



# INTERIM REPORT

Art. 16.2 Law 4033/2011 (art. 14.2 Directive 2009/18/EC)

## MARINE CASUALTY SAFETY INVESTIGATION

### Death of one seafarer, one stevedore and serious injury of one stevedore

#### Marine casualty Safety Investigation

#### Law 4033/2011 as amended and applies

(summary extract of art. 1.b, 4.1.a  
& 4.1.b)

The conduct of Safety Investigations into marine casualties or incidents is independent from criminal, discipline, administrative or civil proceedings whose purpose is to apportion blame or determine liability. The sole objective of the conduct of a safety investigation is to ascertain the circumstances that caused the marine accident or incident through analysis, to draw useful conclusions and lessons learned that may lead, if necessary, to safety recommendations or proposals addressed to parties or stakeholders involved in order to take remedial actions, aiming to prevent or avoid future marine accidents.

#### Points of Interest

- This Interim Report has been prepared by virtue of art. 16.2 Law 4033/2011, as applies (art. 14.2 Directive 2009/18/EC) as the full investigation report will not be published within 12 months of the marine accident date.
- The Interim Report has been published for the sole purposes of the safety investigation process with no litigation in mind and should be inadmissible to any judicial or other proceedings (administrative, disciplinary, criminal or civil) whose purpose is to attribute or apportion blame or liability.
- The Interim Report only aims to present a concise summary of the events occurred on 09<sup>th</sup> of August 2015 that led to a very serious marine casualty.
- The Interim Report does not constitute legal advice in any way and should not be construed as such.

## Very serious marine casualty

August 2016

HBMCI conducts the safety investigation of the above mentioned marine casualty. The content of this Interim Report is based on current available information and data collected and analyzed during the safety investigation process into captioned marine casualty. The completion of the procedure as defined in relevant legislation may reveal or identify new information, data or evidence and consequently cause changes or amendments in data provided by this Interim Report. All times quoted are local times (UTC+8) unless otherwise stated.

#### M/V IONIC

M/V IONIC, under Greek Flag was laden with Zinc and Copper from Huelva, Spain. On 9<sup>th</sup> of August 2015 at evening time she arrived in Fangcheng port, China. At approximately 2330 mooring operation was completed and she had moored alongside with her starboard side at berth 17. IONIC is a 59000 tons Bulk Carrier, built in 2013. She was designed with 5 cargo holds equipped with folding type hatch covers and geared with 4 cranes. Each cargo hold was accessed from main deck through two hatch coaming entrances structured with vertical and Australian (spiral) ladders.

No 1 cargo hold was fitted with the "Australian ladder" at its aft section while the vertical ladder was fitted at its forward section. The configuration of access to cargo holds no 2, 3, 4 and 5 is diametrical opposite as the Australian ladder is fitted at their forward part and the vertical ladder at their aft part. The close to 11,7 m of length Australian ladders were fitted in a duct with only two openings, one at the entrance of the hatch and one at their end, approximately 5,3 m from holds bottom.

#### Marine accident synopsis

Following IONIC berthing, at approximately 0030 the draught surveyor boarded her and the draught survey commenced. At about 0200 cargo holds No 1 & 3 were opened for ventilation and preparations for discharging were undergoing. At approximately 0203 port facility's 4 stevedores came on board and were directed to the Tally Room, located at the accommodation's main deck, in order to wait for the unloading to be commenced. However, the Foreman Terminal in charge of the stevedores's team did not board IONIC.

At approximately 0525, after the plastic covers protecting the cargo in cargo hold no 3 were removed by two stevedores with the assistance of a terminal crane hoisting them, the discharging operation from said hold begun.

As estimated by IONIC crew, at around 0528, two stevedores entered no 1 cargo hold aft access through the Australian ladder without any prior permission granted by IONIC Officers or crew. As the cargo stowage of the 12,562.79 MT of "Zinc concentrate" was covering the duct's lower opening at no 1 cargo hold, the duct space where the Australian ladder was fitted was oxygen deficient. The AB on the deck watch that was accidentally pass near by the entrance of no 1 cargo hold aft entrance, saw one of the stevedores lying on the deck having difficulties in breathing and reported the situation to the Officer on deck watch through his portable VHF and in parallel he shouted "Emergency, emergency". It is presumed that seconds after the AB observed the second stevedore lying on the landing platform of the vertical ladder leading to the "Australian ladder". Despite the fact that assistance had already been called, the AB decided to enter the enclosed duct space in order to recover the unconscious stevedore. Unlikely he also collapsed due to the oxygen depleted atmosphere in the landing platform of vertical ladder. Moments after the 2nd Officer on the deck watch came on scene and reported the emergency situation to the Chief Officer that rushed to the "scene". He immediately ordered the 2nd Officer to alert the crew and prepare the emergency response team for entering enclosed space. The 2nd Officer returned to the accommodation right away and reported the casualty by phone to the Master that was in the Ship's Office. The Master informed the ship's agent by phone and requested immediate shore assistance and went immediately on the spot.

