Death in Enclosed space

Casualty Circular No. 2 of 2003

F.No.11 NT(5)/2003 Dated 23rd June 2003

Sub: Death in Enclosed spacet.

1. Naration

1.1 A bulk carrier of GT 20659 was enroute from Canadian East Coast to Mainland China via "The Panama Canal". The vessel was loaded with various grades of scrap cargo. Ballast tank-gauging unit was reported to be malfunctioning. Location of this unit was in the stool spaces and access is through manholes in the cargo holds.

1.2 The subject of man entry into the stool spaces was discussed with the Bosun a day before. During the morning of the next day, the stool spaces in No. 1, No. 2 & No. 3 holds were opened. Thereafter, the crew proceeded to open stool spaces in No. 4 hold. At this time, the Chief Officer & Chief Engineer came on deck and apparently entered the No. 3 hold. Not long thereafter, Electrician, who was also called by the Chief Officer to come to No. 3 hatch for inspecting/repairing the Ballast gauging system, came on deck. However, he was not able to find either the Chief Officer or the Chief Engineer and out of curiosity, he peeped into the forward booby hatch of No. 3 hold and observed that the Chief Officer & Chief Engineer both were lying at the first platform.

1.3 An alarm was raised and subsequently, the bodies of both Chief Officer & Chief Engineer were brought out on the deck. Attempts were made to revive the Officers using Oxygen resuscitator and CPR, however, in vain.

2. LESSONS LEARNED : -

2.1 It appears that there were toxic gases present in the hold and that the cargo may have generated the same. Instructions given by the Charterers at each load port warning against an Oxygen deficient atmosphere in the holds and forbidding entry, were not heeded.

2.2 Although, the cargo of scrap as declared by the Shipper was not classified under IMDG, however, the BC Code does mention "dangerous depletion of Oxygen in the cargo spaces" under UN No.2793 - Steel Swarf.

2.3 Enclosed space entry procedures are mandatory as per ISM Code requirements and these are to be strictly followed by all including Senior Officers. Any faulty assumptions in this regard can be fatal.

2.4 Although, rescue was initiated immediately, the initial rescue methods used were not in compliance with safety procedures and caused two failed attempts resulting in invaluable delay. There is an urgent need to address the issue of rescue from enclosed spaces through narrow openings including availability of lifting equipment/ gear, it's practicality and associated periodical drills.

3. This issues with the approval of the Nautical Adviser to the Government of India.

Back to NT Circulars main page