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

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DGS Circular 42 of 2025

Casualty Branch Circular – 04 of 2025

Subject: Death of seafarer due to fall from Crane Cabin

1. Overview

This circular highlight fatal fall-from-height incident aboard the bulk carrier, which occurred during cleaning of a cargo crane operator's cabin. The incident exposed serious deficiencies in hazard identification, equipment integrity, and fall protection measures.

Figure 1: MV Yuka

2. Incident Description

The vessel Yuka D discharged a cargo of steel scrap at the port of Chittagong, Bangladesh, using its cargo cranes operated by shore personnel. Upon completion of unloading operations, the vessel proceeded in ballast to the port of Paradip, India, to load a new cargo of steel slabs. Yuka D arrived and anchored off Paradip on 20 May 2024.

Figure 2:Crane Operator cabin: Outside view

Figure 3: Location where the seafarer landed after the fall

Figure 4: Crane Operator Cabin - Inside view

On the morning of 22 May 2024, while the vessel remained at anchor awaiting berthing instructions, two ordinary seafarers were tasked with cleaning the interiors of the cargo crane cabins, which required maintenance after the cargo operations in Chittagong. About 30 minutes into the work, one of the seafarers, fell from the cabin of cargo crane no. 1 onto the cross-deck between cargo holds 1 and 2, a drop of around 12 metres. Despite the crew's immediate response, the seafarer sustained fatal injuries. The safety investigation determined that the most probable cause of the fall was the failure of the sealing mechanism of the bottom window in the cabin of cargo crane no. 1.

3. Cause Analysis

The analysis outlined below is derived from the initial findings of the preliminary investigation into the incident:

3.1 Immediate Cause:

a. Failure of bottom window assembly: The seafarer fell through the bottom window, which gave under the seafarer's weight.

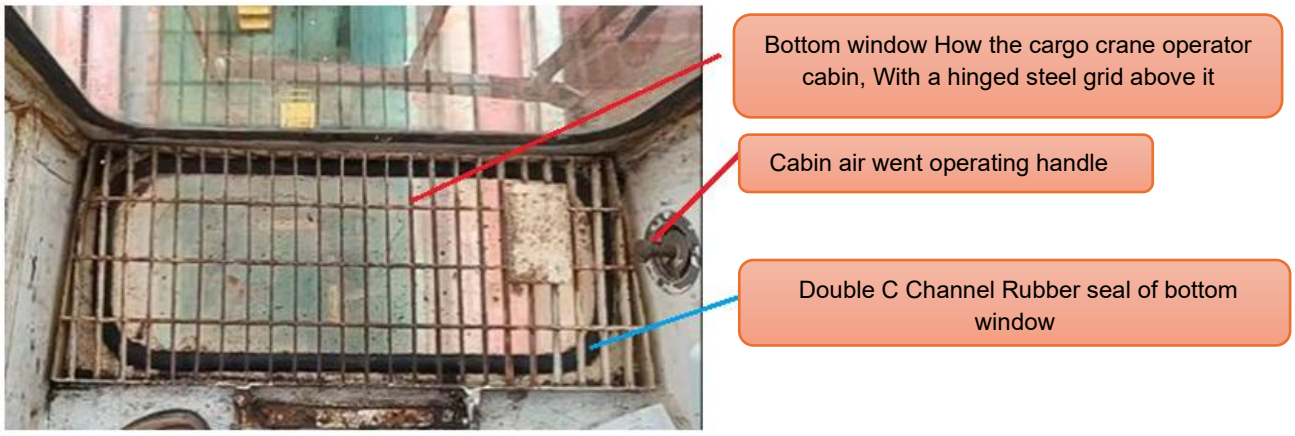

Figure 5 : View of the Crane cabin internal structure / grating arrangement

3.2 Contributing Factors:

a. **Grating Removal:** The protective steel grating over the window was removed to access the glass for cleaning due to seized cabin air vent handle. Normally, the grating is swung out to clean the glass, but due to the obstruction from seized air vent handle, the seafarer had to remove it completely, leaving the fragile glass exposed

b. **Glass Design Limitation**: The glass pane and rubber seal were not designed to support any weight.

c. **Pre-existing Damage**: The glass may have been previously weakened.

d. **Seal Failure**: The rubber seal (double C-channel type) possibly failed under weight of the seafarer.

e. **Corrosion:** Thinning of metal around the window frame may have weakened the structure.

f. **No PPE Used**: The seaman was not wearing a safety harness while working at height, where there is risk of fall injury.

g. Absence of Safety Barriers:

(i) No physical guard remained after grating was removed.

