were called immediately and administered first aid. The wound was disinfected and the cadet was shifted to the ship's hospital for further treatment. Subsequently at 1214 LT, the vessel's manager was informed about the incident, and at 1238 LT, the vessel sent a message to CIRM for medical advice.	- Lack of situational awareness is one of the leading causes of personal injuries. - Hazard assessment is a must for even the most routine job. -Weekly accommodation inspection of living quarters should focus on identification of any unsafe conditions.

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					slammed shut and caught his right-hand middle finger causing amputation of the terminal part of the distant phalanx. The Engine cadet entered the engine room with an injured middle finger of the right hand. His right-hand middle finger had got stuck in between the door and door frame of the engineer's changing room. On examination, the tip of the finger was found cut. Immediately first Aid was given on board and remote medical assistance was sought from CIRM. Further medical treatment was arranged at Hong Kong after medevac of the Engine Cadet on 16th Mar 2023.	At 1800 LT, after discussion with the office and CIRM, the vessel received orders to proceed to Hong Kong for medical evacuation of the cadet. Further medical treatment was arranged in Hong Kong after the medevac of the Engine Cadet on 16/03/2023. Later he was certified fit for Duty.	
12.	04/04/2023	LPG	Incident onboard - Personnel Related	Marine Casualty	Injury on board. On 04/04/2023, 1115 LT, at berth, Onsan Wharf no. 6, Ulsan, the Chief Officer slipped on the main deck (due to salt deposits on deck) when returning after checking line valves. The impact was on the shin of	Crew members immediately came to his aid upon witnessing the incident and promptly radioed the Master to inform him. The Master directed the crew members to transfer the injured Chief Officer to the hospital. Immediately stretcher was arranged and chief officer was transferred from deck to the hospital on the stretcher.	1. All safety pathways on the deck are painted with an anti-slip coating on top. 2. Carried out extraordinary safety meeting onboard. 3. Safe movement briefing for ship staff. 4. Prior Arrival Port, Deck shall be washed with fresh water, in order to

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					the right leg against Deck Catwalk supports, resulting in Fracture. First aid on board administered. Agent was informed at 1120 LT for immediately arranging an ambulance. At about 1230 LT, ambulance arrived and CO was lowered ashore by crane by ship's crew. At 1300 ambulance departed for further treatment ashore. Chief officer medically signed off for further treatment. Medical Surgery was carried out ashore and after recuperating Chief Officer was repatriated to his Home Town.	In the hospital, the ship staff applied Splints and Bandage around his right leg below the knee and he was administered pain killers. Agent was informed at 1120 Lt for immediately arranging an ambulance. At about 1230 ambulance arrived and CO was lowered ashore by crane by ship's crew. At 1300 ambulance departed for further treatment ashore. Fracture Distal tibia RT & Fracture Proximal Fibula by X-Ray & CT scan, declared unfit for Work. After receipt of the above report, Chief officer medically signed off for further treatment. Medical Surgery was carried out ashore and after recuperating Chief Officer was repatriated to his Home Town.	avoid salt deposits and associated slipping hazard. 5. Carry out training of ship staff using reflective learning 'It will never happen to me' Excerpts of investigation report of the incident.
13.	08/04/2023	Bulk carrier	Incident onboard - Personnel Related	Marine Casualty	Vessel was at Port Narvik , Norway for loading cargo. Decarb of Main engine Unit No. 5 was planned on 08 April 2023. While lifting the cylinder head , the E/R crane was not properly aligned with the cylinder head, which led to the cylinder head swing abruptly while lifting it from place and Oil	Oiler was admitted to UNN Narvik Hospital and he underwent surgery in the Hospital. After successful surgery, he got fit to fly certificate and got discharged from hospital. Flight tickets were arranged to fly him home safely with required wheel chair assistance.	1. Risk assessment must be discussed prior work during the toolbox meeting. 2. Engine room crane was not aligned with cylinder head which led cylinder head swung & hit the leg of oiler. 3. Engine room crane must be properly aligned right over the object to be lifted.

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					Oiler Oiler-1 leg came in between the cylinder head and M/E pipelines resulting in fracture of his leg . Oiler -2 who was in the team responsible to clean the cylinder head informed the CE (who was working down in the crank case) , that oiler - 1 has met with an accident and has pain in his left leg which afterwards was found to be fractured. Immediately the Master was informed by the CE regarding the accident and shore medical assistance was called.		4. Negligence and lack of awareness with regard to lifting of heavy weights by crane are leading causes for the accident. 5. Over confidence, Poor supervision and unsafe acts are other leading causes. Engine room crane NOT to be operated without engineer's supervision.
14.	09/04/2023	Chemical Tanker	Collision	Marine Casualty	Collision On 09/04/2023, 2320 hrs, the Pilot boarded the vessel for shifting her. After the anchor was aweigh at 2342 Hrs LT, the SM proceeded at a safe speed. At 2345 hrs, the Pilot and the Bridge Team noticed a vessel fine off the bow showing both the masthead lights and the 'RED' portside light. This v/l was identified as an outbound	On 10/04/2023 at 0006 LT, vessel dropped anchor nearby. Immediate damage assessment was commenced on collision and after anchoring detailed assessment was carried out. Between 1500 to 1740 LT, inspection was done by P&I, Company local fleet superintendent & Owner's representative. UW survey was carried out of Forward part from BT tunnel to the bulbous bow. UW Survey recordings/reports verified by ABS Surveyor, P&I Inspector and Owner's representatives.. Vessel	1. The incident along with the initial lessons learned were shared with the fleet. 2. Though the Pilot has detailed information of the port approaches and vessel movements within the port, the bridge team reliance on the Pilot should be reasonable., i.e., the bridge team should be always in compliance with COLREGS and other requirements of the port/ terminal.

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					vessel. The pilot tried to contact the other vessel, but without success. At around 2350 hrs, the other vessel did a bold alteration to her port when she was less than 0.3 miles. The course alteration was immediately apparent to the bridge team, and they realized collision was imminent. The vessel stopped engines, immediately followed by astern propulsion and the release of the starboard anchor to get all way off, however the ships collided. The vessel suffered damages on her bow well above the waterline, whereas the other vessel suffered damages on her starboard side including the accommodation block.	shifted from anchorage to berth for cargo discharging. Owner's rep, agent also boarded. Master along with agent were at the Harbour Master's office for interrogation regarding the incident. Vessel commenced discharging on 12/04/2023 at 1705 LT and completed on 13/04/2023 1540LT. At 1725 LT, pilot boarded, vessel unberthed and departed at 1815 LT. The ship was scheduled to complete discharge of the on-board cargo and then proceed to Singapore for permanent repairs under Class supervision. A full investigation into the incident was ongoing and the report and the root cause analysis shall be reported to the Flag State. The vessel was at the Indonesian port of Serang and after discharge of the second parcel she was to proceede to the next Indonesian port for discharge of the last parcel.	3. Besides sharing the incident and lessons learned, the investigators will engage with the Company Training Team to review the existing training/ simulation scenarios. 4. A Navigation safety meeting and safety stand down was conducted. Master's and Navigation officers will be briefed on the incident.
15.	09/04/2023	Oil Product Tanker	Collision	Marine Casualty	M.T. Marvels departed from Kakinada on the 6th April 2023 and was bound for the port of Vadinar for loading her next nominated cargo. On the 9th April 2023, whilst enroute in Lacadive	1. Immediate reporting to the authorities and other stake holders 2. Briefing of the Bridge Team on the Incident 3. Meeting with on board staff and Incident Investigation conducted by DPA	1. Failure to notice and acquire target on Radar to ascertain CPA / TCPA 2. Change over to hand steering need to be done for any actions taken during avoiding close quarters situation 3. Bridge Team awareness is of utmost importance during navigation

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					Sea around 65' off the coast of Colombo, Sri Lanka vessel had a probable soft contact with a wooden fishing boat in position 06°30.7'N / 078°49.7'E at 0547LT. The incident did not result in any reported loss of life, or any pollution. No damages or scratch marks were observed on the shipside of the vessel.	Effective communications emphasized to all fleet	4. Utilization of vessels Engines whilst taking avoiding action in close quarter situation 5. Optimum use of Radars at adequate range scale and tuning for best output is required during navigation 6. Effective communication and reporting to give a full appraisal of the situation at hand. 7. Execution of adequate and timely actions to avoid any such situations in future.
16.	20/04/2023	Bulk Carrier	Grounding	Marine Casualty	Grounding outside river channel while approaching Machong port, China during pilotage, due to failure of steering gear controls. The vessel was under pilotage towards Machong, China on 14/04/2023 for discharging the cargo in bulk. On 16/04/2023 at 1950 LT, the vessel was doing course 343 degrees at a speed of 10.4 knots under pilotage in a very narrow channel.	The vessel's rudder got stuck 10 degrees to port, and then the duty AB on the bridge tried to give the helm to STBD (starboard side), but there was no response. At the same time, the bridge informed E/R and tried the Non-Follow Up (NFU), but it did not work. At 1955 LT, the E/R tried to give the helm to midship with emergency steering, the helm responded to midship and was found working. At 1956 LT, the pilot ordered to let go of the port anchor. By 1956 LT, the vessel was already around 0.24 NM away from the channel and had grounded and listed to port by 1 degree. The depth of grounding on charts was around 7- 14 meters around the vessel. At 2000 LT, the vessel was holding to port 2	• Manoeuvring operation is one of the most high-risk operations onboard a vessel during narrow passage. • Duty officer to start the 2nd steering motor when 1st steering motor fails. • Lack of situational awareness in the bridge team is the leading cause of navigation-related accidents. • Lack of timely maintenance of machinery follows situational awareness as another leading cause. • Steering gear directional solenoid valves should be overhauled at every special survey. • Risk assessment must be discussed prior to maneuvering

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						shackles on deck. E/R told to take soundings of bunker tanks. The crew started taking sounding (measurement of the amount of fluids in the tanks) of all tanks, and void spaces for any ingress of water. The E/R was instructed to take soundings of bunker tanks. The C/O started draft checks. Till 2000 LT, the vessel checked the condition of the Hull and superstructure and it was found satisfactory. The pilot called tugs to proceed to Shajiao anchorage no. 45, and with 4 Tugs refloated vessel. The anchor was weighed and the vessel dropped anchor at above anchorage. At 0036 LT on 17/04/2023, the vessel was brought up. The vessel was at anchorage, awaiting MSA inspection. Later an arrangement was made for Class & P and I surveyors to investigate further. An underwater inspection was also arranged. At 2115 LT, out of 6 tugboats that came for re-floating the vessel, 2 tugboats made fast on the port quarter, 1 tugboat made fast right astern, 2 tugboats pushed from STBD quarter, and 1 tugboat pushed from STBD mid ship. Steering checks were carried out and both motors were working satisfactorily. At 2114 LT 1st tug made fast at aft. 2120 LT	operations in narrow passages during the toolbox meeting.

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						two tugs made fast on the port quarter. 2 tugs started pushing from the STBD quarter, and one tug from STBD mid ships. At 2130 LT vessel started re-floating with the help of tugs. At 2135 Lt they commenced heaving port anchor, at 2148 LT anchor aweigh, sighted & clear. At 2150 LT, the vessel entered the channel with course 342 speed 5.3 knots. At 2345 LT aft tug made fast for proceeding to anchorage. The vessel proceeded to Shajiao anchorage no. 45. The ship crews sounded all ballast tanks, fresh water tanks, and oil tanks after the accident happened. It was found no change in comparison with the arrival condition of all tanks e. The underwater inspection was carried out on 18/04/2023, at Shajiao Anchorage. As per the Underwater Inspection Report it was noted that during the diving inspection, no deformation, damage, dent, or other abnormalities were found on the inspected parts. After the accident happened, ship staff checked the steering gear system and found the directional solenoid valve of the No. 1 steering gear was malfunctioning, which was replaced by a new one.	

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17.	28/04/2023	Petite Soeur	Collision	Marine Casualty	A laden vessel was shifting from one terminal to another after completion of part discharging as per voyage orders. Pilot and mooring master for the next berth boarded the vessel for shifting. Vessel unberthed from the terminal with the assistance of 3 tugs (2 made fast and one assisting). After casting off, the vessel was required to swing to port, cross the south-west bound lane of a traffic Separation Scheme and join the with a dredger vessel that was proceeding in the north-east lane of the TSS. Vessel sustained damages to north-east bound lane of the TSS to proceed to her next berth. While crossing the TSS, vessel made contact north-east bound lane of the TSS to proceed to her next bertWhile crossing the TSS, vessel made contact	On 28-Apr-2022 immediately after the collision, the vessel manoeuvred to port to keep clear of the other vessel and to assess the extent of the damage on own vessel. The master asked the forward station if the bow had made contact with the other vessel, which they confirmed. The master asked if they could see the bow and if any damage was visible. The forward station reported that there was about a one-meter dent on the bulbous bow. The vessel reported to VTMS about the incident, and they requested the vessel to assist the dredger. The master ordered the rescue team to muster and prepare to launch the rescue boat. VTMS also instructed another nearby vessel also to proceed for rescue. At 2215 hrs the rescue boat was lowered, but the operation had to be aborted due to prevailing sea conditions. The vessel was then turned around to create a lee. The rescue boat was again lowered into the	Based on the investigation, the collision between vessel and dredger was caused by a combination of immediate and underlying factors, including inadequate communication, lack of situational awareness, and Lack of compliance of Standard rules and company procedures. The human element played a significant role in this incident, including decision-making ability and distractions caused by AIS error, VHF communication, and meeting with the mooring master. Furthermore, the accident was exacerbated by excessive reliance on the pilot, failure to utilize all available means in accordance with COLREG, such as radar and ARPA, and the absence of an additional lookout. This incident highlights the importance of ongoing training for bridge teams, including the enhancement of their situational awareness and decision-making abilities.

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					with a dredger vessel that was proceeding in the north-east lane of the TSS. Vessel sustained damages to her bulbous bow, without breach of hull and the dredger vessel capsized after the collision resulting in 2 casualties and 3 missing crew members.	water at 2230 hrs. The rescue team proceeded to conduct a search around dredger but could not find anyone to rescue. They also observed that the vessel had capsized completely. It was noticed that the other nearby vessel as instructed by VTMS, had already started rescue operations and had recovered 15 of the 20 crew members from the capsized dredger. Once it was established that no more survivors could be found, the rescue team returned to the vessel, and the boat was picked up on board.	It is also crucial to prioritize effective communication and collaboration with pilots and other navigational components to avert future incidents. The accident happened because neither vessel appreciated the risk of collision in sufficient time to take effective avoiding action and pass at a safe distance. The investigation has also highlighted risks associated with the inappropriate use of VHF radio and AIS information when assessing risk of collision. The collision occurred within a recognised vessel traffic service (VTMS) area; however, the vessels were not warned of the developing risk by the shore authority responsible for traffic safety in the area.
18.	01/05/2023	Crude Oil Tanker	Fire & Explosion	Very Serious Marine Casualty	Major Explosion on Board; Fire on board; Death & Injury. On 01/05/2023, about 1430 LT, the Gabon flagged crude oil tanker with 28 crew members caught fire about 37.5 nm NE of Tanjung Sedili, Malaysia. The incident of fire was reported on cargo deck while work. The ballast	Emergency Communication & emergency procedures were established. Concerned Authorities were informed regarding the incident. Crew were rescued and bought to the safe location and NOK informed. Family member of 3 Missing Crew where informed about this incident and Search and rescue operation and	1. Safety procedures: emphasizing the importance of strict safety procedures and protocols on tanker vessels, including handling hazardous materials, fire prevention, and emergency response. 2. Training: providing comprehensive training to crew members on how to handle cargo, machinery, and emergency situations, as well as proper maintenance of equipment.

