

CASUALTY REPORT

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Case 199903359
File 01.40.50

HELLE STEVNS

Accident at work

August 21, 1999



1. The Casualty:

Type of casualty: In connection with working at the hatch an AB fell overboard
Location of casualty: 27°29'4 N - 069°52'9 W
Date and time: August 21, 1999 at 08.55 (ZT+4)
Injuries: 1 casualty

2. Ship Particulars:

<i>Name of Ship:</i>	HELLE STEVNS
<i>Registration No:</i>	
<i>Home Port:</i>	Svendborg
<i>Control No:</i>	D 3356/OUKI
<i>Call Sign:</i>	
<i>IMO No:</i>	7702592
<i>Type of Ship:</i>	Cargo Vessel
<i>Construction year:</i>	1980
<i>Tonnage:</i>	5224 BT
<i>Length/breadth/draft:</i>	101, 64 m. / 16,50 m. / 9,00 m.
<i>Engine Power:</i>	2500 Kw
<i>Crew:</i>	12
<i>Owner:</i>	K/S Helle Stevns
<i>Classification Soceity:</i>	Bureau Veritas

3. The crew

The Master: Signed on to the HELLE STEVNS on 28 July 1999. He got his master's certificate in 1986. He has worked as officer for 8 years on the HELLE STEVNS.

Chief Officer: He got certificate for fishing vessels 1986 and he got his master's certificate- in 1994. He has sailed as mate/officer until August 1998 where he became Chief Officer on the HELLE STEVNS.

The third Officer: signed on to the HELLE STEVNS on 6 June 1999. He got his master's certificate in a Philippine institute. He has had his license as third officer since 1992 and has been working as such since 1994.

The boatswain: He has 2-½ years education taken at a Philippine Maritime Institute. He has 14 years of experience sailing at sea.

The AB who fell overboard: Signed on to the HELLE STEVNS on 10 June 1999. He had been educated at a Philippine Maritime Education Centre in 1992.

The two other AB's had both signed on to the HELLE STEVNS on 7 December 1998 and they had worked at sea - 10 and 11 years respectively.

The second engineer: signed on to the HELLE STEVNS on 26 February 1999. He has been educated at a Philippine Maritime Institute. He has 11 years of experience sailing as officer.

The Chief Engineer, the third engineer, the cook, and the motor man did not give evidence as they did not witness the accident.

4. Narratives:

The HELLE STEVNS was on a voyage from Mobile, Alabama to Tenerife. The speed of the vessel was 9 knots. On 21 August at 07.30 the boatswain had arrived to the bridge in order to discuss tasks to be carried out with the Chief Officer who was on the 4-8 duty. In the hatch locker between hatch No.1 and hatch No. 2, there were four big bags with donnage, which were going to be thrown overboard. On the ship, they have tried to deliver the wood in American harbour but they had not succeeded. As the weather was calm, the Chief Officer decided that the crane should be used for hoisting the four big bags up to hatch No. 2 in order to throw the wood overboard.

The work began at 08.00. The boatswain operated the crane and three more AB's participated. At 08.20, as the first big bag had been hoisted to the hatch the Master and the Chief Officer came on deck. The Chief Officer had been released by the third officer on the bridge.

The crane house is placed on port side in the centre of hatch No.2. In stowed position, the derrick points aft along the hatch and it is placed in a cradle.

The ship carried a large motor boat as deck cargo. The boat was placed on the fore half of hatch 2. They had attached two guiding lines in the hook in order to prevent that the crane hook would strike the boat while the derrick was turned.

At 08.55, the four big bags had been hoisted to the hatch and the derrick had to be turned starboard and astern in order to be placed in its cradle pointing aft at port side. The crane-hook was hoisted to the limit meaning that the hook was hanging 3 meters below the derrick. The hook was abreast of the windows in the wheelhouse, during the turning of the derrick.

There were no jackstays along the edge of the hatch. According to the Master, it has never been practice to use jackstays.

The AB - who later fell overboard – was on the hatch and he handled one of the guiding lines He followed the hook to the starboard side as the turning of the derrick had started. The Chief Officer was also standing on the fore part of hatch No. 2 with his back turned to the AB. He was handling the other guiding line in order to prevent that it would get hold on a hatch fitting or the lashings on the motor boat. The Master was standing between the Chief Officer and the AB. The other two AB's were standing in the corridor on the port side.

See enclosure

The Master noticed that the AB suddenly fell from the hatch in starboard side. The Master did not hear any yell from the injured AB during the fall. The Master ran to starboard side in order to see whether the AB had fallen on deck but he saw him in the water – submerged. The AB was holding on to the guiding line, which was attached to the hook. The derrick was standing abeam starboard.

