

Fatal Accident on board the Hong Kong registered bulk carrier “Dias” on 4 January 2004

1. The Incident

1.1 On 4 January 2004 Hong Kong registered ship “Dias” was sailing from Abbot Point in Australia to the port of Taean of South Korea loaded with coal cargo. At around 1635, as “Dias” was proceeding to New Guinea Strait, the Chief Officer and the deck cadet were found collapsed inside the bilge space enclosure of No. 6 cargo hold. Rescue operation by the ship’s staff was immediately carried out. At 1740 both persons were pulled out from the bilge space enclosure in unconscious state and brought to the main deck. Cardioids pulmonary respiration was given to both persons but without response, no pulse was found on them. The two persons were proclaimed dead later in the evening.

2. Findings

2.1 The Chief Officer and the deck cadet went into the bilge space enclosure for repairing of a sounding pipe. The bilge space enclosure had been closed for a considerable period and the atmosphere inside the space was likely to be non life-supporting.

2.2 Prior to entry, there was no safety check to the atmosphere inside the bilge space enclosure as required by the ship’s Safety Management System. It also appeared that both the Chief Officer and the cadet had not used any personal protective equipment in entering into the bilge space enclosure.

2.3 The Chief Officer was likely to have consumed more alcohol than he was allowed under the prescribed limit as set out in the company's Safety Management System. It appeared that the enforcement of alcohol policy on board the vessel was slack and the Master did not seem to have shown concern to his subordinates and followed with the policy of the Company.

3. The Lessons

3.1 The Chief Officer had not followed the SMS to apply for the “Permit to Work” before entering into enclosed space. He improperly instructed the junior seamen to cut the sounding pipe inside the bilge space enclosure without considering the

dangers of suffocation and explosion. The Chief Officer had also failed to carry out safety procedures before he and cadet B entered the bilge space enclosure in the afternoon.

- 3.2 There was a general lack of appreciation of the dangerous nature of the cargo and supervision on the part of the Master. The Master was not aware of the work progress in a dangerous environment and appeared to have left himself in a passive position in the incident.
- 3.3 A passive attitude was generally prevailed in the enforcement of the company's SMS with respect to alertness of potential hazards and the implementation of the "Permit to Work" system on board.
- 3.4 In this incident there is evidence to show that the Company was unaware of the unsatisfactory implementation of SMS on board.



A photo of M.V. "Dias"