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

File No.25-19012/14/2023NT-DGS Date: 06.08.2024

Ref. No.Nautical Wing/Casualty Branch/03/2024

DGS Circular No. – 24 of 2024

Subject: Strengthening Onboard Security and Safety Protocols: Lessons from Recent Haldia Port Casualty

This advisory is issued considering the unfortunate incident that occurred recently on board a vessel berthed at a coal jetty at Haldia, resulting in the tragic loss of life onboard a vessel. The investigation revealed that the deceased was neither a seafarer, nor an approved shore personnel engaged in stevedoring tasks on board. Regarding the casualty incident, the Directorate General of Shipping has observed the following:

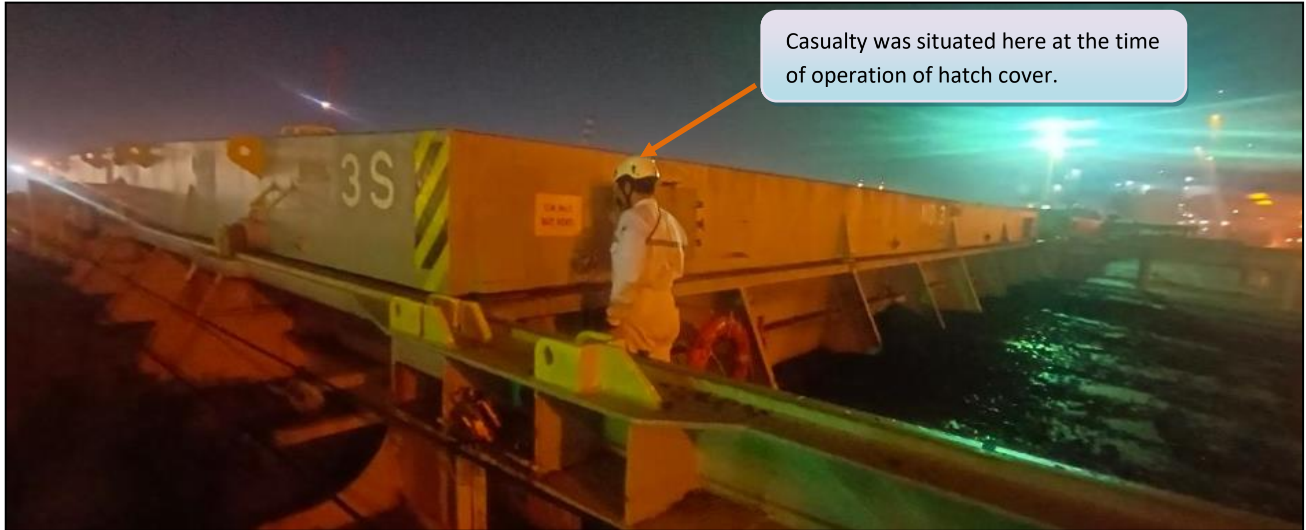


Fig 1: Location of casualty on main deck at the time of incident

What Happened

On 04.10.2023, one person boarded the vessel, as businessman. Reportedly, the access was denied and he was told to leave the vessel. The location of the gangway is near cargo hold no # 3. The hatch cover extends and reaches close to the boarding area of the gangway, in an open hatch condition.

As the person started going down the gangway, it started raining. The gangway watch keeper, and one duty hand went to close the hatch covers of hold no.3 and 5. Meanwhile the deceased person reportedly returned onboard and took shelter from rain underneath the hatch cover of cargo hold no.3. Starboard side, near the gangway.