The Master immediately ran to the bridge deck where he released the life buoy with light and smoke signal. The life buoy landed 20 – 25 meters from the injured AB who in the meantime had relinquished the guiding lines and he was lying astern of the ship. The Master saw the injured AB waving with his arms and legs. It seemed as if he was panicking. It was not possible for the Master to see if he was trying to get to the life buoy.

The boatswain who was sitting in the crane house saw the AB for the last time when he was on the left side of the motor boat, which was situated on the hatch. He expected to see the AB appear from the right side of the boat but this did not happen. However, the boatswain saw that the Master ran aft the hatch. He heard the Master yell, “man overboard”. The boatswain left the crane house and ran over to hatch No. 2. At this point, he saw the AB in the water outside the edge of the accommodation. He also saw the life buoy be thrown out and hit the water approx. 20 meters from the AB. The smoke signal had been activated.

One of the AB's had followed the Master and had seen the injured in the water.

When the Chief Officer had handled the guiding line he turned around and saw the Master running aftward. He did not see the AB falling down. The turning of the derrick had stopped and the derrick was placed abeam of starboard. He ran astern and began to prepare the starboard lifeboat.

During the next 4- 5 minutes, as the ship approached life buoy, the starboard lifeboat was put into the water with the second and the third Officer, the second engineer and an AB. The boat steered towards the smoke signal on the life buoy and the search began. The ship had reached the life buoy within 6 minutes. All on board were told to be on the lookout for the AB.

The AB who had fallen overboard was at no time observed during the investigation.

No one on board the ship had any knowledge concerning AB's ability to swim.

The wind was SE 5 m/s. The height of the waves was less than 20 cm and the visibility was good. Temperature at the seawater was measured to 32 grp.

At 10.10, the Master sent a distress report via Immarsat C that was caught by Stavanger Rescue Centre 3 minutes later from where the report was forwarded to Miami Search and Rescue Centre. At 11.18 the ship received a telex from Miami SAR Centre from where it was informed that a US Coast Guard aeroplane was on its way in order to participate in the search. The plane reached its destination at 14.25.

The search was lead by the HELLE STEVNS and continued until 23.15. At this point, they decided to end the search in consultation with the US Coast Guard. This was done because they estimated that it would no longer be possible to find the injured AB a live. The HELLE STEVNS remained on the same position until 24.00.

The lifeboat was in the water for the first three hours of the search.

The railing, which was situated where the AB fell down, was examined for possible marks without any result.

Narratives regarding the signing on of the injured person:

In the afternoon, after the accident the second engineer asked the Master if knew that the injured had fainted in the airport in Amsterdam before he signed on to the ship. Moreover, that they had a medical report on board the ship. The master who had signed on to the ship after the incident was not aware about this. He found the medical report that had been made in Amsterdam on 10 June 1999 among the injured AB's papers. They looked for medicine and syringes among the injured AB's possessions but did not find anything. The medicine recommended in the medical report had not been delivered on board the ship. Other crewmembers could tell that the agent had been told to buy medicine and syringes. However, the ship had departed before the medicine had been brought on board the ship.

There were not any indications on the fainting in the injured AB's bill of health. The Chief Officer and the Chief engineer did not have any knowledge to the injured AB's disease before after the accident.

The third Officer knew that the injured had been ill just before he signed on to the ship. They had travelled together by plane to the airport in Amsterdam where the AB had fainted and been put to hospital. The third Officer signed on in Antwerp. The AB did not sign on until 5 days later in Rotterdam. The third Officer had spoken with the AB when he came on board the ship. The AB told that he had received a medical report from the hospital that he gave to the Master at the time. At the same time, the AB was told to take some medicine. The medicine was not, however, available on board the ship.

The Master who was on board at the time the injured signed on has explained as follows: On 6 June, the third officer and an AB were to sign on to the ship in Antwerp. Later the same day the Master was told that both of them were delayed but not why. Later the Master was told by the agent that it had been a long flight and that the AB could not get up – possibly because of fatigue and dehydration. The Master was told the same thing by the third Officer who came on board later the same day. The third Officer also told that the AB had been put to hospital. The Master did not hear anymore except from Shipping Company who informed him that the AB possibly could not come on board and that the AB who already was on board had to stay. (He should have signed off that day).

In the evening on 10 June 1999, while the ship was loading in Rotterdam the AB came on board the ship. He had been discharged from hospital as recovered. He brought along his papers and his health certificate.. There was not any medicine and neither the AB nor the agent – who came on board later

- said anything on this matter. At night, they had finished loading the ship and they departed from Rotterdam on 11 June at 07.15. The journey went well and the AB could work.

5. Supplementary investigations

Safety Committee Meeting:

They had a Safety Committee Meeting on board the ship on 10 may and 1 August 1999.

The day after the accident – 22 August 1999 – they had an extraordinary Safety Committee Meeting. On the meeting, they decided that the crew has to wear life jackets and use lifelines when they are on the hatches.