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					tanks may not have been gas free, which could have resulted in the fire incident. The vessel was on its voyage to Singapore from China. 25 crew members were rescued (18 crew members were rescued by crude oil tanker MS ENOLA and seven crew members were rescued by another vessel EVER BLISS) with 03 crew members reported missing. A search operation was initiated by Malaysian Maritime Enforcement Agency (MMEA) on 02/05/2023. According to MMEA, 03 crew members (02 Indian and 01 Ukrainian) had died as on 03 May 23.	also were kept updated every 12 hours, Continuous communication and monitoring the SAR with Singapore MRCC and Malaysian Maritime enforcement agency for 3 missing crew. Medical Assistance was given to all rescued crew.	3. Risk assessment: conducting thorough risk assessments to identify potential hazards and mitigate them through preventive measures. 4. Communication: ensuring clear and effective communication among crew members, especially when assigning jobs on equipment containing hazardous and flammable gases. 5. Emergency response plans: developing and regularly practicing emergency response plans and frequent training, to minimize casualties and environmental damage. 6. Regulatory compliance: adhering to international and local regulations regarding the transportation of hazardous materials and implementing recommended safety measures. 7. Human factors: recognizing the role of human factors, such as fatigue, stress, and crew training, in preventing accidents and improving overall safety. 8. Continuous improvement: encouraging a culture of continuous improvement in safety practices and technology to adapt to evolving risks and challenges.

Sr. no	Incident Date	Ship Type	Incident Category	Severity of Incident	Brief summary of Incident	Brief summary of action taken	Lessons learnt
							These lessons aim to enhance the safety of tanker vessels and reduce the likelihood of explosions and their associated consequences.
19.	02/05/2023	Bulk Carrier	Personnel Related	Marine Casualty	Vessel departed Puerto Drummond (Columbia) on the 24th of April 2023 and was scheduled to arrive Sao Luis (Brazil) on the 2nd of May 2023. On 1st May, while the vessel was at sea in latitude 02:09N and Longitude 046:31W (North of Brazil coast), the chief Officer and deck cadet entered the Dirty Water tank on the port Side. They lost consciousness in the tank. The ship's crew rescued both crew members to the open deck. Both Crew members were unconscious when brought out of the tank. They were given medical Oxygen to revive. The Chief officer regained consciousness, but deck cadet was not showing signs of improvement. Immediately the captain	Master then contacted ISOS (They provide 24 x 7 medical advice to masters on MTM ships).ISOS advised Master to administer medication to the deck cadet, after which his breathing improved for some time. Later it was again reported that he had difficulty breathing and body was stiffening. ISOS then advised keeping the deck cadet in a sitting position. The Deck Cadet was moved to the sitting position, but his breathing was not improving, and he was vomiting. ISOS then instructed further medication after which deck cadet`s body was reportedly easing up. The oxygen levels were reported back to normal but shortly after it was reported his body was stiffening again. . Contact established with MRCC Belem, Brazil and the vessel was diverted to Belem. The vessel was about 180nm away from Belem. MRCC was requested for helicopter medical evacuation of the Chief Officer and deck cadet.	Lack of Risk Perception and Risk Awareness. Chief officer was under the assumption that the tank was small and would not contain any harmful gases. Unsafe practice. The chief officer demonstrated poor judgement and complacency. There was no attempt by him to test the atmosphere and to ventilate the spaces using forced ventilation. Lack of Assertiveness by Cadet. The cadet was well trained for enclosed space entry procedures. He allowed the chief officer to follow unsafe practice. Failure to follow procedures. Tank and Enclosed entry procedures (SAF 0050 and SAF 0055) were not complied by the persons entering the Dirty Water Tank (Port). Inadequate work process planning. Daily toolbox meeting procedures (SAF 0100) was not complied with. The plan to discharge the Dirty Water Tank (Port) by opening the manhole and making a man entry was not

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					contacted International SOS(ISOS) for medical advice. Same time the MTM offices were informed. The decision was taken to immediately divert the ship to the nearest port - Belem. Brazil MRCC at Belem was contacted for air lifting (medical evacuation) of the deck cadet and the chief officer. The Shore medical team from ISOS provided the necessary guidance, but deck cadet could not be revived and was later declared as "deceased" by them.	Company Emergency Response team appointed agents and local P&I correspondent to facilitate medical evacuation. MRCC later advised that a helicopter was not available at Belem. ISOS instructed Master to carry out the following checks on the deck cadet. Torchlight focused on pupils for any response: found both left and right eye pupils not responding . The cadet was declared deceased.The doctor declared the deck cadet as deceased basis the observation reported to him.	discussed in the Daily toolbox meeting.
20.	02/05/2023 04:15 AM	General Cargo	Collision	Marine Casualty	On 02nd May 2023 a collision occurred between a vessel and a dingy boat in position 11 46.692N 092 48.578E at 0415 hrs on 02.05.2023 whilst the vessel was approaching Port Blair Anchorage. Interview of Master and crew revealed that a collision had occurred between the dingy boat and Vessel while the boat was	Vessel reduced the speed and maintained a reciprocal course for searching for any casualties. Master informed Port Blair Port Control and called & sent message to MRCC Port Blair and continued searching the above mentioned area for any casualty. As per the Master, speed of the vessel was reduced and a reciprocal course was maintained for searching the area for any casualties. The Master of the vessel informed Port Blair Port Control at 0426 hrs and later during the day break they	a. Small fishing/wooden boats are always not having any means of communication & Navigational lights, so it is always advisable to have close watch on boats in near vicinity to understand their intention. b. Inadequate comprehension / misjudgment of the developing situation by the Master and the entire bridge team. c. Improper handing over of bridge watch by Second Officer. d. The Chief Officer took over the watch without being properly

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					trying to cross the vessel's bow. There was no light illuminating from the boat initially before the incident but at very last moment they lit one red light, immediately vessel gave one prolonged blast on ship's whistle and flash light also shown to the boat. Vessel immediately altered course to port but collision could not be avoided as the boat tried to cross the vessel's bow.	found some floating grocery items, but no casualty was sighted by them, thereafter MRCC was informed by the Master at 0515 hrs (approx. 01 hour after incident). Around 0954 hrs vessel was allowed to proceed to North Point anchorage by MRCC Port Blair. It was informed by the SIC, MMD Port Blair that the dingy boat had sunk and two personnel of dingy boat were rescued by Indian Coast Guard. Later on Indian Coast Guard (ICG) also started searching the area by Helicopter and two personnel of the dingy were rescued by ICG The PI Report indicated that there was a failure to follow the basics of Bridge watch keeping and failure to implement the emergency response procedures by Bridge Team. Vessel's, Bridge team was unaware of their responsibilities and obligations with regards to Safe Navigation. Delay and hesitation in using main engines for desired r.p.m / speed changes proves lack of awareness of Navigation officers in the Emergency response procedures. The dingy boat sank and two personnel of dingy boat were rescued by Indian Coast Guard with no other causalities. The Master of vessel	appraised of the developing situation. Prior taking over bridge watch, proper assessment of the developing situation was not carried out by Chief Officer. e. The OOW was not aware of his authority to use Main engines in emergency. The standing order of master should have made it clear that during emergency situations using of main engines is at duty officer's discretion. The navigating officers seemed unaware of the emergency response procedures. f. Look outs posted during 0000-0400 watch were not certified watch-keepers. g. Company's SMS procedures pertaining to familiarization with duties and emergency response not effectively implemented onboard. The master's standing order or night order had no mention for use of main engines in emergency, if required. h. Failure to comply with Bridge Watch keeping Duties. The Chief Officer and Second Officer should have been aware of their responsibility and authority as per COLREG. i. Lack of Familiarity of shipboard operations. Main Engines were not used during emergency as

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						failed to provide assistance to persons in distress at sea. Master / Crew did not release MOB marker or lifebuoys even after realizing that vessel had a collision with dingy boat. It indicates that failure to render assistance to the persons in distress. Company's SMS procedures pertaining to familiarization and emergency response appear ineffective.	officer on watch was unaware that he can use Main engine in case of emergency. j. Qualified and certified Bridge watch keeping personnel not assigned for lookout duties. The Master should not have allowed such a breach of applicable rules and regulations / STCW. k. Lack of Communication between Engine Room and Bridge is evident from sequence of events and subsequent statements of crew members. Engine Room was manned, but no communication was made between Engine Room and Bridge during incident. As per statements, duty engineer was totally unaware of the developing situations. l. Master didn't carry out the Williamson Turn as required by IAMSAR after the collision with the Dingy boat. m. After the incident the search carried out was not as per the procedures/requirements of international or national regulations. Although contact was made with MRCC Port Blair, no follow up was done on the search and rescue co-ordination. n. The collision of vessel "ITT Jaguar" with the dingy boat "Ganga

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							Sagar" was a result of sequence of errors, lack of competence and utter disregard to comply with rules and regulations by the onboard vessel "ITT Jaguar" Bridge team.
21.	06/05/2023	Oil Product Tanker	Fire & Explosion	Marine Casualty	Vessel picked up pilot at 1712 hrs/06.05.2023 on arrival for berthing at BD3, Chennai. While the vessel was getting alongside berth with pilot on-board, Engine room informed master that there was heavy smoke observed near Auxiliary engine no.3 and its control panel and black out occurred. Since there was no ship's power available for cargo unloading except essential power supplies from emergency generator, pilot on-board decided to take the vessel to inner anchorage with the help of 3 tugs under cold move at 1825 hrs. Subsequently, vessel was safely anchored 1.5 miles from brake water at Chennai inner anchorage.	- Ship's emergency team swung into action and simultaneously, shore contingency team was constituted and manned at designated Contingency room of Shipping house. - All engine room personnel came out of the engine room by 1800 hrs and head count was taken - Chief engineer decided to release the fixed CO2 system for engine room. - All preparations were made for release of CO2 in engine room and by 1815 hrs CO2 was released in the engine room. - Boundary cooling continued till the boundary temperatures became normal. - After 12 hours of boundary cooling, ventilation of the engine room commenced for man entry for damage assessment. - Stand-by tug arrangement was made to deal with exigency due to total power loss at inner anchorage. - At 1353 hrs/07.05.2023, Master & CEO completed damage assessment	1. Planned maintenance of of all Auxiliary engines including its associated piping system to be carried out effectively. 2. Tightness of all bolts/unions/connections of all fuel oil and lubricating lines to be checked thoroughly. 3. The insulation/lagging/cladding of all hot surfaces to be maintained in good order at all time. 4. Regular safety rounds and proper monitoring of all running equipment to be done that can help in avoiding recurrence and reducing extent of damage. 5. Adequate protection and shielding of pipe flanges, unions and joints on all pressurized Fuel oil/ Lube oil lines. 6. Good housekeeping standard to be maintained on-board at all times and all oily rags or inflammable materials to be kept at designated safe places only.

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						and confirmed substantial damage to Auxiliary engine no.2 and 3 including cables passing from their vicinity. - Vessel was brought alongside New Coastal berth at Chennai on 12.05.2023 for carrying out fire related damage repair work. - All fire related damage work were completed at NCB berth, Chennai on 09.08.2023 and vessel shifted Chennai anchorage for resuming her commercial activities.	
22.	17/05/2023	Chemical Tanker	Incident onboard-Personnel Related	Marine Casualty	Injury on board. On 17/05/2023, 1610 IST/1400 UTC, 3rd Engineer accidentally injured his left ring finger (crush injury) during routine maintenance of Auxiliary Engine. After overhauling the fuel pump and whilst putting back in normal position and when pressing the pump in the correct position, the pump slipped and his left ring finger got caught between the seat and body of the fuel pump. The middle finger bones were found broken but the phalange was still attached to the metacarpal.	1. Initial observation found that 3rd Engineer sustained injury in his tip left ring finger. The affected area was cleaned by antiseptic solution, and dressing applied for the affected finger to stop bleeding. 2. 3rd Engineer was thereafter given painkillers and taken to his cabin for observation and support. 3. Master Immediately reported to the Office and requested Med Sea (Medical advisor) for medical treatment recommendations. 4. May 20, 2023 3E was taken to the Hospital at Algeciras anchorage. 5. May 21, 3Eng's finger was operated on (Wound cleaning, stitching, splint dressing. 6. May 21, 3Eng's was sent to the hotel for observation.	1. Accidents can happen anytime without any warning. 2. Toolbox meetings including On-Site toolbox meeting and robust risk assessment are integral part to any routine or non-routine task – No Onsite Toolbox meeting conducted & No Risk Assessment was carried out for this job as was considered as a routine task. 3. Risk assessment should be specific to the task and should address any hazard entailed within. Use of overhead chain block was not considered. 4. Compliance with company's SMS / PPE Matrix /checklists should NEVER be a paper exercise. Required PPE was in use but was removed during the job, hence bypassing the safety.

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						7. May 26, 3Eng was flown back to India to visit the company doctor and was thereafter repatriated to his hometown. .	5. Do Not commence any task without being certain that the safety concerns have been addressed. 6. Do Not succumb to imagined time pressure or the urge to complete the task in a hurry by bypassing safety protocols.
23.	17/05/2023	Oil Product Tanker	Incident onboard - Personnel Related	Marine Casualty	Injury on Board. On 02/05/2023, 2230 LT, when vessel was at Oil Tanking Jetty No 2 / Karimun / Indonesia, Trainee Engine Rating (TER) was on watch with 4th Engineer during unloading operation. He was coming down from Engine Room ECR Platform to 2nd Platform, while coming down his leg twisted, as he slipped and had a minor fall on the platform. On 03/05/2023, 0900LT, the TER reported swelling on the ankle area of the left leg. Master asked for doctor visit in Karimun, but as per agent no doctor was available in Karimun & disembarkation is not possible.	While coming down through ladder from engine room ECR platform to 2nd platform TER left leg twisted when he was at the 2nd last ladder platform, because of twist he slipped and had a small fall on the same platform. Afterwards 4th Engineer with the help of Engine Cadet was moved him to his cabin and asked to take rest. First aid was administered on board. Till this point it looked completely fine and only very slight pain on the left leg Dorsum of Foot/ Metatarsal Bone. Radio medical advice was requested. On 03/05/2023, 1229LT, when vessel was at sea, radio medical advice was received for ankle sprain. Medications were advised but TER refused to take them & allowed only ice pack to be used stating that pain has reduced & he is feeling normal with slight pain whilst walking. On 16/05/2023 when vessel was in Kuwait TER was sent ashore to the hospital for checkup. Diagnosis was	It was an accident of slipping and falling resulting in fracture when vessel was in port. Adequate precautions should be taken against trips and falls while carrying out routine and non- routine tasks onboard.

