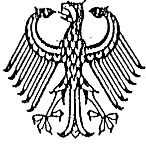

Bundesstelle für Seeunfalluntersuchung

Federal Bureau of Maritime Casualty Investigation

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Press Release 6/15

The Federal Bureau of Maritime Casualty Investigation (BSU) hereby gives notice that the investigation report No 140/14 was published on 22 May 2015. The report deals with 3 fatal accidents on board the MV SUNTIS.
Upon request the report will be forwarded. Alternatively this report – as well as all previous reports – is available on the website http//www.bsu-bund.de and can be downloaded.

Short version:

Very serious marine casualty – three dead seamen on board the MV SUNTIS

At about 0645 on 26 May 2014 three crew members were found unconscious in the tween deck in the area of the cargo hold access hatch to the cargo hold on board the MV SUNTIS in the port of Goole/UK. The crew members were recovered but did not survive despite rigorous attemps at resuscitation. The death of the three crew members is due to suffocation as a result of oxygen deficiency.

The MV SUNTIS carried a load of timber. Cargo holds laden with wood rate among the most hazardous spaces because the organic digestion process of timber draws oxygen from the atmosphere.

Two crew members, possibly one after the other, climbed into the forward tween deck hatch during the discharge operation and collapsed there. The chief officer attempted to rescue both seamen and lost consciousness as well. The crew had already sailed with a cargo of wood for a longer period of time and was

familiar with the hazards associated with oxygen depleting cargoes. It was not possible to clarify with sufficient certainty why the ordinary seamen still climbed into the cargo hold.

Long Version:

Very serious marine casualty – three dead seamen on board the MV SUNTIS

At 0645 on 26 May 2014 three crew members were found unconscious in the tween deck in the area of the cargo hold access hatch to the cargo hold on board the MV SUNTIS in the port of Goole/UK. The crewmembers were recovered but did not survive despite rigorous resuscitation attempts.

The MV SUNTIS carried a load of timber. On 26 May 2014 the discharge operations started with the unloading of the deck cargo by a shore based crane and dock workers.

Two seamen, ordinary seamen, were assigned to remove the tarpaulins that were attached to protect the deck cargo.

Both seamen, possibly one after the other, climbed into the forward tween deck hatch. The chief officer and a third seaman missed both crew members and went searching for them. Since both could not be found in the aft superstructure area, the seaman walked over the wood loaded cargo hatch covers and the chief officer at the starboard side over the main deck to the front. Having arrived at the end of the hatch, the seaman saw the chief officer calling into the forward tween deck hatch and then climbing down into the hatch. Having arrived at the hatch and being able to look into the hatch, he could observe the chief officer collapsing. With the assistance of dock workers having been alerted and with the use of an emergency escape breathing device and a breathing apparatus as well as lifting slings the three collapsed seamen were hoisted onto the upper deck. None of the crew members survived despite immediate resuscitation attempts. The death of the three seamen is due to suffocation as a result of oxygen deficiency.

Cargo hold laden with wood rank among the hazardous spaces, because the organic digestion process of timber draws oxygen from the atmosphere. There are no warning signals for oxygen reduced spaces, e. g. foul odor, and therefore there is no natural awareness for hazards.

The crew had already sailed with a cargo of wood for a longer period of time and was therefore familiar with the hazards posed by oxygen depleting cargoes. It could not been sufficiently clarified why the two ordinary seamen climbed in the cargo hold. It is understandable that the chief officer initiated rescue measures immediately. However, it proved fatal for him. Self-protection must have priority in enclosed spaces and rank first with the desire to enter a space without breathing apparatus in order to rescue an unconscious colleague. When this is not complied with another life is endangered. Had the process instructions been complied with, the accident could have been prevented.

Summarized, the following organizational and technical measures shall be complied with:

- Dangerous spaces shall be safely locked, e.g., by a padlocks
- Confined spaces shall basically only be entered with the permission of the master or the responsible officer
- The atmosphere shall be measured as to whether dangerous vapors or gases are existent and if the oxygen content is sufficient
- The expected hazards and countermeasures shall be discussed before carrying out work
- Prior to taking up work a crew member is appointed to monitor, coordinate and supervise the work
- Another crew member is posted at the access as a flagman and keeps continuously in touch with the persons in the confined space. In case of an unforeseen event the safety post can call for help
- It shall be ensured that ventilation and illumination is cared for

Volker Schellhammer
Director of the BSU