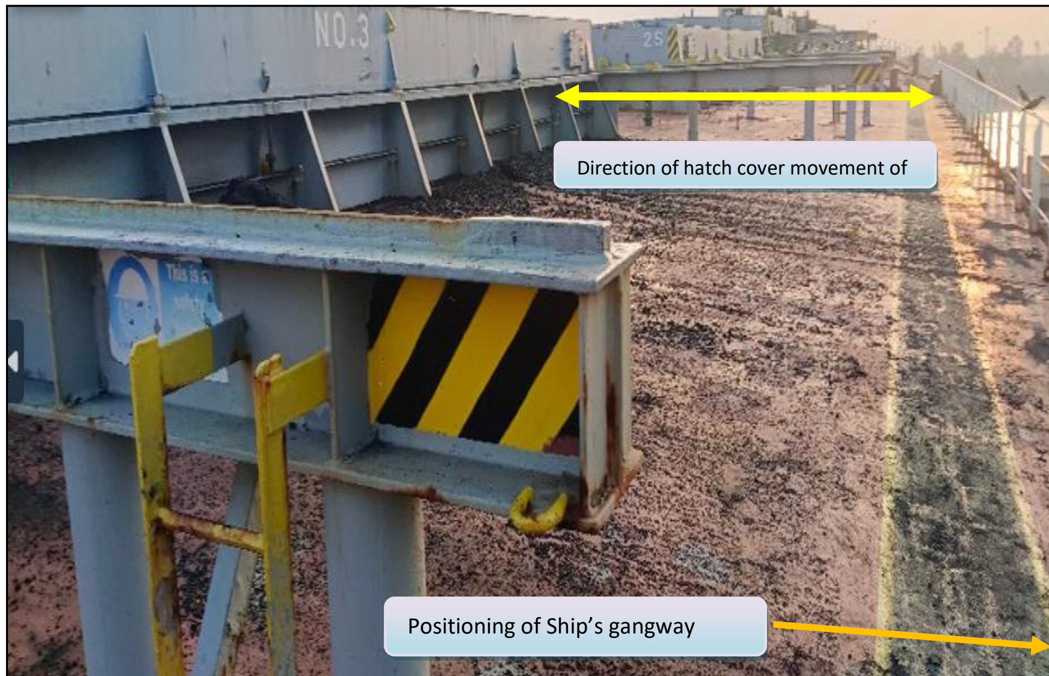


Fig 2: Hatch cover operation and positioning of gangway

Why it happened

The casualty occurred while closing the hatch cover of cargo hold no.3. The preliminary investigation has identified the root cause and the causal factors of the incident to be as follows:

1. **Failure in basic seamanship**: The presence of only two duty hands on deck to handle cargo and security duties resulted in the gangway being left unattended while they proceeded to close the hatch covers. The general seamanship for giving verbal call or flashing the torch in the area was not carried out.

2. **Failure in compliance with the Safety Management System (SMS) procedure**: The compliance of the hatch cover closing procedure as mentioned in the safety manual was neglected.

3. **Insufficient duty hands**: The manpower at the time was not sufficient, which caused the security duty hand to leave the gangway unattended.

4. **Insufficient illumination at the location**: It was observed during the dark hours that the illumination under the hatch covers was insufficient. The area was lit poorly by the forward

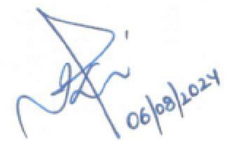
mast aft facing flood light, which was probably obstructed by the rain at the time of the incident.

Recommendations

The investigation has also revealed certain gaps in safety measures which may have contributed to the casualty. Considering the circumstances that lead to the incident and to prevent the recurrence of such incidents, the following recommendations are provided by the Directorate:

1. The gangway should be always manned. To reduce the need for constant monitoring, the gangway can be lifted from the jetty during hours of darkness.
2. To ensure safety, security, and operational efficiency, there must always be an adequate number of personnel on deck.
3. Basic seamanship practices, along with safety procedures outlined in the SMS manual, must be strictly always adhered to.
4. Ensure proper illumination of the area between the hatches and underneath the hatch covers.
5. The port should prohibit entry to unauthorized persons during odd hours.
6. The vessels shall ensure that all enclosed and restricted spaces are not accessed unless duly authorized by the vessel personnel. Accesses to enclosed spaces are to be authorized and controlled by ships personnel.
7. Seafarers should receive comprehensive education regarding their responsibilities for all security matters.

This is issued with the approval of the Competent Authority.



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

To,

All Ports & Stakeholder's through DGS website

This Marine Notice reminds ship owners, operators, masters, crews, recognized organizations, port authorities on inherent dangers posed by enclosed spaces onboard and need for adequate training for shore personnel who are engaged on board by port stevedores.

Brief particulars of the incident referred in the circular

	Incident
Name of Ship	KAVO ALKYON
IMO No	9291121
Flag	Marshall Islands
Type of Ship	Bulk Carrier
Year built	2005
Gross tonnage	38845
Owners / Managers	FALCON VENTURES
Classification Society	American Bureau of Shipping
Cargo	Coal
Location of incident	Coal Jetty at Haldia
Weather conditions	Slight/Calm
Date of incident	04/10/2023
Type	Very serious Marine casualty
No. of fatalities	01
Injury	0
Age	----
Nationality	Indian
Personnel involved	Businessman
Nature of incident	Entrapment underneath the hatch cover while it was being closed.
Location	On main deck underneath hatch cover of no:3 Hold