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						fractured base of leg. Treatment was administered & plaster cast was applied. He was declared unfit for duty & his repatriation to India was arranged.	
24.	19/05/2023	Oil Product tanker	Incident onboard - Personnel Related	Marine Casualty	Injury on board-Burns. On 17/05/2023, 1400 LT, at sea during Generator No. 1 overhauling, C/E and Motorman suffered serious first & second-degree skin burns due to hot lube oil (temp 250 'C) bucket accidently falling on their bodies in E/R workshop. C/E sustained 2nd degree deep & superficial burn injury on right hand. right leg, thigh & right. side of face. Fitter suffered 1st & 2nd degree superficial burns on rightt arm, knee & face. Master decided to divert to nearest port Cochin for treatment.	During Generator No. 1 overhauling, C/E and Motorman suffered serious first & second-degree skin burns due to hot lube oil (temp 250 'C) bucket accidently falling on their bodies in E/R workshop. Master decided to divert to nearest port Cochin for treatment. On 18/05/2023, 0742 LT, vessel arrived at Cochin port inner anchorage and both the crew were disembarked for further medical treatment. They were admitted in Sunrise Hospital, Cochin and found to be stable after undergoing treatment. CE underwent surgery including skin grafting on 20/05/2023 and due for dressing change after 5 days, and the fitter underwent standard treatment. Both were declared unfit for duty. Fitter was found fit for duty from 02/06/2023 & C/E declared fit for duty w.e.f. 17/07/2023.	1. New SMS procedure to be revised to include following 2. Heating the oil in open container is prohibited in Engine Room. 3. Standard and marine approved Oil bath with thermostat can be used for calibration of thermo meters only. 4. Shrink fit bush must be cooled down in cold rooms for easy installation.
25.	23/05/2023	Bulk Carrier	Incident onboard - Personnel Related	Marine Casualty	Injury on board. On 23/05/2023, 1120 LT, when vessel was enroute from Mizushima to	Pilot was informed regarding the bosun's injury and need evacuation from nearest port. All parties were informed about the incident & need	1) All crew need to be aware of proper and effective use of PPE. (2) All deck officers and crew should be fully familiarized with the hatch

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					Newcastle Australia via Seki Saki & was transiting the inland Sea of Japan under pilotage, Master reported that Bosun injured his hand, whilst working during hatch cleaning operations. He was found sitting on deck with his left hand severely injured with some fingers dislodged & bleeding heavily.	for evacuation in view of the injury. At 1150 LT, the vessel was diverted to Port Fukuyama, Japan for Medical Evacuation of the Bosun. At 1355 LT, vessel arrived Fukuyama anchorage & dropped anchor. At 1408 LT, Japanese coast guard boarded vessel for accident investigation & at 1425 LT he was airlifted and later admitted to a hospital in Higashi, Hiroshima. Coast guard personnel left vessel at 1630 LT. On 24/05/2023, 1146 LT, vessel departed Fukuyama anchorage & resumed passage. The ship managers. as agents for Owners informed the Owners, P&I Club & local agents. They appointed their local correspondent who attended to Bosun's treatment and care. The Next of Kin of Bosun was notified.	cover safe operating procedures, including guidance contained in the manufacturers operating manual (3) Clear warnings of intended operation of hatch covers must be communicated to duty crew and shore workers on deck (3) Prior to opening or closing hatch covers, a thorough check should be made to Ensure track ways are clear of obstructions and no persons are standing near or resting on the coamings during operation (4) Crew should be assigned to ensure the coamings remain clear during operation and means of immediately alerting the operator to stop clearly established. (5) Hatch cover opening & closing at any point of time is physically supervised by an officer apart from the Crew members involved in the operation.
26.	04/06/2023	Multi Support Vessel	Fire & Explosion	Marine Casualty	Vessel was working at Neelam platform in Mumbai High. All the 4 no's auxiliary Engines were running during operation. Leakage started from ' O' ring of the fuel oil outlet pipe line due to loosening of holding bolts of flanges while Auxiliary	2nd Engineer observed fire at Aux Engine no. 4, B-Bank turbo charger. The Auxiliary engine was immediately off loaded, stopped/isolated. Manual fire alarms and announcement on PA system were done. AE no. 4 was stopped. Vessel proceeded to a safe location away from its DP, crew were mustered, head count taken. At 1406	1. Adequate precautions, safeguard, regular fire rounds shall be performed effectively to prevent any fire incident. 2. The inspection of fuel oil lines, connections, clamps and other securing arrangements associated with Auxiliary engines shall be carried out properly

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					engine No 4 was in operation . This resulted in bleeding of fuel line and sprayed on hot surfaces of turbo-charger casing of B bank which caused fire. The Auxiliary engine was immediately off loaded, stopped/isolated. Shipboard contingency team extinguished the fire using water spray from charged hose . Boundary cooling was continued and temperatures was consistently monitored.	LT, fire pump was started and ventilation and electrical power supply was cut off. Boundary cooling was started on main deck and fuel tank area. Firefighting teams were deployed. At 1408 LT, NLM control was informed regarding fire. NLM informed that Ocean Garnet and a Crew boat were sent for assistance. At 1418LT, undesignated distress message was transmitted and later designated message was transmitted MF / HF, VHF. Ocean Garnet was standby for assistance along with another vessel Emerald. At 1500 LT, fire was fully extinguished, temperature was reducing and cooling continued. At 1505 LT, all other vessels departed and only Ocean Garnet was standing by for assistance. At 1506 LT, NHAVA and NLM were informed that fire was extinguished and all under control. At 1518 LT, distress message was cancelled on VHF Ch. 16 and on MF/HF. At 1618 LT, Ocean Garnet was released and informed to MLM control. Reason for Fire: AE#4 was running on load, AE#4 B-Bank fuel oil out let pipe flange bolts sheared off and fuel oil was falling on B-Bank turbo charger and got fire. On 05-06-2023	3. Adequate inspection for proper shielding of the flanges, joints, securing bolts of fuel oil lines associated with auxiliary engines shall be carried out regularly. 4. Continuous and regular operations of Auxiliary engines and rounds on it should not become a complacent trend and watch keepers should not take it granted for the fail-safe operation of equipment. Thorough rounds to be taken on running equipment. 5. Undertaking regular fire drills for preparing the crew more confident enabling them to act promptly, efficiently in any emergency situations, therefore all vessels are advised to undertake such drills as per the plans and based on real situation. Shore office shall monitor on the above for strict compliance.

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						master reported that vessel is at BFL waiting for berthing instruction.	
27.	05/06/2023	Bulk Carrier	Incident onboard - Personnel Related	Marine Casualty	All crew members were assigned inside accommodation cleaning job due to rough weather. Crew member was carrying out cleaning job inside the A-Deck accommodation. He was called on B-Deck Alleyway to clear the water from alleyway (which resulted due to FW line leak in Cabin store on same Deck).He started to clear the water from the alleyway and clean the store room. When the vessel started rolling moderate to heavily the crew member held on to the storm railing with his right hand to prevent falling. Suddenly the vessel rolled over to the other side making him lose his balance but he held on to the railing with his left hand too; However during this time his leg slipped	All crew members were asked to stop the work , vessel course was diverted to avoid rolling for the purpose of providing first aid to crew members and carrying out remaining work Pain relieving tablet was administered & RMA-Seabird & CIRM ROMA was contacted for further medical advice. The evening of same day "STIMSON MANEUVER" carried out as per the RMA instruction to bring the shoulder back to the original position. However "STIMSON MANEUVER" did not result in success & further advice was obtained from RMA. RMA provided the medication and treatment which was complied with and it was decided to divert the vessel and airlift the patient. JRCC Juneau instructed vessel to proceed at rendezvous position which was 50nm NW of Dutch Harbor (Alaska). Crew member moral was kept high during the course of treatment & medication. Vessel arrived at Rendezvous position on 07-Jun-23/1000Hrs LT /1800 UTC and at 1100 Hrs LT	Weather condition was not favorable for carrying out any work on main deck and hence crew were instructed to work inside accommodation. This resulted in a sudden change of planned work. The Fresh water leak in the cabin store caused water to flow in the B-Deck alleyway. Lack of situational awareness and risk perception lead to this injury.

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					and his left shoulder got twisted. This caused dislocation of left arm humerus bone from the shoulder blade with severe pain.	injured crew was air lifted and medevac completed successfully. He was later on treated successfully at Mumbai under the guidance of the company Doctor.	
28.	13/06/2023	Dredger	Incident onboard - Personnel Related	Very Serious Marine Casualty	The vessel which is a 2001 built Trailing Suction Hopper Dredger (TSHD) was under contractual agreement with Paradip port Authority for carrying out the maintenance dredging. The vessel was carrying out the dredging operation in the port till 05.06.2023. The dredger needs maintenance after doing continuous dredging work every month. The vessel was brought to jetty and secured alongside CQ-3 berth on 05.06.2023 for routine maintenance work and inspection. On 13.06.2023, at around 11 am after taking precaution Second officer and GP rating on instruction of chief officer proceeded to hopper for inspection in the floating	At 1137 am general emergency alarm sounded and announced in PA system, people gathered at hopper. The seaman who was with 2/O asked for knife to cut the safety belt, meanwhile one assistant machinist, one SHM and workshop personnel went down into hopper through hopper ladder with knife cut the rope, removed 2/O out, placed on the hopper pipe removed water from stomach and first aid (CPR) given. Meanwhile port control was informed and project office for ambulance. Ambulance and rescue team arrived at approx1150 LT, 2nd officer lifted with the help of crane in the basket and landed directly at the ambulance at 1200 LT. 2/O was taken to the hospital where the doctor's tried their best and finally informed the casualty as brought dead.	a. 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. b. To develop and review SMS procedures for specific tasks on-board in order that all involved are aware of procedure. c. Risk assessment procedure for maintenance and repairs in hopper tank to be reviewed and actions in check list to be diligently followed. d. Safe Working Practice to be followed while working in potentially hazardous area. e. Company circular may be issued to all vessels under their management for using only tested, approved and certified pontoons for inspection of hopper. f. Additional on-board safety training may be given to crew for working in hopper.

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					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 deck. The hopper was having water of about three meter depth, which cannot be emptied. The floating pontoon is moved in water by two lines attached to it at forward and aft part of the hopper tank. After 30 minutes of inspection at around 1135 Hrs, due to instability of floating pontoon, the pontoon tilted one side and toppled. Seaman fell down first and swam up to hopper pipe at middle of the hopper. Second officer who was wearing life vest and safety harness hooked to railing of the pontoon, got trapped between the railing and could not came out of the capsized heavy floating pontoon. Seaman tried to pull out 2/O, but could not succeed as 2/0 had hooked		g. No safety belts to be hooked while the pontoon is floating in water. h. Rescue team to be made available in the hopper or in the crane basket as near as possible for immediate response and rescue.

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					his safety belt to the railing of pontoon.		
29.	20/06/2023	Container vessel	Personnel Related	Marine Casualty	On the morning of 19th June, 2023, Chief Officer was carrying out cargo hold inspection. He was coming out of cargo hold no.2 to portside under deck passageway when the accident happened. He was closing the weather tight door, with the right hand holding the wheel and the left at the edge of the middle part with a protruding plate for padlock arrangement. With some air draft, he was not able to remove his left hand and not able to control the closing moment of the door. Wearing a cotton gloves, the tip part of his left index finger was cut, and nail was pulled out. At abt. 1016LT, he reported the incident to the Master, and Master called CE and 2nd Officer to meet him in the ship's office.	The cut portion of the index finger with the nail was found inside the gloves. First aid was provided, with painkiller. Bandage was done and vitals monitored. Remote medical assistance was taken from 3Cube. The recommended pain killers and analgesic gel were administered to CO. Over the next few days his pain continued on & off. 3Cube recommended medical attendance at next port call Algeciras. He was later repatriated home after initial treatment and obtaining fit to fly certificate.	All ships staff has been briefed in respect of safety precautions, company procedures and safety awareness. COSWP recommendations to be followed and additional crew training carried out. When heavy work is carried out, cotton gloves not to be used and leather gloves to be used instead.

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					CE met Chief Officer in the ship's office nursing himself with his injured finger. Master and 2nd Officer then arrived in the ship's office. First aid was applied to the wound. t		
30.	28/06/2022	Sailing Vessel	Fire & Explosion	Marine Casualty	Fire on board. On 28/06/2022, 1830 LT, the vessel caught fire at Hayat Jetty, UAE. The fire was uncontrollable & total loss of the vessel was reported.	The vessel crew tried to fight the fire with available extinguishers on board along with the port fire brigade but could not control the blaze.	The cause of the fire was the battery spark, it is prudent to disconnect the cable after vehicle loading considering the MSVs are of wooden make.
31.	29/06/2023	Tug	Flooding	Marine Casualty	Flooding in engine room. On 28/06/2023, 2030 LT, water ingress in engine room was observed while the vessel was in Mumbai inner anchorage. At 2034 LT, the vessel tried calling Mumbai VTS, however there was no response. DPA & CSO of company were informed by the Master. The company advised vessel to shift near shallow water of Lakdi Bandar – Mumbai port.	At 2218 LT vessel dropped anchor near Lakdi Bunder. Vessel and ship staff had been reported as safe and vessel had been advised to continuously monitor the situation and send 4 hourly reports. On 29/06/2023, 0033 LT, ICG received a mail from M/S Triton Maritime regarding suspected water ingress. MRCC contacted CSO of the company & ascertained that all crew on board were safe & situation was under control. Vessel and ship staff were safe & crew continuously monitoring the bilge level. Water was being pumped out continuously by submersible pump. Crew was continuously	Regular inspection to be carried out by ship staff as well as visiting superintendent

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						monitoring the water level and draught. At 2300 LT, the Master informed that the leak had been arrested by blocking the hole. On 30/06/2023, Triton maritime reported that the vessel was at Arlo Shipbuilding Pvt. Ltd., MbPT Mumbai. After dry docking the vessel, a small hole was observed in bottom area & plate renewed as per classification requirement.	
32.	04/07/2023	Chemical tanker	Incident onboard - Personnel Related	Marine Casualty	Injury on board. On 28/06/2023, 1630 LT, the Bosun had skin burn during tank cleaning. The Vessel was at sea enroute from disport Kandla to Fujairah, After discharging Crude Palm Oil (CPO) vessel had commenced tank cleaning with hot sea water at a temperature of 80° C at a pressure of 8 bars. During this process the bosun who wanted to wash his gum boots with hot water to remove oil stains came in contact with high pressure hot water from small a tank cleaning hose. Water got deflected on his legs when he opened the high-pressure hose and	Bosun was immediately transferred from deck to ship hospital and first aid was given. For the first 3 hrs, he was in severe pain, after which the pain was no more due to medication. Bosun was being attended by ship's medical officer regularly. On 29/06/2023, the vessel arrived Jubail port & the Bosun was examined by the port doctor. On 03/07/2023. the bosun was signed off at Fujairah & visited shore doctor. Further bosun underwent medical treatment in Dubai hospital from the 03rd to 07th July. The Bosun arrived in India on 08/07/2023, and his medical condition was stable. He was taking medical treatment through the company doctor in Mumbai. On 06/09/2023 was declared medically fit by the company doctor.	• Conduct effective on-site toolbox meeting and Step back 5 x 5 assessment as per TSM Poster 027. • Significance of effective work site assessment, hazard identification and implementation of control measures. • Following proper PTW including Lock Out Tag out. • Planning of any unscheduled/non-routine task adequately and assessing the risks involved. • Use proper PPE including safety helmet, gloves, goggles, earmuffs etc. as per TGP 1.2.3.

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					he received 2nd degree burns. Open skin left knee and blister formation on both legs knee downwards and around both ankles.		
33.	26/07/2023	Car Carrier	Fire & Explosion	Very Serious Marine Casualty	Fire on board. Death on board of one seaman. Injury of another seaman. Crew evacuated, Vessel abandoned. On 25th July at around 2145 UTC, vessel reported a fire incident in cargo hold. Vessel suspects this to be EV fire. Fixed foam system was used to extinguish the fire. Vessel departed Bremerhaven and was in the German Bight. The incident was reported to VTS, German and Netherland coastguard. The rescue operation was carried out by the Dutch coastguard. The vessel was abandoned by all crew and no belongings of any crew could be taken during rescue, except the documents. In this incident death of ASE was reported.	All 21 crew Members plus one Company superintendent (Not a crew member) were evacuated ashore by Netherlands coast guard and were shifted in hospital undergoing treatment and check-up. Unfortunately, ASE passed away on 26 July 2023 AM hours local time (Netherlands) on board. It was reported by the company on 26-07-2023 that they had received information from agent that other 20 crew were out of danger. NOK of the deceased were informed. On 31-07-2023 notification of injury to OS on board was sent by the company. The injured had fractured his forearm due to jumping from height when abandoning the ship. He was given medical care in Amsterdam Hospital and was further treated in Mumbai under specialist care. On 30-07-2023, 13 crew departed from Amsterdam, arrived 31-07-2023 in India. 5 crew who came to Mumbai were met by company staff at airport and were well. Ambulance was arranged to pick up injured OS from	As per info received on 09-011-2023 from company, the fire on board the vessel was a huge case and the P&I investigation and Flag State Investigation on this case were still going on. The statements of Master and all crew members has been forwarded to investigating agencies for checking purpose and will be shared once received from at the company end.

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						Mumbai airport on 31-07-2023 morning. Deceased ASE's Mortal Remains arrived on 6th Aug 2023 AM at Mumbai. Same were repatriated to his home town on 07th Aug 2023 early morning and were cremated.	
34.	31/07/2023	Bulk Carrier	Incident onboard - Personnel Related	Marine Casualty	Injury- Crushed finger. On 31/07/2023 at 1700 LT, during the shifting of lube oil drums from the main deck to the forecastle deck, the Engine cadet's right-hand middle finger got crushed between lube oil drums.	Immediate first aid was given onboard and referred to a shore doctor in order to know the extent of the internal injury, at Jurong East, Singapore. On 01/08/2023, the local agents informed that he was referred to Singapore General Hospital for further assessment of his injury. There, an X-ray was performed and the findings were: 'There is an acute displaced fracture of the distal phalanx of the right middle finger with associated soft tissue defect consistent with the submitted history. No dislocation.' He was then treated with hand surgery after being diagnosed with a right middle finger laceration with a nail bed injury. The Surgery was performed on 01/08/2023 and involved nail avulsion and nail bed repair. He was also given a 14-day Hospitalization Leave deeming unfit for duty for 14 days, from 01/08/2023 to 14/08/2023 and was also provided	• To ensure freshers are always being supervised by superiors to carry out risky jobs and this is briefed to them before joining. • Make sure proper training is carried out for cadet before re-employee. • Adequate risk assessment to be carried out prior undertaking tasks and inherent dangers associated to be briefed to the personnel carrying out the tasks.

