

Casualty Circular 2 of 2006

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NO: 11-NT(119)/2005

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NARRATIVE

An accident occurred on board a foreign flag vessel on 19th December 2005 while opening hatches to commence the loading operation. The vessel had an electro hydraulic system for this purpose. As the hydraulic system was not developing sufficient pressure, the manual arrangement of opening the hatch by way of connecting the runner wire of the derrick to the pontoon was planned. The runner wire was secured to the hatch pontoon and made to pass through a D Shackle, in violation of established procedures. D Shackle was secured to the Guard-rail stanchion located on mast house, again in violation of established procedures.

The Officer on watch had positioned himself on the main deck and was directing the operations. Order to cease heaving from the Officer on watch to the winch-man was neither understood nor executed, as a result of which the stanchion to which the D Shackle was attached gave way. The steel wire and the D Shackle that uprooted from Guard-rail and struck the winch man on the head who was in close proximity. The winch man suffered serious injuries to his head and neck that proved to be fatal subsequently.

PROBABLE CAUSES OF THE ACCIDENT

1. Hydraulic system for opening the hatch covers was not maintained in operational condition.
2. Ship staff did not follow emergency procedure for opening hatches in the event of failure of the hydraulic system.
3. Un-seamen like practices such as passing the runner wire through a D Shackle instead of a snatch block, attaching the D Shackle to the Guard-rail stanchion instead of it being secured to a strong Eye Pad on deck was the root cause of this casualty.
4. Opening of hatches being an essential shipboard operation needs a documented procedure in accordance with ISM Clause 7.0, the same was not included in the SMS Manual of the ship.
5. Mis-communication and inappropriate handling of the winch by the winch man.
6. Use of inexperienced winch-man.

LESSONS LEARNT

1. Procedures, instructions including Check List for key shipboard operations need to be documented after identifying and analyzing the risks involved.
2. Trainees should only work under the supervision of trained and experienced personnel.
3. Senior management level Officers should ensure that personnel assigned to similar activities have appropriate familiarization and adequate skills for the job being performed by the concerned personnel.

Sd/-
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