Bundesstelle für Seeunfalluntersuchung

Federal Bureau of Maritime Casualty Investigation

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PRESS RELEASE 14/17

The Federal Bureau of Maritime Casualty Investigation (BSU) published the investigation report 42/15 on 15 June 2017. The report deals with the fatal accident on board the MV ASKOE on 6 February 2015 in the Baltic Sea. This report – as well as all previous reports – is available on the website **www.bsu-bund.de** for download.

Short version:

Fatal accident on board the MV ASKOE in the Baltic Sea on 6 February 2015

At about 0730 in the morning of 6 February 2015 a crewmember noticed a lifeless rating on watch in an open cargo hold access hatch. The Antigua & Barbuda flagged ship was en route from the United Kingdom to Sweden.

While the crew recovered the casualty the ship headed to Rostock, where the investigation into the circumstances of the accident started immediately.
Unfortunately, the cause of the death could not be ascertained.

As a consequence, the access to dangerous cargo should be strictly limited and monitored.
The investigation report was published on 15 June by the FederalBureau of Maritime Casualty Investigation and can be downloaded at www.bsu-bund.de.

Long version:

Fatal accident on board the MV ASKOE in the Baltic Sea on 6 February 2015

The Antigua & Barbuda-flagged bulk carrier ASKOE, sailing from Southampton in Great Britain, transited the Kiel Canal in the night of 6 February 2015 in an easterly direction. The pilot disembarked from the ship after she passed through the lock at Kiel at about 0100. The rating on watch secured the anchor before he was supposed to rest.

At about 0730 in the morning of 6 February 2015, a crewmember noticed an open cargo hold access hatch and discovered the already deceased watch rating on watch inside. While the crew recovered the casualty, the ASKOE sailed to the nearest port, Rostock, where the police, the Institute of Forensic Medicine and the BSU started their investigation of the accident.
Despite all efforts, it could not be ascertained why the rating on watch was in the cargo hold access hatch, why he lost consciousness and ultimately passed away.

The safety recommendations included in the draft of the investigation report addressed to the ship's command and owner of the AKSKOE, recommending that the ship's command of the ASKOE limit the number of crew members with access to locked holds to that absolutely necessary in the future, was already implemented by the ship's owner.

Therefore the safety recommendation was removed from the final investigation report.

Jürgen Albers
Deputy Director