Sr. no	Incident Date	Ship Type	Incident Category	Severity of Incident	Brief summary of Incident	Brief summary of action taken	Lessons learnt
						with a fit to travel certificate. On 15/08/2023, he was repatriated to India where he was further reviewed. He was certified fit for duty w.e.f. 08/09/2023.	
35.	03/08/2023	Bulk Carrier	Incident onboard - Personnel Related	Marine Casualty	Injury - Cut on the left-hand ring finger. On 03/08/2023, while the vessel was at Taboneo anchorage, Indonesia loading coal cargo, the AB was involved in operating the ship's general crane located on the bridge deck with other ship's crew in lowering the ship's garbage into a boat. This general crane's jib is at a fixed angle and the crane is only provided with a swivel motion. The hoisting and lowering function of the floating block winch has a remote-control operating function. On investigating regarding the injury, it was reported that the AB had tried to push away the rotating floating block of the crane which had come very close to the ship's side railing to prevent causing damage	The crew took him to the ship's hospital where he was rendered first aid, the wound was cleaned and bandaged, and medicines were administered. After being kept under observation in the ship's hospital, the AB was shifted to his cabin. Master immediately informed the agent staying on board and discussed the possibility of sending the injured crew to see a doctor ashore. On 04/08/2023, the AB was disembarked from the vessel at 2000 LT at Taboneo anchorage, Indonesia, and was in Ciputra Hospital, Banjarmasin under treatment. On 06/08/2023, the company reported that AB will undergo surgery on 06/08/2023 and will return to the vessel on 07/08/2023, Monday Morning. As per the email received from the company on 07/08/2023, the AB had completed his surgery on 06/08/2023 and had joined back the vessel around 1600 LT on 07/08/2023. The AB was still in pain, and hence he was signed off on	1) All personnel to be given proper training prior assigning them a given job, including crane operation. 2) All personnel need to be briefed and emphasized the use of proper PPE.

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					using his left hand whilst holding the operating remote control in his right hand simultaneously. In doing so his glove and his left-hand ring finger got stuck in one of the holes of the sheave block. His fingertip got cut and nail uprooted. It was observed that the crew was wearing proper PPE during the operation.	medical grounds from the vessel in Vietnam on 17/08/2023.	
36.	04/08/2023	Container Vessel	Personnel Related	Marine Casualty	Injury on board- Shin bone fracture. On 04/08/2023 at 1138 LT, when the vessel was carrying out a container discharging/loading operation in the port of Valencia, the AB had an accidental fall in bay 40 aft STBD side cross deck whilst checking the lashing. He suffered a closed shin fracture on the right leg tibia bone. The AB and OOW were checking the lashings of loaded containers. The AB reported to the OOW that a lashing bar was incorrectly secured. They tried to	The ship's crew administered first aid and medication. Master informed the local agent and asked for medical assistance. The local doctor and police arrived at 1312 LT and on initial inspection fracture was suspected. The AB was moved to the poop deck. Shore medical team arrived at 1330 LT and he was rendered first aid. At 1400 LT, the AB was evacuated from the vessel by stretcher to an ambulance by medical team to the hospital, to undergo treatment at Vithas Hospital, Valencia. The NOK was informed by the company. Further, the company informed that the local agents have informed that surgery for the crew member will be done.	• Risk Assessment to be carried out for in-port operations or especially for working on lashings. • A proper RA would have identified the awkward heavy load of the bar requiring additional manpower. • Safety inspections to identify unguarded openings so that measures can be put in place to mitigate the risk of an accident. • Encourage the crew to seek help when handling heavy loads.

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					confront the stevedore to correct the lashing without success. The AB then decided to correct the lashing bar himself after discussing it with the OOW. Later the OOW saw the AB lying on bay 40 lashing platform and shouting in pain. The AB informed that while he tried to release the long bar, his left foot slipped through the opening and his right shin slammed onto the edge of the opening.	On 10/08/2023, the company reported that the AB would be permitted to leave the hospital on 10/08/2023 after midday. On 14/08/2023, the Fleet Personnel Manager informed that the AB had reached his hometown on 13/08/2023, and would be reporting to the company doctor on 14/08/2023 at Kochi. Actions taken after the incident- • Safety barrier fitted to the opening from where the AB fell • Ad-hoc safety meeting held to discuss the incident and raise safety awareness • Incident shared with other fleet vessels	
37.	11/08/2023 12:03 PM	Bulk Carrier	Personnel Related	Marine Casualty	On 07/06/2023 at 1530 LT, while greasing the Mooring Winch shaft, the right palm of the OS got in the gap between the clutch and drum and got jammed/cut through. Bleeding, skin rolled out behind palm and a deep cut in palm passing through and around middle finger and Thumb finger. The injured was in shock as he	He was shifted to the ship's hospital, bleeding was stopped, the wound was cleansed and First Aid was administered. He was shown his hand with all fingers intact to calm him down. He was able to move all his fingers. Unable to ascertain if any fracture to the middle finger, Slight discoloration and full numbness were observed in the middle finger. The patient was stable and able to communicate. The wound area was crushed and the patient was in too much pain, unable to ascertain the	• All crew to be reminded to ensure the safety of the operation. • Proper risk assessment to be carried out prior to assigning jobs. • Clear communication is to be established among team members. • Crew must be always situationally aware. • Crew must not work close to movable and rotating gear.

Sr. no	Incident Date	Ship Type	Incident Category	Severity of Incident	Brief summary of Incident	Brief summary of action taken	Lessons learnt
					thought he had lost his finger.	extent of the damage, as moving the wounded area causes bleeding. At 1827 LT, the office of the technical manager/ operator, Tokyo, was informed that the patient's photos of injury were sent to CIRM and CIRM advice was received by 1933 LT and the same was administered. CIRM advised immediate hospitalization. Agent contact details were provided by office for seeking disembarkation. Agent at Majishan advised the best medical facility in Zhoushan. The vessel received confirmation at 2206 LT from the vessel operator and was diverted to Zhoushan Anchorage, China for emergency disembarkation and medical treatment. On 08/06/2023 at 0958 LT- A tug boat arrived alongside And the injured Seaman safely disembarked the vessel in the Tug Boat along with his personal effects which took him ashore for hospitalization 1130 LT- the OS arrived at Zhoushan Hospital in Zhoushan, China for his treatment On 13/06/2023 at 1957 IST, the Superintendent reported that surgery to connect blood vessels of his 3rd finger had been carried out at a hospital in Zhoushan, China. He	

Sr. no	Incident Date	Ship Type	Incident Category	Severity of Incident	Brief summary of Incident	Brief summary of action taken	Lessons learnt
						was under medical observation for about 5-7 days. Visa application and Immigration formalities for his repatriation to India were in process. On 21/06/2023, the company reported that the OS was discharged from Zhoushan Hospital on 19/06/2023. He departed from Zhoushan, China on the morning of 20/06/2023 and safely arrived at Mumbai on 20/06/2023 at 2210 LT. He was received and admitted at Laud clinic in Mumbai at 2300 LT on 20/06/2023 for further treatment which was taken care by the company.	
38.	21/08/2023 06:00 PM	Oil Product tanker	Incident onboard - Personnel Related	Marine Casualty	On 4th April 2023, the vessel was in the Arabian Sea on a voyage from Persian Gulf port and was proceeding towards China. The ship staff were carrying out maintenance of the starboard side Ballast Water Treatment System (BWTS) - cleaning the backwash filter. A tripod was used to lift the BWTS top cover and integrated motor to gain access to the filter. When the filter cover was lifted,	• First Aid was administered and Medsea medical advice was sought. Office personnel was informed. • Based on the location of the vessel, the nearest port able to receive the chief officer was identified as Mumbai. • As per advice of MedSea, the vessel was diverted and speed was increased to arrive Mumbai early. • MRCC was contacted to assist in medevac operations and they agreed to send a speed boat to a rendezvous position.	1 To conduct an extra ordinary safety meeting on the vessel to reassure the crew and put in preventive actions. 2. To install a temporary lifting arrangement, complete the PMS task of cleaning of the filter and to fit it back in position. 3 Training of all Deck crew & officers to be carried out for on proper lifting and usage of lifting equipment. 4 A Safety Alert to be sent to fleet vessels to carry out

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					the crew using a guide rope to clear deck pipes, pulled the filter cover at which point one of the tripod legs collapsed, and the filter cover fell on the Chief Officer's (C/O) left leg. The C/O was transferred to the ship's hospital and first Aid administered.	• Indian Coast Guard arranged a coast guard boat to medevac the C/O and he was transferred to shore hospital for further treatment. • P and I was informed. • On further examination it was confirmed that C/O suffered multiple fracture of his left leg bone. (Tibia). • He has been recovering well at the hospital.	extraordinary safety meeting on all vessels. 5 A message to fleet vessels to Stop usage of tripod unless permitted by office. 6 4 Vessels (Excel, Experience, Exceed, Expedite) not to use Tripod to lift BWTS filter cover. These vessels to fabricate and test temporary davits for lifting of BWTS filter cover. 7 To install a fixed approved lifting arrangement for lifting of the BWTS filter cover on 6 Vessels (Excel, Experience, Exceed, Expedite, Excellence, Express) this vessel and all other sister vessels with similar arrangement. 8 IP to be briefed/train before joining next vessel. 9 Learning from the Incident to be shared with the Fleet. 10 Review all the lifting arrangements for all vessels and make a process for testing, maintenance, and use of the equipment. 11 Incident to shared, in Crew Conferences to drive awareness. 12 Safety Moment to be made to drive learnings of use of tripods.

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39.	21/08/2023	Bulk Carrier	Incident onboard - Personnel Related	Marine Casualty	Injury - finger amputation while operating hatch cover. On 20/02/2023 at 0900 SMT, a trainee seaman was injured after coming in contact with a cargo hold hatch cover wheel while the vessel was on the Japanese coast, Tsugaru Straits carrying out hold cleaning as the weather was conducive. All hatch covers were being opened sequentially for hosing down of hatch channels and coaming. The deck fitter and trainee seaman formed part of the forward team and the seaman helmsman with another trainee seaman formed the aft team who was operating the control box. As cleaning of the intended portion of the No. 2 hold was completed, the above crew members started closing the hatch cover. The deck fitter positioned himself on the Port forward while the trainee seaman was	First aid was given, to clean the injured area and to stop the bleeding. Basic first aid was provided on board and medication was administered The vessel informed the company doctor and shore office. The RCC Shiogama was informed immediately for medical assistance. At about 1222 SMT paramedics landed on board and provided additional support and covering of the injured hand and medical evacuation by helicopter was done around 1236 SMT. The injured crew was conscious, the bleeding had stopped, all his vitals were normal, and he was able to walk by himself while being evacuated. The injured crew was taken directly to Hakodate Municipal Hospital, Japan, where he had to go through emergency surgery. He was kept under observation for the next 2 weeks in the local hospital. After necessary medical treatment, trainee seaman was repatriated to India on 04/03/2023. An incident alert was sent to all vessels in the company. The incident was discussed with all crew to emphasize the importance of daily work meetings, risk assessment, and toolbox talk at the job site.	• Importance of daily work planning meetings, risk assessment, and toolbox talk to be done at the job site. • Requirement for effective communication and co-ordination between team members especially when not in direct contact with other team members. • Job to be supervised by a team member maintaining a bird's eye view of the operation. • Importance of training and briefing trainees before being assigned to tasks on board and in particular when being assigned to critical tasks on board. • Importance of maintaining a safe distance from moving parts and keeping the body out of line of fire. • Never attempt to clear obstructions by hand when the hatch is moving. • Requirement for a standard risk assessment to be made ship-specific by the team on board taking manufacturers' guidelines and specific design of equipment installed.

Sr. no	Incident Date	Ship Type	Incident Category	Severity of Incident	Brief summary of Incident	Brief summary of action taken	Lessons learnt
					observing on the starboard side forward. As the hatch cover was being closed by SHM, the deck fitter heard the trainee seaman screaming and immediately signalled the operating crew to stop closing. It was noted that the hatch cover (forward starboard outboard side) had run over the trainee seaman's fingers and his left hand small and ring finger were amputated and bleeding. It seems that the injured crew member was attempting to clear an obstruction (probably the hatch securing cleats), during which his hand got in the way and was run over by the rolling hatch cover panel wheel. This resulted in the crew member's left small and ring finger being amputated.		
40.	22/08/2023	Bulk Carrier	Personnel Related	Marine Casualty	Injury on board. On 05/05/2023 1830 LT, when the vessel was in Belfast	The wound was treated onboard initially under Radio Medical Advice (RMA). Vitals were found to be	• All personnel onboard need to be briefed about risk management.

Sr. no	Incident Date	Ship Type	Incident Category	Severity of Incident	Brief summary of Incident	Brief summary of action taken	Lessons learnt
					port, repair quay whilst working in ER, the Junior Electro Technical Officer, slipped and hit his head on a steel bar causing a blunt trauma to the head, leading to laceration injury on the scalp.	normal. He was disembarked on 05/05/2023 at Belfast for treatment at Shore Hospital. Wound care with suturing was done under Local anaesthesia. He was stabilized and advised treatment in his home country. He was repatriated to India and the patient was declared Fit for Sea service w.e.f. 17/06/2023.	• All personnel onboard always must wear proper PPE. • Proper toolbox meeting needs to be carried out prior to every job. • All near misses need to be discussed and proper precaution taken to avoid any injury/incident onboard.
41.	26/08/2023	Oil Product Tanker	Personnel Related	Marine Casualty	Injury on board- Wrist fracture due to fall. On 18/07/2023, the vessel was en route from Gibraltar to Port Said. At 1005LT, a seafarer, sustained an injury on his right hand during watchkeeping hours, when he fell whilst descending from the AE platform missing the intermediate platform and falling directly on the deck. He arrested the fall with his right hand.	Immediate medical attention was given by the crew with first aid. CIRM was contacted and as per advice, further treatment was administered. On observation, the seafarer's wrist had swollen and was sore, and was immobilized as part of the first aid. Radio medical advice was sought, which confirmed immobilization of the wrist and an X-ray at the next port to check for fracture. From the time of injury till arrival at Port Said, he was given complete rest. On arrival in Port Said, Egypt, on 20/07/2023 2010LT, the seafarer was sent to a doctor where an X-ray determined he had sustained a lower-end radial fracture to his wrist and was declared unfit for duty, and repatriated accordingly. Follow-up medical attendance observed that the fractured wrist had maintained alignment.	• Platforms and ladders should always be treated with caution. • It is always preferable to work from/move around at deck level if possible. • Where this is not possible, the hazards must be highlighted during the toolbox talk and appropriate care taken when moving up and down access ladders.

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42.	29/08/2023	Container Vessel	Incident onboard - Personnel Related	Marine Casualty	During morning 0400 to 0800 watch motor man was working on AC cooling water pump at 0600 LT. As the work was small to readjust/ tight the gland nut to arrest leakage, he decided not to stop the pump as AC Compressor and Provision Compressor were running. He tightened leaking gland nut of pump and after that he was clearing the chocked drain. During this his small finger accidentally touched the running shaft coupling.	First aid was provided immediately to stop/control bleeding. MM was sent to port doctor visit for further medical assistance. Motor man got the stitches on the cut of his left-hand little finger in Altamira, Mexico. He was advised rest for 15 days and is onboard. His stitches will be removed in next convenient port.	Seafarer used wrong practice to clear chocked drain. This drain can be cleared from outside where drain hose is connected. Lesson learnt that not to work on machinery while it is running and job to be undertaken after thorough risk assessment.
43.	30/08/2023	Container vessel	Incident onboard - Personnel Related	Marine Casualty	Burn Injury- Unforeseen incident due to a broken gasket leading to the spray of hot condensate water. While the vessel was at sea the engine fitter faced a burn injury while working on the steam condensate return line due to a broken gasket leading to the spray of hot condensate water. On 23/01/2023, the duty engineer reported to 2E that the leakage from the steam condensate line had	Necessary first aid was provided immediately in the affected areas in consultation with 3Cube (RMA) and he was found stable. On 29/01/2023 at 1635 LT, the fitter signed off the vessel and was disembarked for further medical treatment on arrival first port of call, being Rotterdam. He was repatriated back to India. He was given a fit-for-duty certificate on 09/05/2023 when he went for a review of his injuries.	• Once relevant permits/checklists are completed same is to be cross-checked by management team members (top 4). • Work on pressurized systems should be properly organized and all the safety barriers must be established and cross-checked by another team member. • Risk assessment must be discussed prior to work during the toolbox meeting.

