SUMMARY

On 25 March 2021, the dry cargo carrier NATALY was at anchor off Landsort, Sweden, waiting for berth and loaded with woodchips. When anchoring, one of the anchor chains had kinked, and the chief mate and the two deck hands, one AB and one OS, had subsequently opened the chain box. The work was prepared through issuing of an enclosed space entry permit.

During the work it was noted that a working light was out of order, and one of the two deck hands, the AB, was asked to fetch a replacement. At the same time, the OS was on the forecastle for further preparations. A sound made him go down from the forecastle, and he then saw the hatch down to the forward shaft of the cargo hold being opened. The shaft, that from a ventilation perspective was part of the cargo hold and consequently an enclosed space, was not to be entered until atmosphere was deemed to be safe. All the way down at the bottom, he saw the AB lying and realized that BA set was necessary to assist him. Hence, the OS immediately called for emergency assistance.

After a great deal of problems, the AB was brought up on deck through the narrow space while the master called for assistance. Though CPR commenced directly as the AB was on deck, he was still unconscious when the rescue helicopter arrived, and the AB was announced dead upon arrival at the hospital. The post mortem suggests that the deceased was subjected to severe hypoxia and that the cause of death is suffocation as a result of spending time in the shaft.

An audit of the vessel's SMS that was conducted after the occurrence revealed several non-conformities. Furthermore, one observation was made by the auditor showing that communication between the vessel and the shipping company, Hermann Lohmann Schiffahrtsverwaltung GmbH, regarding safety management issues may be regarded as too limited. This leads to the conclusion that the SMS was not effectively implemented, which in turn constitutes an underlying factor to the occurrence.

The direct cause of the accident was that the AB went down into an enclosed space where there was a lack of oxygen. The hatch to the shaft was not cordoned off, which means that a safety barrier was broken. It has however not been possible to establish why the victim went down into the cargo hold shaft.

The incomplete implementation of the shipowner's and the vessel's safety management systems is an underlying factor

Safety recommendations

Hermann Lohmann Schiffahrtsverwaltung GmbH is recommended to:

Due to the occasion, continue to develop its safety management system in such a way that a continuous improvement of the safety culture may be obtained (see section 3.3). *(RS 2022:02e R1)*