SUMMARY

Shortly before noon, a crew member on NORDIC STANI discovered that the Chief Engineer, who had gone out on deck for duties, was missing. The vessel was searched and shortly thereafter turned to the opposite heading. A SAR-operation was performed, but the Chief Engineer was not found.

The cause of the Chief Engineer´s disappearance has not been possible to establish with certainty. A possible cause, however, is that he has fallen overboard as he attempted to move between a cross-bay and the deck and then died. A fall from a ladder that he must have used could have been made possible by the fact that an arrangement to prevent fall did not exist. A contributing factor may have been that the vessel at the same time turned to port, causing it to heel somewhat to starboard.

SHK concludes that there are no specific requirements for arrangements to prevent fall overboard from ladders placed, like in this case, close to the vessel's side. However, there are requirements saying that defined risks shall be taken care of to prevent injuries and accidents. Such a program for risk assessment is existing on the vessel, but the ladder in question is not addressed. The shipping company has after the occurrence revalidated the risks and mounted protection from fall at ladders from where there is a risk to fall overboard.

The vessel's master contacted first the company DPA and then the Swedish JRCC, following the company instructions. SHK finds no strong reasons for the master to contact the company before contacting an RCC. The company has subsequently decided to change the procedures and the order of priorities.

After termination of the SAR-operation, JRCC contacted the Police Dispatch to hand over the case as a case of a missing person. However, the Police Dispatch wouldn't accept the case but referred JRCC to another unit. This meant that during a period of time, there was no case registered at the Police regarding the missing Chief Engineer. Had the Chief Engineer been found during this time, the identification had been hampered.

The investigation finds that at the time of the occurrence, there were no established routines for which cases that should be taken care of directly by the Dispatch. The Police has, however, since autumn 2016 established new written routines and informed officers in command about current procedures.

Safety recommendations

As the Police as well as the shipping company have taken actions in accordance to what has been revealed in this report, SHK refrains from issuing any safety recommendations.