Sr. no	Incident Date	Ship Type	Incident Category	Severity of Incident	Brief summary of Incident	Brief summary of action taken	Lessons learnt
					increased. Hence 2E decided to reduce the steam leakage on this leaking condensate return line. A toolbox meeting was carried out. The fitter, 2E, and wiper proceeded to the site to place a clamp on the flange to reduce the leakage. On closing valves, the leakage reduced and almost stopped. Hence the team concluded this line was isolated and proceeded with this repair. The location of the leaking pipe/ flange was at a height of 4m. The fitter wearing the steam splash suit, face shield, and safety harness approached the leakage location using a ladder. While trying to place a clamp a broken piece of the gasket flew out from the flange resulting in a spray of hot water onto the fitter. The fitter was unable to unhook his safety harness in a timely manner to move away from the location quickly. In order to quickly unhook he took out his		

Sr. no	Incident Date	Ship Type	Incident Category	Severity of Incident	Brief summary of Incident	Brief summary of action taken	Lessons learnt
					gloves. Also, the face shield was protected only from the front area. As had turned to the right to unhook the opening between the face shield exposing the right side of his face. Thus, the right hand and right side of the face came in contact with the hot spray. His right face was burned/ scalding and his top skin was affected. His hand near his wrist got scalded and his top skin was affected.		
44.	07/09/2023	Oil Product Tanker	Incident onboard - Personnel Related	Very Serious Marine Casualty	It was decided by the company to load cargo in slop tanks which had to be cleaned. On 07.09.2023 early morning, the crew brought the equipment and portable blower fan was fixed for gas freeing, EEBD/SCABA equipment were placed near the tank hole. Gas detector was placed inside the tank to check the level of oxygen and toxic gas, giving results which were safe for tank entry. 02 AB's in	Master called nearest port, Bandar Abbas, to request for rescue and as instructed by Port control, vessel moved closer to port area. First Rescue team, which arrived about 2 hours after crew fell unconscious, failed, so they called for more assistance. After several attempts made by the second Rescue Team with Fireman, they finally managed to bring out both crew from the tank around 1246 hrs local time who were unfortunately declared dead. Vessel arrived at Bandar Abbas anchorage around 1500 hrs were Local Port Authorities boarded for	Based on Master reports, it was possible that H2S Gas pocket burst while crew entered due to movement inside. Additional reports will be provided after Company representative board the vessel on vessel's arrival at UAE Port in a couple of days.

Sr. no	Incident Date	Ship Type	Incident Category	Severity of Incident	Brief summary of Incident	Brief summary of action taken	Lessons learnt
					proper PPE entered to fix the wilden pump in the bottom of the tank, while Bosun, who was available with C/O at the tank entry, continuously communicated with both crew. It was possible that H2S Gas pocket burst once they were inside due to movement. Gas started to fill up the tank that led to AB 1 falling unconscious. AB 2 panicked as he tried to pull/rescue AB 1. Due to the toxic gas filling up the tank quickly, he too, got unconscious. Upon understanding the situation, C/O also donned EEBD and did a manhole entry to the tank to rescue both crew but failed repeatedly. Other crew, 2/O and ETO also attempted to rescue them, but failed too. By this time, Company was already informed by the Master.	Investigation. Remains of the bodies were disembarked around 2300 hrs.	
45.	11/09/2023	Bulk Carrier	Incident onboard - Personnel Related	Very Serious Marine Casualty	The V.O.C. Port authority informed regarding the accident on 12.09.2023 @1300hrs of the failure of	The crane operator was shifted to Govt. General Hospital (GGH) from the Port Hospital. After reaching to	(i) Thorough verification of crane is required prior operation/ usage of the crane.

Sr. no	Incident Date	Ship Type	Incident Category	Severity of Incident	Brief summary of Incident	Brief summary of action taken	Lessons learnt
					NO.1 crane on at berth no.4 on 11.09.2023 at 1750 Hrs resulting in the death of a crane operator. The subject vessel had arrived at VOC Port Authority on 11.09.2023 at 0645 Hrs LT for loading the cooking coal in bulk with ship's crane and loading operation begun at 1145 Hrs LT using all four cranes. Around 1750 hrs LT, No.1 crane fell down in hold no.2 suddenly. It broke from centre gear and the crane operator in crane's cabin fell down from crane to bottom of the hold from a height about 15 meters which resulted in serious injuries to the crane operator. The crane operator was given first aid by the ship's crew and transported to Port hospital by port hospital ambulance.	the GGH, the injured crane operator declared brought dead. From the Analysis of the statements and evidences received from the Vessel M.V.KIANA that the no.1 crane failed due to the material failure of the Jib at the grab end sheave block due to improper maintenance. The incident caused the pull out of the crane operator cabin from the crane and fell into the no.2 hold along with crane operator. The crane operator after shifting to the Govt. General Hospital found brought dead. Police FIR was filed at Thermal Nagar police station at Thoothukudi on 11.09.2023 under section 302(A) of Indian Penal Code,1860. The dispute claim aroused due the incident got resolved out of the court of Law by mutual agreement between the parties concerned.	(ii) Any maintenance carried onboard the crane, required to be carried out by qualified professionals. (iii) Ship and shore personnel should wear safety gear all the times of work. (iv) Crane maintenance like cutting, welding and replacing the materials of the JIB to be undertaken by qualified & class certified personnel only.
46.	13/09/2023	Crude Oil Tanker	Incident onboard -	Marine Casualty	On 13/09/2023 at 0920LT Man Overboard (MOB) at	• 0923LT: Mayday alert was transmitted on VHF to all stations	The importance of timely and appropriate actions during a MOB

Sr. no	Incident Date	Ship Type	Incident Category	Severity of Incident	Brief summary of Incident	Brief summary of action taken	Lessons learnt
			Personnel Related		the Galveston Fairway Anchorage was the ship's Bosun. Mayday alert was transmitted on VHF to all stations regarding MOB and preparations for rescue boat launching commenced on 0923LT. The vessel received Mayday acknowledgement from USCG on VHF at 0930LT. The USCG Rescue helicopter approached towards the vessel at 0936LT. MOB was rescued and lifted onto the USCG rescue helicopter at 0944LT. The distress alert was cancelled and all stations were informed about the rescue and the helicopter crew was informed to take the MOB to UTMB hospital, Galveston at 0948LT.	regarding MOB. Preparations for rescue boat launching commenced. • 0930LT: Received Mayday acknowledgement from USCG on VHF. • 0936LT: USCG Rescue helicopter sighted approaching towards the vessel. • 0944LT: MOB was rescued and lifted onto the USCG Rescue helicopter. • 0948LT: Distress Alert was cancelled and all stations informed about the rescue. • 0948LT: Helicopter crew informed about taking the MOB to UTMB hospital at Galveston The Bosun was declared fit and was brought back to Mumbai on 18/09/2023 morning for further evaluation.	Emergency Situation was realized. Master was quick to act therefore allowing the USCG to rescue the Person in time.
47.	14/09/2023	Crude Oil Tanker	Incident onboard - Personnel Related	Marine Casualty	The 14th September 2023 at 1545 LT in position 27° 13.42'N / 093° 44.16'W the 33-year-old Indian Male national serving on board as Chief Officer, was pronounced deceased by the medic from the US	The SEARHYTHM departed Houston on September 13, 2023 with two (2) Chief Officers on board. Chief Officer in-charge (CO 1), whereas the deceased Chief officer (CO 2)who joined in Houston on September 11, 2023 and was sailing as parallel Chief Officer until he took	The company sent out a Fleet Circular on September 15, 2023 covering the following – 1) Routine ballast tank inspections restricted to not more than three (3) tanks in the day by the same team. 2) There should be at least an hour's gap between exit from one (1) tank to

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					Coast Guard who was winched on to the vessel for a medevac operation, whilst the vessel was on a loaded passage from Houston to Rotterdam. Vessel was diverted to Houston OPL, to land the body of deceased Chief Officer to Galveston Medical Examiner's office to determine the cause of death and for repatriation of the body back to his family in Mumbai, India. Chief Officer's itemized personal effects were forwarded to Agents 'GAC Houston' for onward forwarding to his home address in Mumbai, India. The cause of death as determined from the autopsy report performed by the Galveston Medical Examiners office was ruled as Coronary heart disease.	over as Chief Officer from CO1 after his familiarisation, as this was his first promotion to the rank of Chief Officer. As per the work planned for September 14, CO 1 and CO 2 were schedule to carry out a routine six (6) monthly inspection of No.4 (P) and No.4 (S) Water Ballast Tanks. On the morning of September 14, 2023, all preparation for man entry into No.4 (P) and No.4 (S) water ballast tank were made and a review of the risk assessment for enclosed space entry conducted to ensure that the hazards identified were specific to the tank/spaces being entered. A toolbox talk was also carried out to discuss the hazards identified in the risk assessment and ensure the team fully understands the importance of staying hydrated and what to do in an emergency or if the tank atmosphere is compromised. Thorough check of tank atmosphere, lock-out/tag-out, fixed/portable/personnel gas detectors and rescue equipment were made prior to entry, to ensure proper availability and suitability for use. CO 1 and CO 2 first entered No.4 (S) water ballast tank on September 14, 2023 at 10:38 LT and completed the	an entry in the next tank by the same team. 3) If ambient (air) temperatures are above 30 deg C or carrying heated cargoes when you can expect tank temperatures to be much higher, vessels will need to request their Technical -Superintendent for approval, along with the RA, which should include measures in place for dehydration/exhaustion. Given the usual confined and darkened nature of an enclosed space, this activity should not be carried out by personnel suffering from phobias such as claustrophobia, or who are susceptible to panic or anxiety attacks. All new, inexperienced crew must be advised on the dangers of enclosed space entry.

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						inspection and exited from the tank at 10:58 LT. Later, at 11:01 LT on September 14, 2023, both CO 1 and CO 2 entered No.4 (P) water ballast tank. On descending to the bottom forward most bay of the tank, CO 1 noticed that CO 2 was feeling tired/breathless and assuming dehydration, requested for some water and Tang to be sent down. CO 1 told CO 2 to sit down and catch his breath since he was breathing hard and that they should discontinue the inspection and proceed back up and out of the tank, once he was rested sufficiently. CO 2 responded that he would be fine, if he rested for a few minutes and then they could continue with the tank inspection. CO 1 checked the gas readings on the personal gas meter worn by CO 2 and oxygen registered at 20.9% whilst the rest of the gases were registered as '0%'. CO 1 then stepped away from CO 2 and checked the personal gas meter worn by himself and oxygen registered at 20.9% whilst the rest of the gases were registered as '0%'. CO 1 then walked around the area until CO 2 rested (no more than 5 meters away from him and with CO 2 in his sight at all time). In the meanwhile, CO 1 continued checking his	

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						personal gas meter, a few more times and the reading remained unchanged. After a few minutes has elapsed, CO 1 asked CO 2 to try standing up. CO 2 stood up, took a half step forward and sat back down. At this stage Master, who was monitoring the communication between CO 1 and the personnel stationed at the entrance of the tank, requested that the team exit the tank. As CO 2 was still experiencing breathlessness, CO 1 initiated emergency to remove CO 2 from the bottom forward most bay of No.4 (P) water ballast tank. At this time, CO 2 still in a semi-conscious state, insisted that they would exit the tank together and that there was no need to call others for assistance. This was the last verbal communication between Co 2 and CO 1. On September 14, 2023 at 11:30 LT, rescue plan was initiated and at 11:50 LT, CO 2 was removed from No.4 (P) water ballast tank with the assistance of six (6) other crew members (Pump man, Bosun, 4/E, O/S, A/B and Motorman) who entered the tank to assist in the rescue operation. In the meantime, Master made had contact with SEA BIRD 24x7 Radio Medical Advice (RMA) service providers in Mumbai, India and as soon as CO 2	

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						was removed from the tank, his vitals were checked and passed on to Doctor (Sea Bird RMA). CO 2 was immediately transferred to the ship's hospital and on advice from Doctor (Sea Bird RMA) he was put on medical oxygen and administered medication as per Radio medical advice received from Doctor. At 12:24 LT on September 14, 2023, Master in consultation with 'Valles Vancouver' decided to turn the vessel back around and head back to Houston as CO 2's Vitals were not improving. Arrangements were made for a Medivac by 'Valles Vancouver' in coordination with USCG and Agents 'GAC Houston'. CO 2 remained on medical oxygen throughout the period until the medics from USCG arrived on board. The helicopter from USCG along with a medic arrived at the rendezvous position at 15:40 LT on September 14, 2023 and a medic winched on to the vessel at 15:42 LT. The medic examined CO 2 and pronounced him as deceased on September 14, 2023 at 15:45 LT in position 270 13.42'N / 0930 44.16'W. The helicopter from USCG departed along with the medic at 15:55 LT and	

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						deceased CO 2 was taken back to the Ships Hospital whilst arrangements were being made to shift his remains to the freezer room (fish room). Vessel returned back to Houston OPL and at 10:09 LT on September 15, 2023, the remains of deceased CO 2 were landed to a helicopter to be transported to a local Coroner's office to determine the cause of death and for repatriation of the body back to Mumbai, India. Deceased CO 2's itemised personal effects were also forwarded to Agents 'GAC Houston' for onward forwarding to his home address in Mumbai, India. Vessel resumed her passage to Rotterdam on September 15, 2023 at 11:00 LT and on September 19, 2023 at 12:25 LT, received confirmation from local PnI correspondent ashore via communication with Galveston Medical Examiner's office, that CO 2's cause of death was ruled as 'Coronary Heart Disease'.	
48.	18/09/2023	Dynamic PSV	Incident onboard - Personnel Related	Marine Casualty	On 18-09-2023 1400 LT while the vessel was at Ras Laffan anchorage – Qatar, a cargo barge was cast off from the vessel due to the adverse weather and increasing wind speed. Two ABs were tasked with	Both crew members promptly reported at the vessel's bridge for medical assistance and the AB was administered with first aid to control bleeding and administered a tetanus shot by Ship's Medical Officer. Contact was established with Ras Laffan Industrial City (RLIC) Port	This incident demonstrates the importance of avoiding operations when risk of injury is very likely due to persistent rough weather situations when handling ropes, maintaining focus during mooring/unmooring operations, and recognizing the inherent risks in working with ropes

Sr. no	Incident Date	Ship Type	Incident Category	Severity of Incident	Brief summary of Incident	Brief summary of action taken	Lessons learnt
					recovering ship's Yokoham fenders from the starboard side of the own vessel. The AB's were tasked with retrieving a 1/2-inch nylon rope (pig tail attached to Yokohama fender (webbing) pickup sling) associated with the Forward Yokohama Fender. This rope was tied to the fender's (webbing) pickup sling that would later be hooked to the vessel's crane for fender pickup/recovery. While the AB was pulling the nylon rope to access the end of the webbing sling, the swell caused the rope he was holding to slacken unexpectedly. This sudden slack was followed by a forceful jerk, resulting in the rapid release of the rope from his grip. Unfortunately, this led to the amputation of the AB's tip of the right index finger and an open fracture of the middle finger. The AB was wearing hand gloves (Cut-resistance PU-coated) at	authorities by the vessel and MEDEVAC initiated. The AB was transferred to the crew boat for further onshore medical attention and an ambulance at RLIC Port to Hammad Hospitals. Safety Stand down Meetings were convened for both shifts, providing a platform for comprehensive discussions about the incident with the entire crew. Incident was disseminated to wider fleet communication focusing on the finger injury incident during mooring/unmooring operations.	in dynamic situations during inclement weather sea/swell/wind. Job to be stopped if sea state conditions have changed in managing fenders and carry out a specific risk assessment. The behavior of treating such tasks as routine work can lead to reduced individual focus and awareness of identifying potential hazards, particularly in the face of changing environmental conditions or other factors.