(ii) No alarms or interlocks to prevent or warn against barrier removal.

(iii) No warning signs to alert the seafarer to the hazard.

There was no evidence that fatigue, substance use, or adverse weather played a role in the accident.

3.3 Breach of Regulations and Other Issues

a. ISM Code (Clause 7): Inadequate risk identification and failure to establish safe procedures.

b. ILO Maritime Labour Convention: Breach in providing a safe working environment and effective safety training.

c. Company SMS: Failure in conducting a job-specific risk assessment and ensuring proper controls in confined or elevated spaces.

4. <u>Lessons Learnt</u>

The safety investigation into the incident highlighted several key lessons to prevent similar accidents in the future:

a. Routine Task Risk: Familiar tasks can lead to complacency. Hazards in routine jobs are often underestimated, highlighting the need for vigilant risk assessments.

b. Barrier Integrity: The removal of physical protections (like gratings) can expose hidden risks. Such components must be treated as critical safety barriers.

c. Structural Inspections: Equipment such as window assemblies and sealing mechanisms can deteriorate over time and must be regularly inspected to prevent structural failure.

d. Training on Equipment Hazards: Lack of awareness about equipment limitations (e.g., glass not designed to bear weight) can result in fatal misjudgements during work.

e. Use of Safety Signage: Absence of visual warnings can cause workers to overlook hazards. Clear signage could have reinforced awareness.

f. Proactive Safety Culture: Unsafe conditions often go unnoticed when safety practices are reactive. A proactive approach to inspections and hazard identification is essential.

5. Recommendations

a. **Safety Officer's Inspections**[1]: Reinforce the safety officer's inspection program[2] to look out for any potential hazards and the means of preventing incidents. The safety officer must ensure that each accessible part of the ship has a health and safety inspection at least once every three months, or more frequently if there have been substantial changes in the conditions of work.

b. **Install Functional Safety Systems**: Introduce interlocks, alarms, or mechanical restraints to prevent removal of safety barriers or to detect unsafe configurations.

c. **Design Improvements: Redesign critical components** such as gratings and windows—to allow safe maintenance and cleaning without the need to remove

[1] 13.4.2.1 (Code of safe working practises for merchant seafarers) The safety officer is required by the regulations to try to ensure compliance with the provisions of this Code and any health and safety guidance and instructions for the ship.

[2] 13.4.2.3 (Code of safe working practises for merchant seafarers) The safety officer should also promote safety on board, subject to the agreement of the master.

protective features. Install additional safety barriers, such as transverse steel bars, below exposed areas (in this case the crane operator cabin bottom window) where there is a risk of fall injury.

d. **Toolbox meeting**: Reinforce toolbox talk before the work begins ensuring that all crew involved in the work understand and are aware of any hazards and their associated risks.

e. **Mandatory PPE Use**: Enforce the consistent use of fall protection equipment (e.g., harnesses) for all work at height where there is risk of fall injury.

f. **Fleet-wide Awareness**: Circulate lessons from this incident across the fleet via safety bulletins and toolbox talks to reinforce shared learning.

(Capt. Harinder Singh)
Nautical Surveyor & Dy. Director General of Shipping (Tech)

To,
All stakeholders through the DGS Website
Ship Owner/ Ship Operators/ Ship Manager/ Ship Masters

Brief Particulars

Vessel Details	
Name	Yuka D
Flag	Malta
Classification Society	American Bureau of Shipping (ABS)
IMO Number	9586710
Type	Bulk Carrier
Registered Owner	Yuka D B.V.
Managers	Norbulk Shipping UK Ltd.
Length Overall	179.50 m
Registered Length	172.98 m
Gross Tonnage	22,137
Minimum Safe / Actual Manning	14 / 21
Authorized Cargo	Dry cargo in bulk
Port of Departure	Chittagong, Bangladesh
Port of Arrival	Paradip, India
Type of Voyage	Short International
Cargo Information	In ballast – 6,137 mt
Date and Time	22 May 2024, at 08:30 (LT)
Type of Marine Casualty	Very Serious Marine Casualty
Location of Occurrence	20° 13.2’ N, 086° 50.6’ E
Injuries/Fatalities	One fatally injured crew member
Damage/Environmental Impact	Failure of the bottom window of the cabin of cargo crane no.1
Ship Operation	At anchor; cleaning
Voyage Segment	Anchored
External Environment	Daylight, clear sky, good visibility; SSW gentle breeze; smooth sea, no swell
Air & Sea Temperatures	35 ℃ (air), 28 ℃ (sea)
Persons on Board	21