The rescue team from enclosed spaces consisting of the Bosun and an AB, equipped with PPE and breathing apparatus devices proceeded on scene and at approximately 0540 under Master's instructions entered no 1 cargo hold aft access. At about 0550, the rescue team managed to take out the unconscious stevedore. Three minutes later the rescue team reentered the enclosed space however it was no possible recover the AB due to the fact that his body had tumbled down the narrow stairs of the "Australian ladder" during the recovery of the stevedore.

At approximately 0615 shore medical assistance came on board and administered first aid to the stevedores however the one that was recovered from the cargo hold duct space declared deceased. The other stevedore was taken to hospital and was fully recovered. At 0635 Fire Brigade rescuers came on board and finally recovered the casualty AB.

China Maritime Safety Administration held a preliminary investigation on the marine casualty. IONIC continued with the discharging operation at afternoon hours. At approximately 2330 on 15 August 2015, IONIC departed from Fangcheng Port and continued with her trading operations.

#### Investigation

The safety Investigation and analysis has highlighted contributing and underlined factors that resulted in the examined marine casualty. Such factors are quoted in random order:

- BLU CODE and BLU Manual provisions and guidelines in relation to Ship and Terminal exchange of information were not followed in full;
- Communication difficulties in English language;
- Shore personnel lack of supervision;
- Lack of implementing safety measures for enclosed spaces entry;

and others as will be listed in the final safety investigation report.

#### Final safety Investigation Report

A draft safety Investigation report is under preparation and is expected to be finalized shortly and circulated to involved and interested parties for consultation. The final safety Investigation report will subsequently be issued following the consultation period.



**Marine casualty  
Safety Investigation  
Law 4033/2011 as amended and  
applies**  
(Conjunction extract of art. 1.b,  
4.1.a & 4.1.b)

The conduct of Safety Investigations into marine casualties or incidents is independent from criminal, discipline, administrative or civil proceedings whose purpose is to apportion blame or determine liability. The sole objective of the conduct of a safety investigation is to ascertain the circumstances that caused the marine accident or incident through analysis, to draw useful conclusions and lessons learned that may lead, if necessary, to safety recommendations or proposals addressed to parties or stakeholders involved in order to take remedial actions, aiming to prevent or avoid future marine accidents.

Grigoriou Lambraki Street 150  
P.C. 185 18  
Piraeus, Greece

Tel: 213 1371970  
213 1371969  
213 1371968  
Fax: 213 1371269  
Email: hbmci@yna.gov.gr  
Website: www.hbmci.gov.gr

### Vessel's Particulars

Name	IONIC
Flag	GREEK
Registry	Piraeus 12182
Ship's type	General Cargo / Bulk Carrier - Supramax
IMO	9541849
Call sign	SVBU8
LOA (m)	196.00 m
Breath (m)	32.26 m
Year & place of built	September 2013 / SPP Korea Shipbuilding Co. LTD
Construction material	Steel
Gross Tonnage	34456
Net Tonnage	19579
Engine / Power	1 x Magdeburg 6NVD 48A – 2 U/ 700 HP
Classification Society	ABS
Minimum safe manning	11
Crew on board	20

### Voyage Particulars

Date of arrival	09-08-2015
Trading Area	International
Cargo on board	Zinc concentrate - Copper concentrate

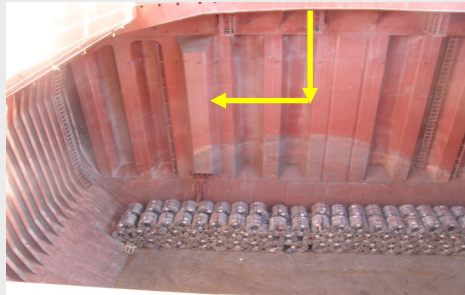
### Marine Casualty Information

Date & time	09-08-2015, at approx. 2230
Type of marine casualty	Very serious marine casualty
Weather & environmental conditions	Night time, visibility good wind force 2 Bf, wind direction variable
Location of casualty	Fangcheng Port Terminal, China
Damages to ship	None
Fatalities / injuries	Fatalities One AB & one stevedore One stevedore hospitalized and fully recovered

M/V IONIC



Cargo Hold No 1 showed from fore section. Duct is pointed in yellow.



The hatch access to no 1 cargo hold (starboard aft section)



The locations pointed where casualties were found.