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					the time of the incident. Weather conditions at time of incident were Swell 4-5 ft & Wind 18-20 Knots.		
49.	28/09/2023	Oil Product Tanker	Incident onboard - Personnel Related	Marine Casualty	On 28th Sep 2023, at around 1000 Hrs LT, after completion of minor repairs in the 2S WBT, the Chief Engineer, while ascending a vertical ladder on the second platform, accidentally missed a step and slipped from the last couple of rungs. This caused him to fall backwards onto the tank longitudinal behind him, displacing his helmet and resulting in an impact on the back of his head. He also suffered abrasion injuries on his chest due to the fall. Vessel was on a voyage from Ruwais, UAE to Pengerang, Malaysia. Weather was slight to moderate with Winds NE 4/5 and around 1.5m Sea/ swells.	Emergency alarm was raised and ship staff promptly reached the location (2S WBT) and brought him to the Ship's Hospital using a stretcher. Chief Engineer's vitals (BP, Pulse rate, and breathing) were checked and found to be normal, however, he remained in an unconscious state for the first 3 Hrs and later gained conscious and complained about pain in the back part of his head. Oxygen was administered and medication given as per Medical advice. Vessel was deviated to Port of Mumbai for Medical evacuation and Chief engineer disembarked at outer anchorage using a tug.	1. Checks prior Enclosed space entry to be diligently carried out for all equipment including PPE and fall protection, lighting, ventilation, and Rescue Equipment. 2. Ballast tank spaces have damp and slippery conditions; It should be ensured that PPE worn is antiskid and non-slippery. 3. Three-point contact should always be maintained while using vertical ladders and fall protection/ safety harness to be worn for vertical ladders > 1.5 m 4. It is preferable that Helmet borne torches are used instead of hand torches in dark areas to have better frontal visibility, and to keep hands free. 5. Personnel ascending ladders are to be closely monitored by the attendant and members of the work team. 6. Enclosed space rescue drills to conducted regularly and rescue

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							equipment to be tested and in working condition.
50.	04/10/2023	Bulk Carrier	Incident onboard - Personnel Related	Marine Casualty	On 04-10-2023 at 0410 LT visiting businessman named Mr. Hossain Khozaifa came on board for offering a price list to the crew. His entry on board was recorded in the ISPS log book at this time. Vessel was undergoing cargo discharging operations of coal in bulk at Haldia port. At 0420 LT heavy rain started which was the reason why the AB Mr. Yahya and OS Mr. Ahmet took immediate action to close the hatch cover no3 as is the normal practice to protect the cargo. At 0435 LT the businessman was found stuck under the no 3 hatch cover on its starboard side area. He was crushed between where the hatch cover meets the coaming on closing. During closing of the hatch cover the view of the deceased was obstructed by the hatch covers and he could not be	The following action has been taken: Direct actions taken: At 0440 LT the foreman called the Ambulance with his local cell phone. Master informed Sagar VTMS and Haldia Port using VHF. The ship's agent was also informed and called on to be on board. The company was also informed. At 0510 LT port security armed guards boarded vessel and checked the mortal remains and first debriefing of the crew was carried out. At 0540 local agent boarded vessel. At 0904 LT local police boarded, 1030 P & I surveyor was on board. At 1200LT the mortal remains of the businessman were removed by local police. Preventive actions: A circular is to be prepared after a detailed Internal investigation that will follow within the next few days after the brief investigation has already been completed. The circular will focus on the lessons learnt and will be sent to the fleet's vessels to avoid recurrence.	All deck officers and crew should be fully familiarized with the hatch cover safe operating procedures, including guidance contained in the manufacturers operating manual Clear warnings of intended operation of hatch covers must be communicated to duty crew and shore workers on deck Prior to opening or closing hatch covers, a thorough check should be made to ensure trackways are clear of obstructions and no persons are standing near or resting on the coamings during operation. In case of darkness a proper lighting and the proper reflecting safety vests must be ensured. Even if the we can assure that the checks of the trackways are conducted, in case of darkness a more thorough check should be conducted. Crew should be assigned to ensure the coamings remain clear during operation

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					seen from where the hatch cover closing console was situated. Further the AB Mr. Yahya confirmed that he already checked the hatch coaming area and found clear before closing the hatch cover. At 0440 LT the foreman called the Ambulance with his local cell phone. Observation was made that the deceased person was not part of the stevedores discharging the vessel at that time. Also, he seemed to be unfamiliar with the vessel's general layout and cargo operations which involves various on-board moving machinery operations. Hence, he had unknowingly put himself at undue risk when the ship's crew were in a hurry and busy carrying out their standard operational duties of closing the ship's hatch covers during the occurrence of sudden heavy rain and therefore, they could not observe the accident victim. The vessel		and means of immediately alerting the operator to stop clearly established

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					was therefore in no way responsible for the unfortunate incident.		
51.	08/10/2023	LPG	Incident onboard - Personnel Related	Marine Casualty	Bosun suffered a Finger Injury when transferring scrap metal and lube oil drums from a scrap metal skip. Whilst removing the last drum from the skip, it slipped and crushed the Bosun's little fingers on his right hand against the wall of the garbage skip.	He was immediately given first aid and sent to the International Modern Hospital for further treatment. The injury was diagnosed as a complete amputation of Distal end of right 5th finger. He was signed off and admitted to the Canadian Specialist hospital for plastic surgery where skin grafting was done. He was found stable and discharged from hospital on 10-10-2023 and was repatriated to his hometown on 11/10/2023.	There was poor evaluation of hazardous involved in the task. Thorough Risk assessment & tool-box meeting must be carried out during the critical operation & before the task is carried out.
52.	13/10/2023	Oil Product Tanker	Incident onboard - Personnel Related	Marine Casualty	Injury on board. On 13/10/2023 at 1400 IST, when the vessel at sea was enroute to Port Gresik, Indonesia, the Fitter reported welding flash exposure to his right eye when carrying out work in the E/R workshop.	He was provided first aid and treatment and was rested. On 16/10/2023 it was observed that the redness inside the eye had not subsided and thereafter, RMA was sought and medicines administered. The Fitter was sent to the shore Ophthalmologist on arrival port.	• Welding equipment to be switched off before removing the welder's shield. • Corrective/ Preventive actions: 1. All personnel involved in Hot Work refreshed on procedures as outlined in the Code of Safe working practices Chapter 24 - Hot Work. 2. All crew involved in Hot work are trained to use an Electrode holder while temporarily assessing the quality of the weld. 3. The use of cutting off the supply before the change of electrodes should be carried out.

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							4. An assistant should always be in continuous attendance during welding operations and he/she should be alert to warn the welder if any hazard is identified during the process. He/she should be also able to cut off power instantly in case of an emergency. 5. All personnel close to the site of welding should wear PPE including Screen or other effective means to protect from harmful radiation. 6. Maintain good housekeeping while commencing hot work to avoid uncomfortable working place.
53.	18/10/2023	Oil Product tanker	Incident onboard - Personnel Related	Marine Casualty	Injury on board. On 18/10/2023 at 1424 LT, the 3/O sustained head and shoulder injuries on board whilst filling the air bottles in the free fall lifeboat. The pressurized air hose got disconnected from the air bottle connection and the whip lashed the 3/O's forehead and both shoulders resulting in a deep wound cut on the left side of the forehead and severe pain on both hands and shoulders.	Immediate first aid was given to 3/O and he was safely evacuated for further treatment ashore. The officer was admitted to the hospital, and P&I and NOK were informed. The company had arranged the flight for the Officer's Wife, who reached Brazil and met 3/O. The Officer and his family reached home safely on 20/11/2023 and visited the Company Doctor.	• Non-routine jobs should be briefed in detail by a senior officer. • Proper risk assessment is to be made to identify all hazards involved in the operation. • Any difficulties faced in the non-routine jobs are to be identified and raised to the company. • All vessels having BA compressors of one filling line for both SCBA and Lifeboat air bottles of different pressures need to be identified and verified for the safety valve settings. • Details of the filling hose should be provided by the supplier along with the test certificate.

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							• PMS routine for inspection of Lifeboat air filling hoses and couplings to be included. • "Whip restraints" should be used to prevent whiplash of the high-pressure hoses. • Engineers should be involved in the operation/maintenance of machinery such as BA Compressors.
54.	26/10/2023	Bulk Carrier	Personnel Related	Marine Casualty	On 26/10/2023 1400 LT, while working in the engine room, there was an injury to the Fitter wherein he injured his right-hand finger. The Fitter sustained an injury to his right index finger with ligament and bone exposure when securing the replaced ME No. 3 cylinder head exhaust valve. His index fingertip was pinched in between the securing stud and the cylinder jacket. The hemorrhage was well-controlled and a clean dressing was applied. The Fitter was right-hand dominant. The vessel was enroute from Singapore but was diverted to Durban, South Africa.	The vessel's medical partner, International SOS – MEDSEA, provided urgent attendance at the medical facility ashore. This was based on details submitted by the Master to the MEDSEA. As per instructions from MEDSEA, the vessel was diverted to Durban, South Africa to disembark the injured seaman. The vessel arrived in Durban on 31/10/2023, the injured seaman was disembarked and taken ashore to the hospital for further treatment. The first information received from Shore Hospital, Durban was that the seaman was stable and would require a few days before he was fit to sail.	• Working in the engine room main engine is quite risky work. • Proper use of PPE is to be used at all times. • Poor communication and diversion from safety procedures are the main causes of injuries in the engine room. • To follow the Risk Assessment as per the plan which was made prior beginning of work.

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55.	27/10/2023	Crude Oil Tanker	Personnel Related	Marine Casualty	On 27/10/2023 at 0930 LT, the Motorman who was working in the engine room accidentally spilt hot sludge emanating from a heavy fuel oil purifier de-sludging port on his face, right arm and wrist.	First aid was administered and the office was informed. A doctor was consulted on the phone and initial on-board treatment was administered to the Motorman. The vessel was diverted to Gibraltar Port. Arrangements were made to disembark the Motorman from Gibraltar on 29/10/2023 for shore treatment. Treatment for blisters and skin burns along with pain medicines were administered and he was kept under continuous supervision on board. The Motorman was safely disembarked by launch on 29/10/2023 and was shifted to the A&E unit at the local hospital and was checked by Doctors/Nurses. The doctor examined the injured crew and confirmed that he was in stable condition and would remain at St. Bernard Hospital in Gibraltar for treatment. After x-rays, skin treatment and discussions with the UK specialist burn unit, the crew member was transferred to the ICU (Intense Care Unit) to remain for 24 hours for further treatment. After treatment at the ICU, the Motorman was transferred to another ward where he was reassessed for his fitness certificate.	• Checking the sludge port of the purifier for oil leak/sludge accumulation was a routine task. The frequency of checks was increased due to the poor quality of fuel bunkered. Extreme caution is to be observed when handling sludge. The vessel received a Fuel analysis report on 27/10/2023. The report states high sediment value which can lead to excessive sludge formation. The vessel was facing a sludge generation issue right after purification was started. The de-sludge timings were reduced from 60 minutes to 30 minutes. • Despite taking all the precautions like checking the de-sludge timer, and wearing appropriate PPE, the incident took place. • It would be worthwhile to stop the purifier, open the top cover remove the accumulated sludge and continue with the purification process in such cases.

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56.	27/10/2023	Merchia	Hijacking & piracy	Marine Casualty	Hijacking & Piracy-Attack by robbers. (Attack by robbers in Malacca strait onboard the vessel with knives to Master in his cabin which left him with severe stab injuries including a penetration chest injury) On 27/10/2023, when the vessel was transiting Singapore straits near the Johar VTS, the Master was attacked by 5 to 6 robbers in his cabin at 0430 LT and he was left with severe stab injuries. The Master called up the 2/O on the bridge to inform him that there were robbers on board and that he was injured. He asked him to sound the alarm and shouted from his cabin to alert the crew members. The 2/O ran to the Master's cabin and found him with stab injuries. In the commotion, robbers got away.	The Master was immediately administered first aid. A search was ordered for robbers on board. DPA was informed. C/O & 3/O on bridge tried contacting Johar VTS-6 & VTIS West, but no response. The call did not connect with Singapore MRCC. At 0500 LT, the vessel informed the agent about the attack and requested early pilot and medical assistance. At 0630 LT, Hanseatic Maritime Department was called for assistance. Singapore VTS contacted the vessel and information was passed. The vessel was instructed to divert to WPBG "A" for medical assistance. At 0748 LT, the pilot boarded, 0820 LT Singapore Police Coast Guard boarded for a search of robbers and medivac of Master. The vessel was anchored at 0900 LT and the Medical team boarded. At 1000 LT, the Master was disembarked. At 1000 LT, the Master was medivac to the National University Hospital in Singapore. NOK was informed. Master had suffered multiple stab wounds to the chest and right chest penetrating injury with blood loss, Right 2nd rib anterior mildly displaced fracture, and right 3rd rib cartilage injury. Left middle & ring finger laceration injury.	• More vigilant anti-piracy watches to be maintained. • There was a lapse in the consistency of anti-piracy measures & watches in piracy-prone areas which led to this almost fatal attack on the Master. There should be no let-up in vigilance by the ship's crew when transiting waters that are prone to such incidents.

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57.	30/10/2023	Passenger Ship	Grounding	Marine Casualty	On 31/10/2023 at 1505 LT, amidst seasonal weather conditions, when the vessel was enroute to Swaraj Dweep from Long Island at a speed of 13.2 knots with the second officer on watch, the vessel experienced sudden vibration and immediately the speed was reduced by the second officer. The vessel had 73 passengers and 1 infant onboard. Meanwhile, the Master and Chief officer reached the bridge and realized that the vessel smelt the ground. The STBD hull had touched the seabed. The vessel was stopped and followed all the procedures as per SMS including recording of tank sounding, and visual inspections of all places. All were found normal and no unusual change in soundings, then the vessel proceeded to Swaraj Dweep and back to Port Blair. During the return voyage to Port Blair, at	The crew followed all emergency procedures as outlined in their SMS manual, including recording soundings of all fresh water and fuel oil tanks. They also conducted visual inspections of various areas on board such as the 20-passenger area, fwd./aft cargo holds, AMR room, steering flat, engine room, bridge, coffer dam, etc. No unusual changes in soundings were observed by the vessel and everything appeared normal to the Master. At 1536 LT, the vessel continued on its intended voyage to Swaraj Dweep and arrived at Swaraj Dweep at 1612 LT. Thereafter, the vessel departed from Swaraj Dweep at 1617 LT and arrived at Port Blair at 1842 LT on 30/10/2023. During her return voyage to Port Blair, the vessel observed that there was an increase in STBD Main Engine Gear Box lube oil temperature to 70 degrees while rising to normal 840 RPM. As the alarm was set at 75 degrees, the vessel decreased the STBD engine RPM to 750 as per the CEO's request to the Master. Upon arrival to Port Blair on 30/10/2023, the crew opened up all accessible fresh water and ballast tank areas for visual inspection once again to ensure that	• The Master should approve the passage plan before the commencement of every voyage as per SMS. • All watchkeepers/duty officers should follow the approved passage plan only. • As per SMS, All navigation checklists should be complied with and followed by the crew. • During restricted/shallow water, additional watch keepers should be kept at the bridge, if required. Master should be on the bridge during such areas. • GPS position should be recorded regularly as per SMS. • Chart corrections/ NOGO areas should be marked in charts. • The master should report factuality such incident to the shore office immediately and the Master should sail the vessel only after statutory authority's permission. • More ISM familiarization given to the bridge team and usage of SMS forms should be given to junior officers by management-level officers.