Williamsons turn:

The Master has tried to do Williamsons turn in order to find out how long time it takes. The first test lasted 5 minutes. The second test lasted 4 minutes. After the ship had been made longer, the turn lasted for 3 minutes and 17 seconds on a trial manoeuvre.

Resting time:

According to the Chief Officer, All of the AB's are only working in the daytime between 08.00 – 17.00 and therefor the AB must have been rested.

Medical Report from Academish Ziekenhuis, Vrije Universiteit:

The AB fainted in Schiphol Airport after he had arrived with aeroplane from the Philippines. He was put into Academisch Ziekenhuis where he stayed from 6 – 10 June 1999.

When he was discharged from hospital, the AB received a medical report. The report was delivered on board the ship when the AB signed on and after the accident the report was found among his employment papers.

The hospital informed the AB that he had to take medicine for 6 months by injection on a daily basis.

6. Comments made by the Investigation Division:

The AB fell overboard from hatch No. 2 in starboard side. He held on to a guiding line that had been attached to the crane hook while the derrick was turned astern. The guiding lines had been connected to the hook in order to prevent it from hitting the motor boat that had been placed on the hatch. There are container tracks and small depressions between the hatch sections in the area from where the AB fell.

None of the persons on board the ship observed the direct cause for the AB's fall.

The Investigation Division believes that it is likely that the AB may have lost his balance by hitting a container track or by stepping in to a depression. Perhaps the turning of the derrick and any rotations of the hook may have caused a jerk in the guiding line which the AB held on to and thereby he could have lost his balance.

The height of the hatch coaming is 2 meters and the breadth of the corridor is approx. 1 meter. This may have contributed to the fact that he fell overboard instead of on the deck in the corridor.

The line of the work was familiar to the AB according to the Master.

The planning of the work:

The Chief Officer and the boatswain discussed on the bridge how to throw the donnage overboard. The Master and the Chief Officer were both on deck while the work was done.

Apparently, they did not discuss measures of precautions on the bridge neither before they started to do the work nor when the work took place.

According to the Master, it is not practice to put up jackstays along the edge of the hatch.

The Investigation Division is of the opinion that the procedure was not efficient because they had not made the necessary precautions in order to prevent the fall. The Master and the Chief Officer should have considered the risk of someone falling overboard, especially considering the height of the hatch coaming and the breadth of the corridor.

When risk of falling occurs it is evident to make an adequate work place assessment.

The day after the accident – 22 August 1999 – they had an extraordinary Safety Committee Meeting. On the meeting, they decided that the crew has to wear life jackets and use lifelines when they are on the hatches. The safety precaution rules have to be introduced in the working environment manual of the ship.

Man overboard manoeuvre:

According to the Master and the boatswain, the life buoy landed relatively close to the AB who fell overboard. It was possible for the AB to hold on to guiding line while the Master ran aft in order to release the life buoy.

There was calm wind and sea and the visibility was good. The temperature of the sea was high.

They started to do Williamsons turn immediately after the life buoy had been released. Furthermore, they put a lifeboat into the water. The lifeboat had reached the buoy within 6 minutes.

Apparently, it was not possible for the AB to swim to the buoy. This may be caused by the fact that he was unable to swim or he could have been damaged during the fall.

Medical Report from Academisch Ziekenhuis, Vrije Universiteit

The AB was hospitalised in a hospital in Holland immediately before he signed on to the ship, because he had fainted in Schiphol Airport. When he signed on to the ship he brought along a medical report in which it was indicated that he had to take medicine by injection for 6 months on a daily basis. The medicine was not on board the ship.

The Master who was on board the ship at the time for the accident should not have signed on the AB before he had been through a medical examination for seafarers with a satisfactory result. Furthermore, the Master should have paid attention to the medical report among the AB's papers especially knowing that the AB just had been discharged from hospital. The Master should have read the papers and if necessary, he should have consulted an expert.

It is not possible to decide if the AB's health condition has had an influence on the sequence of events leading to the accident. However, as the injured was conscious and he had a hold on the guiding line while he was in the water, it is unlikely that the AB became ill standing on the hatch.

Sea Watch

All of the AB's onboard the HELLE STEVNS are only working in the daytime between 8.00 to 17.00 and they do not participate in the sea watch. According to the opinion of the Investigation Division, the HELLE STEVNS has violated the notice on watch keeping onboard ships. This has, however, no connection to the sequence of events leading to the accident.

7. Conclusion:

The accident happened while the AB was holding on to the crane hook with a line and came close to the edge of the hatch and he lost his balance. It is the opinion of the Investigation Division that the procedure for the doing of this work was inefficient because of the risk of falling.

According to the opinion of the Investigation Division, both the Master and the Chief Officer should have considered the risk of falling and secured that the work on the hatch would be done safely.

8. Enclosures