Sr. no	Incident Date	Ship Type	Incident Category	Severity of Incident	Brief summary of Incident	Brief summary of action taken	Lessons learnt
					approximately 1505 LT, the vessel experienced a sudden and unexpected vibration. The watch-keeping officer immediately took action and slowed down the vessel's speed. Meantime, the Master and chief officer promptly made their way to the bridge to assess the situation and took over the Command. Upon inspection, Master found that NMKO altered without intimation/permission of Master and Master realized that the vessel had touched the ground and the starboard hull may contact with the sea bed. The vessel felt a slight increase in STBD main engine gearbox LO temperature. The vessel opened all ballast tanks and all areas were once again checked visually, no dents or any unusual changes were found in all the inspected areas. The vessel went through underwater	there were no dents or structural deformations present. The Master found everything to be satisfactory. Overall, despite experiencing some unforeseen issues during their journey, the vessel followed proper protocols to ensure safety on board. On 31/10/2023 at 0630 LT, the vessel sailed to Shaheed Dweep as per her scheduled voyage and returned to Port Blair on the same day at 1030 LT with passengers. During this voyage, the vessel experienced no abnormality and fluctuations except an increase in STBD Gearbox temperature. As per the Underwater CCTV inspection, the vessel required docking for renewal/inspection of STBD propeller and hull repair. Upon preliminary enquiry, it was found that no passage plan was prepared on 30/10/2023 and 31/10/2023 as per SMS and also Chief Officer did not sign the passage plan from 29/09/2023. GPS log book not updated from 1400 LT on 30/10/2023. During the CCTV inspection on 31/10/2023, the diver observed a dent in the STBD side of the hull and scrubbed scales to view clearly which revealed a hull breach at that location. Master informed that there was an increase in tank	

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					inspection and class and statutory surveys.	sounding of STBD FW tank (2S) from 1.20m to 1.50m, after underwater inspection.	
58.	31/10/2023	Eastern Orchid	Collision	Marine Casualty	On 31-Oct-2023 while enroute to Futong port for berthing under pilotage whilst crossing the Sungai Pakning area vessel was suppose to change from sea pilot to Harbour pilot, however at 0645LT sea pilot informed vessel that harbour pilot will board at 0715LT and therefore vessel will stop / maneuverer / drift Sugnai pakning anchorage area. At 0703LT vessel started to proceed to pick up the pilot, however at 0706LT vessel noticed that due to strong current own ship is drifting towards anchored Vessel mt Atlas link which anchored on port side, immediately steps including increase speed to full ahead, use of thruster and helm were taken. At 0709LT eventually bow of atlas link collided with the cofferdam port side b/ of accommodation,	At 0750 LT, the vessel anchored at Sungai Pakning for further investigation and damage assessment. No report of injuries or pollution. The vessel was safe and anchored for further damage assessment. The vessel had notified the company, flag authorities, and the charterers.	The Master and other bridge team members of the Eastern Orchid are recommended to undergo Bridge Team Management training as a minimum prior their next contract. The incident and the findings shall be shared with the training team to evaluate if any other training is needed for the team members.

Sr. no	Incident Date	Ship Type	Incident Category	Severity of Incident	Brief summary of Incident	Brief summary of action taken	Lessons learnt
					adjacent to the pump room – hull damaged. For further Investigation vessel anchored Sungai Pakning.		
59.	10/11/2023	Oil Produce Tanker	Fire & Explosion	Very Serious Marine Casualty	"M.T. PATRIOT was alongside at Chennai berth Coastal Berth 1 (CB no.1) undergoing repairs by Shore workshops. At around 0010LT / 10th Nov 2023 Cutting of nut bolts on the main deck was in progress. There was an explosion and fire Common boundary between 7 Port, Slop Port and Residual tank Shore fire brigade was deployed 0145LT - Fire has been extinguished and boundary cooling is in progress 1 Workshop personnel (As per above details from ROYALTECH) confirmed as fatality and 3 other personnel with burn injuries have been shifted to hospital.	A. Operations Manager and Senior Fleet Manager were deputed to the location of the Incident to support the Technical Superintendent, Fleet Manager and vessel staff to recover from the situation and arrange the necessary repairs. B. Fleet Manager attending the vessel during the repairs period was sent back to the office for retraining on the hotwork. C. Designated Person joined the Team at site and remained with the vessel to support and provide assistance to deal with the administrative & regulatory requirements arising out of the situation. He continued to stay on board until the hotwork was restarted with all necessary permissions from Flag and port authorities. D. Further, complete co-operation was provided to the Authorities with all details and documents to facilitate Incident Investigation process.	• Follow up Circulars and Emails have been sent out to all fleet for always ensuring and stressing on SMS compliance with Safety procedures. Frequent follow up with all vessels by the attending superintendents and ISM department to ensure continued compliance. • Safety of all operations on board the vessel are now controlled by the Designated Person as a preventive measure to confirm compliance with SMS procedures. • A change in SMS procedures was effected to revise the procedures relating to afloat repairs and repairs at layby berth including maintaining all safety precautions as per company standards even if the jobs are being carried out by shore personnel. • Requirement of having the SMS procedures implementation at all times has been stressed frequently to the entire fleet vessels through safety circulars, safety flashes, pre-joining briefings and on-board trainings by attending superintendents.

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						E. Drug and Alcohol Testing was conducted through an authorized shore laboratory for the on-board staff arranged by DPA. F. Immediate stop to all hotwork on board the entire fleet vessels was initiated on 10th November 2023. G. A Circular to the same effect was issued to all fleet vessels – "Safety Circular 27 of 2023 - Explosion and Fire in Slop Tank".	• A detailed assessment of situation conducted to ascertain Safety of the fleet vessels as a preventive measure. • All hotworks on board including the Engine Room workshop (Designated Area) are now being fully controlled and approved from the ISM Department only by Designated Person and Alternate Designated Person. • Hotwork procedure for Designated area (E/Rm Workshop) also was formalized and a Hotwork register was initiated for maintenance of records of hotwork within the same. • A random check on the safety of hotwork and other operations such as enclosed space entry, pumproom entry etc. on board is being carried out during the vessel visits by the office Team. • A CIC for Hot Work Procedures has been completed in the month of December to promulgate safe practices. • Continual Training sessions are being planned for office Superintendents for ensuring Safety of the Fleet vessels and complete adherence to SMS procedures.

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							• Informal talks with the vessel staff through telephone calls has been taken more regularly to understand if there is support required to ensure SMS compliance. • A Meeting was conducted with all the office Superintendents, Fleet Managers, Operation Managers, Technical and Operations Heads, Chief Operating Officer and Chief Executive Officer to entail the details of the Incident and the implemented corrective and preventive measures. SMS procedures compliance was emphasized to all office staff and in case where deviation is required then approval for the same to be positively taken from the ISM Department. • All joiners going through the office joining on board are being briefed on the details of measures being implemented due to the Incident and the preventive actions taken by the Office in this regard. They are briefed to strictly follow the company's safety procedures and encouraged to use stop work authority if unsafe conditions are observed. Revised company safety procedures are being stressed upon during the briefing.

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							• Company Physical Seminar is planned for the 1st week of March wherein a detailed Case study shall be taken up for detailed discussion with the sailing staff. Case Study will lay strict emphasis on preventive measures to avoid such Fire and Explosion Incidents. • A computer based training is being undertaken for the Incident occurrence and shall be implemented for completion by all staff in office as well as ashore – Target 15th March 2024. • Crew Training has been taken up as an initiative to implement strict compliance with the hotwork procedures and safety precautions to be taken. • Concept of 'STOP' for Safety program has been re-introduced and emphasized during Training on board as a Behaviour based safety initiative to enhance safety management on board fleet vessels.
60.	14/11/2023	Oil Product Tanker	Personnel Related	Marine Casualty	On 13/11/2023, 0950 LT, the vessel was in the Red Sea while on a voyage from Karachi, Pakistan heading towards Suez Canal, Egypt for northbound transit.	Immediately after the incident the Master initiated first aid measures which involved the removal of the exposed clothing covering the Pumpman's body. Cool running water was passed over the burnt areas and an assessment of the extent of	On completion of the final incident investigation report the lessons learned will be added and circulated with the fleet. ➢ Identification of hazards as part of Risk Assessment should be well defined.

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					Repairs were undertaken involving a change of gaskets of the spool piece on the steam line. The ship staff cut the gaskets to match the flange size and proceeded with the reinstallation of the spool piece in place. When undertaking the reinstallation there was egress of Hot Water and Steam from the open pipe section of the steam line which made contact with the Pump man resulting in scalding burns on a major part of his body. The Chief Officer and AB who were accompanying the Pump man during the repairs, suspended the task and immediately evacuated the Pump man to the ship's hospital. The Master was informed who in turn sought medical advice from the company doctor. First Aid and medical treatment were provided to the Pump man accordingly.	injuries was made. Master notified the office and medical advice was sought from the company doctor. Medical treatment was commenced onboard with medical advice from the company doctor. Considering the extent of burns sustained a decision was taken by the office and the Master for medical evacuation of the injured Pump man at Suez Canal Anchorage immediately upon vessel's arrival at the anchorage. After closely liaising with the local agents the Pump man was medically evacuated on 14/11/2023 at 1330 LT, and shifted to a shore medical facility.	➢ Lock Out and Tag Out mechanisms must be appropriately carried out. ➢ Permit to Work System (Cold Work) should be thoroughly reviewed and complied with. ➢ Appropriate PPE to be worn when working with Steam sources. The lines should be well drained prior commencement of work

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61.	16/11/2023	Vishva Malhar	Fire & Explosion	Marine Casualty	Fire in third officer cabin. After departure from Dhamra port while vessel was en-route to Ennore on 16.11.2023. At pons. 16°58.18'N / 084°15.76'E Chief officer who had just finished tool box meeting on bridge at 09:40 hrs. , When CO was coming down he found smoke coming out of 3rd officer cabin. On inspection, CO found a small fire in 3 rd. officer's cabin.	Chief Officer informed the incident of fire in 3rd officer's cabin to bridge and raised emergency alarm. Emergency stations were called to fight fire. Accommodation power supply was isolated, A/C Blowers stopped and fire pump started. Emergency team 1(Headed by Chief Officer) proceeded to fight fire while team 2 started boundary cooling. Cabin door was not opened to avoid smoke coming into the accommodation, Porthole glasses at port side and aft were broken to fight the fire after isolating electrical power supply from engine room. Once fire was extinguished Chief Officer entered room with fireman's outfit, SCBA and DCP extinguisher to ensure fire is extinguished completely. At 0955 hrs. Chief officer reported that fire has been completely extinguished. Power supply of 3rd officer's cabin and adjacent cabin has been isolated and vessel's power was restored. There was no casualty, no injuries, no Pollution, No Structural damage. No Loss of stability Arrangements were made for necessary repairs and restoring the cabin to normalcy.	Dissemination of Information in regard to similar incidents happened earlier appears to be not followed. Effective training and briefing on board in regard to switching off powers of electrical equipment's especially in unattended cabins appear to be lacking. Master and management level officers should ensure continual briefing and training on board, especially when there is a crew change. Effective air conditioner should form a vital requirement so as to avoid a requirement of additional fans in the cabin. Under-rated switch socket should be replaced and checks for electrical integrity of personal electronic gadgets should become mandatory on board while doing weekly cabin inspections. Master should make weekly surprise round of accommodation to verify the integrity of electrical switch and sockets.

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62.	21/11/2023	Sailing Vessel	Fire & Explosion	Marine Casualty	On 21/11/2023 at 1800 LT, fire was reported on board the vessel when loading operations were on alongside the jetty at Old Mundra port. The driver and cook who were near the accommodation and others on deck saw smoke coming from the engine room. The oilman came out from the smoking engine room and informed about the fire in the engine room.	Other shore workers including crew members came out of the vessel. Tindal /crew cut rope/mooring hawsers of the vessel to move her away from the jetty. The vessels in the same berth close to each other were shifted to safer places. The first fire tender reached the site around 1900 LT and commenced extinguishing the fire. Fire from the engine room came under control by the application of foam by the APSEZ Mundra fire department tender under GMB jurisdiction. But around 2130 LT it was observed that the vessel again caught fire & the fire spread to the forward part. Fire extinguishing continued by the fire brigade, but it was not successful in controlling the fire. No casualty or injuries to seamen or others. All shore workers and the vessel crew found safe and healthy conditions. The exact cause of the fire is to be determined. The vessel appears to be a total loss, even though fire extinguishing was in progress. Around 80% of the vessel was burnt. Vessel had grounded alongside the jetty.	One concerned crew shall take proper care on duty while any pump or engine is running on board.
63.	22/11/2023	Container Vessel	Incident onboard -	Marine Casualty	Injury on board. On 22/11/2023 1930 LT (IST), the Chief Cook,	He was repatriated to Kochi, India from Port Cartagena on 29/11/2023, for further management. He arrived	All crew are provided with pre-joining briefings, familiarization on board and are regularly

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			Personnel Related		during routine work, on his way from the provision room down to the galley, stumbled on the stairs and injured his right foot. He was referred to a doctor at Panama Port & an MRI was done. The diagnosis was a right Knee meniscus tear & he was advised surgical management. NOK was informed.	in Kochi on 30/11/2023. On 03/12/2023, he was shifted to Chennai for further treatment to a company-approved doctor for his right twisted knee evaluation. On 07/12/2023, the Ch/Ck requested that surgery be done at his hometown in Kochi. He was flown back to Kochi. The Ch/Ck underwent arthroscopic knee debridement on 13/12/2023 & was discharged from the hospital on 15/12/2023. The patient was declared unfit for duty, advised medication, & was reviewed on 27/12/2023 at the hospital.	trained/briefed to prevent slip/trip/falls, during regular sessions of drills/tool box meetings and risk assessment discussions/reviews on board.
64.	24/11/2023	Container Vessel	Personnel Related	Marine Casualty	Injury on board – Right-hand thumb severed. On 24/11/2023, the vessel was alongside in the port of Shanghai, China and the vessel crew was engaged in lifting operations using a Monorail crane. AB was operating the monorail crane and he was alone at the time of the accident. As per initial information from the vessel, while lifting the load from the engine room using a monorail crane, the operator tried to adjust the load by using his right	First aid was provided to him onboard and he was subsequently disembarked from the vessel for further treatment. His surgery was being planned at the hospital. The company doctor had been in the loop and suggested treatment.	Crew engaged in such operations involving lifting gear to have good ssituational awareness at all times. Adequate risk assessment to be carried out prior and likely hazards to be encountered to be discussed in tool box meeting prior commencement of operations. The identified controls measures and preparations for critical operations, including the use of provided checklists, shall be properly discussed, and followed prior operations. Those aspects shall be discussed with the crew during next safety meeting. - It would be an idea to have a toolbox talk meeting (with regards to critical operations during

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					hand at the crane block. During this process, his right-hand thumb got stuck in between the wire and sheave of the Monorail crane block, due to which his right-hand thumb got severed.		port stay) between both deck and engine departments (with all involved crew), prior operation and prior arrival in port (similar like pre-bunker meeting, involving both departments). This could also take place during daily meeting between Top 4. In this case, one PTW for critical operation (covering complete job deck-engine) should suffice. - Considering the risk of fall from ER skylight, it shall be evaluated and consider securing the area with portable stanchions & wire/ropes (while the hatch is open). Those elements shall be marked accordingly and stored in the vicinity. - A knowledge sharing should be considered to promulgate the learnings from this incident.
65.	25/11/2023	Oil Product tanker	Incident onboard - Personnel Related	Marine Casualty	Injury on board. On 25/11/2023, 1308 LT, Oiler completed his job at funnel area and secured the workplace. In spite of it is not ordered, he decided to close the funnel hatch when he was leavıng the area because he thought that ıf it rains, water may enter engine room lower decks that he had just painted. However, the	The doctor arranged by the company was contacted and the case explained to him. Surgeon advised to clean the wound and stitch it. After information exchange, ship staff made preparations and completed treatment as advised. After completion, another video call made to show the result and further advice. Medicines given as per doctor advise. Oiler shifted to his room and Master ordered to monitor him every two hours. Temperature & blood pressure monitored regularly.	The crew should follow all procedures along with the safeguards/instructions defined as per Company's safety system and tool-box meetings. "Stop work authority" should be activated in case of crew has any doubt for all critical jobs. Improper judgment - The crewmember's task assessment was not sufficient that the hatch cover cannot be handled by a single person.

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					hatch was very heavy and he could not support the weight and the hatch slammed on the thumb of his right hand which was between cover seal and hatch coaming edge. He immediately came to engine room and informed the engineers. He suffered an open fracture and crushing of the thumb bone due to a heavy metal plate falling on the left thumb.	After that the photos of the finger to doctor again. He advised to sent him to hospital as soon as possible because he was not sure about the finger's survival. On 26/11/2023, 0924 LT, Oiler was evacuated from the vessel for medical treatment, while the vessel passed off Malta. Master contacted MRCC Malta and a helicopter evacuation was arranged. He was admitted to Mater Dei Hospital, Malta at the time.	Failure to follow rules and Regulations - Although the task group had been notified about the hazards of the operation and safeguards, the safe operation procedures had not been followed properly by the crewmember. Inadequate guards and barriers - There is no warning sign on the hatch cover stating that it should not be handled by a single person because of its weight.
66.	26/11/2023 02:30 AM	Bulk Carrier	Incident onboard - Personnel Related	Marine Casualty	Injury on board. On 25/11/2023, 0510 LT, when the vessel was alongside at Port Hedland berth, OS suffered injury to his left elbow & left ankle when carrying out assigned work on board the vessel which he reported to the duty officer on watch.	Master was immediately informed of the injury. The injuries were assessed & it seems he had dislocated his elbow & slight swelling was found on the ankle due to sprain. At 0755 LT, the injured OS was sent to visit a shore doctor via crew launch. Upon examination by doctor ashore the X-rays showed no fractures, diagnosis was contusion of left elbow & sprain of left foot. He was declared unfit for work & allowed for air travel. At 1230 LT, OS personal effects inventory was taken, all his luggage was packed along with certificates. At 1555 LT Seaman luggage documents collected by agent boat.	All crew instructed to keep torches during dark hours in port watches or arrival/departure stations. Instructed not to take short cuts or bypass the safety in order to save time or energy. Duty officers to monitor the work assigned to the crew members in order to verify safety aspects and safe execution of jobs.

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67.	05/12/2023	Bulk Carrier	Incident onboard - Personnel Related	Marine Casualty	Injury on board. On 05/12/2023, 0155 LT, while removing the stopper for hatch cover, AB's hand was caught in between the hatch cover wheel and the hatch cover stopper while the vessel was enroute to Geelong, Australia. This led to injury on his right hand little finger.	He was immediately administered first aid and further medical treatment was carried out as advised by the Company Doctor. Owners diverted the vessel on the way to Madang, Papua New Guinea during her voyage from Xingxang, China to Geelong, Australia to land the injured crew member for further treatment. On 09/12/2023, 1624 LT, the Injured crew was safely disembarked from the vessel. He was taken to the local Govt Hospital. His wound was cleaned, and redressing was carried out for two days. He was repatriated back to India.	An effective toolbox meeting is to be carried out with the deck team to discuss the precautions that need to be taken before undertaking any operations, especially operations involving powered and hydraulically operated equipment such as hatch cover operation, grab operation, crane operation and use of any power tools. The importance of maintaining a clear line of sight between team members involved in the operation has to be emphasized during the toolbox meeting and this must be strictly complied with. If, for any reason, a clear line of sight cannot be maintained, then alternate communication methods are to be established, such as using a walkie-talkie for communication between team members. The operator must ensure that he has received the go-ahead confirmation from all team members before commencing any critical operation. All crew members have to be made aware that no shortcuts are to be made and use proper safe working procedures such as taking rounds, giving warning before operating, etc., to be observed to avoid such incidents.

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							This incident report and the investigation report will be circulated to other fleet vessels for their information and compliance. This report is also to be discussed by the training department.
68.	05/12/2023 10:30 AM	Container Vessel	Incident onboard - Personnel Related	Marine Casualty	The vessel was stopped in the Indian Ocean for carrying out maintenance on the Main Engine. During this time 2/E suffered Heavy fuel oil burns on his head and face.	The vessel was stopped in the Indian Ocean and carrying out maintenance on the Main Engine. 2/E has suffered Heavy fuel oil burns on his head and face. Radio medical recommended medical evacuation of the 2E WCA OCL was looped in and confirmed Galle OPL is the best and closest option Vessel reached Galle OPL in 10-12 hours. 2E was disembarked via a medical service boat and transferred to a hospital. 2E received the necessary treatment from Galle as well as he was in touch with company doctor. Treatment went well and he arrived home on 10 Dec, 2023. Thereafter continued with the treatment at home and declared fit for sea service by DG approved doctor on 16 Jan 2024.	An effective toolbox meeting is to be carried out with the deck team to discuss the precautions that need to be taken before undertaking any operations, especially operations involving powered and hydraulicly operated equipment such as hatch cover operation, grab operation, crane operation and use of any power tools. The importance of maintaining a clear line of sight between team members involved in the operation has to be emphasized during the toolbox meeting and this must be strictly complied with. If, for any reason, a clear line of sight cannot be maintained, then alternate communication methods are to be established, such as using a walkie-talkie for communication between team members. The operator must ensure that he has received the go-ahead confirmation from all team members before commencing any critical operation.

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							All crew members have to be made aware that no shortcuts are to be made and use proper safe working procedures such as taking rounds, giving warning before operating, etc., to be observed to avoid such incidents. This incident report and the investigation report will be circulated to other fleet vessels for their information and compliance. This report is also to be discussed by the training department.
69.	09/12/2023	G Harmony	Fire & Explosion	Marine Casualty	Fire on board in hold. On 09/12/2023, 2000 LT, fire was reported on vessel in hold no.2, when cargo operation was ongoing at Mundra port CB-3.	The cargo operation was immediately stopped, and Port fire tenders and tugs were deployed for fire-fighting assistance and boundary cooling. Once smoke from hold no. 2 receded, the hold was closed and all vents sealed. All flammable material from port side bulkhead and vicinity was removed including paint from paint locker, and continued boundary cooling and temperature monitoring. From 09/12/2023, 2300 LT to 10/12/2023, 0900 LT, bulkhead temperature reduced from 55 deg to 28 deg. No injury/casualty is reported due to the incident. On 11/12/2023, 1816 LT, Adani Ports and SEZ Ltd informed that the vessel was to be unberthed on 10/12/2023, 1808 LT, from berth CB-3 after cargo	Possibly due to the improper lashing and securing of cargo inside container and subject to confirm

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						completion and vessel dropped anchor in anchorage area Alpha at 1934 hrs. The Marine Control was regularly taking status of cargo hatch temperatures from the vessel on VHF. On 11/12/2023, 1750LT, the Master confirmed on VHF that the hatch no. 2 was sealed and there was no smoke or fire observed. The temperature in the paint store was 25-27 Deg. No IMDG container in hatch no. 2. There were a total of 48 containers in hatch no. 2 containing paper and coil. The vessel was expected to re-berth for discharging of remaining containers during which precautions would be taken by the port. On 13/12/2023, it was reported that Panama authorized an Inspector for the fire Investigation after berthing the vessel. The vessel re-berthed on 15/12/2023 with all safety precautions at berth B-5 at 0600 LT. On 16/12/2023, 1120 LT, APSEZL, Mundra team boarded the vessel to assess the status of fire in Hatch No.-2. The dense smoke with very high temperature 400 degree was observed inside hatch no. 2. The Firefighting operations were immediately started. The affected containers were safely unloaded from the vessel and fire in	

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						hatch no. 2 was extinguished at 1830 LT. The regular fire watch/round was being carried out by vessel crew. The Marine Control had been taking vessel status on VHF every 08 hours. At 2100 LT, the vessel confirmed that there is no smoke or fire observed in hatch no.2 and temperature is 36-37 degree. On 17/12/2023, the vessel might be inspected by class surveyors for damage of hold, if any.	
70.	12/12/2023	Chemical Tanker	Incident onboard - Personnel Related	Marine Casualty	JEWKO was climbing down the stairway from emergency manoeuvring platform to bottom platform, due to sudden rolling of vessel and slippery surface JEWKO slipped and lost balance on ladder and fell down in the Engine Room on 12.12.2023 and injured his groin. There was internal bleeding due to which he was passing blood through his urine.	Junior engineer was moved to ships Hospital and general cleaning of the groin area was carried out for better look at the injured area. With further closer examination it was found no bruise or cut injury near the affected area. Left testicle was observed swollen and pain observed in the groin area. Immediately thereafter rested the patient with minimum body movement, Contacted International SOS on Emergency number for further help. Medical treatment (First Aid) was given to JEWKO before sending him to shore Hospital for check-up and Training, meeting held on-board with all crew and instruction and procedure explain to all crew in case of heavy weather, what we need to do to keep ourselves safe.	Lack of situational awareness results in seafarer not taking extra precaution during heavy weather, while ship is rolling and pitching. Heavy weather precautions were not considered during unplanned work, toolbox, and work plan meeting. Always hold on to railings during bad weather and maintain three-point contact (Attached Safety Advisory 0224 Slip Trip & Fall). ========== • Lack of situational awareness results in seafarer not taking extra precaution during heavy weather, while ship is rolling and pitching. • Heavy weather precautions were not considered during unplanned work, toolbox, and work plan meeting.

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							• Always hold on to railings during bad weather and maintain three-point contact (Attached Safety Advisory 0224 Slip Trip & Fall).
71.	12/12/2023	Chemical Tanker	Fire & Explosion	Marine Casualty	Vessel was struck by a missile in way of Cargo Oil Tank 7 (S) at about 0010 hrs LT (UTC + 3) on 12 Dec 2023, close North-West from the Bab-al-mandab straits (position 13 deg 17.7 min N, 042 deg 59.9 min E), while the ship was on a voyage from Pasir Panjang, Malaysia to Venice, Italy. The vessel is loaded with Palm Oil. All crew are accounted for and uninjured. No oil pollution has been reported. The missile strike ignited the cargo inside the cargo tank and fire-fighting efforts are in progress to try and extinguish the fire. The vessel's propulsion and steering are unaffected, and it is proceeding under its own power at full speed in a North-westerly direction to	The Master immediately informed CSO and was in touch with the Coalition Navy. The Coalition Navy was guiding Master. A United States' naval vessel was on its way to the vessel, expected at the rendezvous position at about 0000 LT on 12/12/2023. As per update received on 12/12/2023, 1853 LT from Head of FLEET Care, US Naval vessels escorted the vessel to safety towards Djibouti for further investigation & hull assessment. On 13/12/2023, 1802 LT, the vessel had safely anchored at Djibouti roads. The vessel was expected to be boarded by the investigating authorities on 14/12/2023 morning. On 15/12/2023, 1711 LT, US Navy personnel were awaiting approval from the Norwegian Maritime Authority (NMA) to board the vessel for forensic investigation. Representatives from the Classification Society and War Risk Insurer have boarded the vessel. RPSL Elegant Marine Services Pvt. Ltd. were providing psychological	The issue has a geo political background. Close coordination with various stakeholders like coalition warships / UKMTO/IFC-IOR and DG shipping will provide tracking and monitoring of ships in the area.

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					try and get away from the area as soon as possible.	counseling to all staff on board & had kept NOK updated.	
72.	18/12/2023	Chemical Tanker	Fire & Explosion	Marine Casualty	Fire & Explosion. Suspected Drone attack. On 18/12/2023, around 0552 LT, the vessel was attacked by a Drone (suspected) on Port Quarter, in the Red Sea. The vessel was heading towards Reunion. All crew including the master (Total 22 Nos) were declared safe and no injury to any crew members was reported. The vessel had three-armed security guards onboard and they were also safe.	Master reported that the vessel was in contact with USS Naval Command Centre Bahrain, and they had sent a vessel to the position of attack for assistance. They had been informed that their vessel was now around 1.5 hrs away from the vessel. However, they have sent a drone and were monitoring the vessel movement through air surveillance. Company was in contact with the vessel's Master / US Naval command center. There was no Fire or any injury to any one onboard. The vessel was moving under her own power southbound towards Bab-El Mandeb as instructed by the US Naval command center. The Escort Naval vessel had turned back, and the vessel was proceeding at full speed in the IRTC Corridor. Owners were going to nominate the port of refuge for damage assessment. Company had advised the master to let all officers and crew members call their family members using the ship's phone on an urgent basis. Company office had also contacted NOK of staff onboard to convey their well-being.	The issue has a geo political background. Close coordination with various stakeholders like coalition warships / UKMTO/IFC-IOR and DG shipping will provide tracking and monitoring of ships in the area.

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73.	21/12/2023	AMI	Personnel Related	Very Serious Marine Casualty	Forecastle Store bilge alarm was triggered, which prompted the Master to send a team of crew which consisted of CO, 2E, 4E, Pumpman and Oiler to proceed to investigate the matter after altering the vessels course to reduce effects of swell. The CO and his team reported that they contained the source of water ingress and cleared the water from the Electrical power packs in the Forecastle store and were exiting the Store. On exiting the store the CO noticed one of the goose necks in the forecastle which had come open and he proceeded to close the flap. Unfortunately during this time the vessel was hit by a huge wave which swept the CO against the hull structures on the forecastle. Death on board of C/O & Injury to 4 crew.	General alarm was raised & verbal order was given to crew to rescue CO & Pumpman. 2/O, 3/O & a crew member rescued the CO & Pumpman & they were brought to the CCR. There was no response from CO & it was observed that he could not breathe. Master started CPR, connected the AED. At the same time, the office was informed about the crew injuries & medical emergency. CPR was continued by crew members. 2/E had sustained cuts on head & left leg below knee small portion of skin had peeled off. Bleeding was prevalent & first aid was administered. 4/E had bleeding on head, right leg below knee skin peeled out. Pumpman right leg above knee swollen & was in pain, unable to move right leg, plus pain in right shoulder. Oiler Right side below knee severe pain, unable to walk. At 1250 LT, MRCC Taiwan & at 1320 LT, CIRM Rome was informed about on-board situation & medivac for injured crew & CO unconscious condition. At 1340 LT, a helicopter rescue team approached the vessel & was monitoring weather conditions. At 1400 LT, the rescue team suspended ops due rough weather.	Any attempt to proceed to areas exposed to heavy weather is to be undertaken only after thorough risk assessment and adequate precautions.

Sr. no	Incident Date	Ship Type	Incident Category	Severity of Incident	Brief summary of Incident	Brief summary of action taken	Lessons learnt
						Due to medical emergency at 1410 LT, the vessel was diverted to Taipei, Taiwan to evacuate the CO and injured crew members for further medical assistance as instructed by Keelung Radio on VHF. At 1830 LT, shore doctor was consulted including office staff by video call & master briefed all on injured crew status. On 22/12/2023, 0048 LT, agents along with a shore rescue team on board checked the condition of the injured crew. Four ambulances were standing by. At 0054 LT, Ambulance team checked the CO's condition. At 0054 LT, through agency staff, the crew was instructed to stop CPR & CO was declared "passed away". CPR on CO was started on 21/12/2023 at 1135 LT till 22/12/2023, 0054 LT continuously without any stoppage in rotation by CPR team..	
74.	23/12/2023	Chem Pluto	Fire & Explosion	Marine Casualty	Fire & Explosion. Drone attack [fallout of Israel Gaza (Hamas) conflict]. On 23/12/2023, at about 1005 IST fire was reported on board the vessel due to a suspected drone attack. Information was received at 1036 LT on 23/12/2023 from the company that the vessel loaded with	The company had informed MRCC and Indian Navy to be apprised of the developing situation. Initially fire was reported on the vessel along with power blackout. The fire was extinguished and the ship's crew tried to restore the power. The fire was completely extinguished by the ship staff& there were no injuries with all crew being safe. There was no	The issue has a geo political background. Close coordination with various stakeholders like coalition warships / UKMTO/IFC-IOR and DG shipping will provide tracking and monitoring of ships in the area.

Sr. no	Incident Date	Ship Type	Incident Category	Severity of Incident	Brief summary of Incident	Brief summary of action taken	Lessons learnt
					Ethylene Dichloride was attacked by Drone on the poop deck. Vessel had loaded from Jubail (Saudi Arabia) and was heading towards New Mangalore. No injury to any crew members.	pollution. No impact on vessel's stability. Vessel had reported damages in the Poop deck. Vessel reported that she had resumed voyage towards Mumbai, however the vessel's steering & propulsion were hampered & requested escort from ICG due limitations on steering. On 23/12/2023, 2004 IST, ICG informed that Indian Coast Guard had been diverted to escort the vessel enroute to Mumbai. The Indian Navy also provided an escort. On 25/12/2023, 1615 LT, the vessel was boarded by the Joint Navy Investigation team, Indian Coast Guard, Indian Navy, explosive special team and special missile task department, MHA officials, and marine Mumbai police, The vessel started STS Operation with Chem Lithium to discharge cargo, after completion the vessel is expected to come to the inner anchorage on the 27/12/2023 for further repairs.	