



# REPUBLIC OF THE MARSHALL ISLANDS

## Maritime Administrator

### OURANIA LUCK CASUALTY INVESTIGATION REPORT

Fatality During Hold Cleaning

Arabian Gulf | 8 July 2018

Official Number: 3445

IMO Number: 9218428





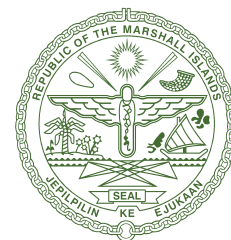
## **DISCLAIMER**

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## **AUTHORITY**

An investigation, under the authority of the Republic of the Marshall Islands laws and regulations, including all international instruments to which the Republic of the Marshall Islands is a Party, was conducted to determine the cause of the casualty.



*Maritime Administrator*



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## PART 1: EXECUTIVE SUMMARY

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On 8 July 2018, the Republic of the Marshall Islands-registered bulk carrier OURANIA LUCK, managed by Prosperity Bay Shipping Company Ltd (the “Company”), was on a ballast voyage in the Arabian Gulf, bound for Fujairah, United Arab Emirates.

At about 2000<sup>1</sup> on 8 July 2018, the Fitter was reported to have fallen from a short, fixed ladder at the bottom of an Australian ladder while exiting Cargo Hold No. 5. An Able Seafarer Deck (ASD), who was also working in the hold, heard the Fitter fall and turned to find him lying on the tank top. The Fitter was unresponsive and appeared to have difficulty breathing. The Fitter was transferred to the ship’s Hospital and was found to have no pulse. Cardiopulmonary resuscitation (CPR) was started and continued for two hours. With no response, the Fitter was declared deceased by the Master.

The Republic of the Marshall Islands Maritime Administrator’s (the “Administrator’s”) marine safety investigation was unable to definitively determine the causal factors contributing to the Fitter’s death since no one witnessed the fall. Presumably, the Fitter fell while climbing a straight ladder which led from the tank top to the platform at the bottom of the Australian ladder, or while transitioning from the straight ladder to the platform.

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1 Unless otherwise stated, all times are ship’s local time (UTC -3).

## PART 2: FINDINGS OF FACT

The following Findings of Fact are based on the information obtained during the Administrator’s marine safety investigation.

1. Ship particulars: *see* chart to right.
2. On 8 July 2018, OURANIA LUCK was underway in the Arabian Gulf, bound for Fujairah, United Arab Emirates. The ship was in ballast after discharging in Umm Qasr, Iraq.
3. It was reported that seas were calm, and the air temperature was about 35 degrees Celsius. It was also reported that the ship was not pitching or rolling.

### Cargo Hold No. 5 Australian Ladder

4. The Australian ladder for Cargo Hold No. 5 is accessed by a short, straight ladder from the tank top which leads to a platform at the bottom of the Australian ladder (*see Figure 1*).

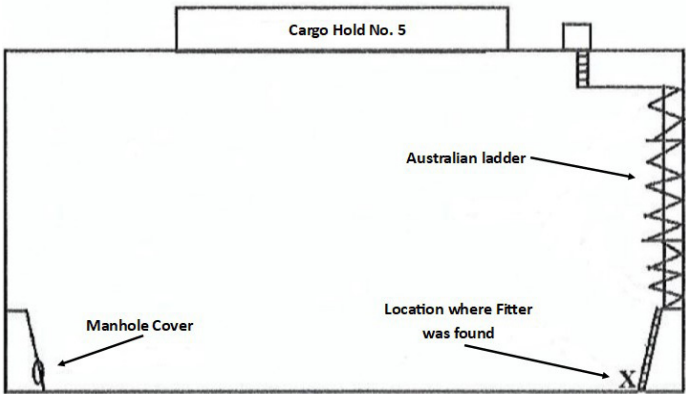


Figure 1: Diagram of Cargo Hold No. 5.

5. The Australian ladder had a railing which provided fall protection, running continuously from the lower platform to the top of the cargo hold (*see Figure 2*).

### SHIP PARTICULARS

**Ship Name**  
OURANIA LUCK

**Registered Owner**  
Ourania Luck Shipping Corp.

**ISM Ship Management**  
Prosperity Bay Shipping Company Ltd

**Flag State**  
Republic of the Marshall Islands

|                |                     |                  |
|----------------|---------------------|------------------|
| <b>IMO No.</b> | <b>Official No.</b> | <b>Call Sign</b> |
| 9218428        | 3445                | V7QV5            |

|                      |                      |
|----------------------|----------------------|
| <b>Year of Build</b> | <b>Gross Tonnage</b> |
| 2000                 | 39,126               |

|                    |                           |
|--------------------|---------------------------|
| <b>Net Tonnage</b> | <b>Deadweight Tonnage</b> |
| 25,373             | 75,961                    |

**Length x Breadth x Depth**  
217.7 x 32.2 x 19.3 meters

**Ship Type**  
Bulk Carrier

**Document of Compliance**  
**Recognized Organization**  
Bureau Veritas

**Safety Management Certificate**  
**Recognized Organization**  
Bureau Veritas

**Classification Society**  
Lloyd’s Register

**Persons on Board**  
23



*Figure 2: Australian ladder fitted in a cargo hold similar to Cargo Hold No. 5 aboard OURANIA LUCK. At the time of the incident, the hold was empty.*

#### ***Incident Description***

6. To prepare for loading of the next cargo, the deck crew were assigned by the Chief Officer (C/O) to manually remove cargo residues from all holds. A risk assessment was completed before work began on 8 July 2018.
7. The daily work schedule was adjusted for the crewmembers engaged in hold cleaning due to the high temperatures. The crew assigned to the hold cleaning were scheduled to work from 0600–1200 and 1800–2000.
8. Before the crew returned to work at 1800 on 8 July 2018, the C/O requested the Fitter to go into Cargo Hold No. 5 and remove the forward lower stool manhole cover. The stool needed overnight ventilating so a bilge valve inside could be repaired the next day. The manhole cover was about 60 centimeters (cm) above the tank top. The Fitter was not involved in the hold cleaning before the C/O's request.
9. The Fitter and an ASD entered Cargo Hold No. 5. The ASD collected cargo residues while the Fitter removed the manhole cover.
10. At about 2000 on 8 July 2018, the Fitter completed the manhole cover removal and went to exit the cargo hold using the Australian ladder.
11. Shortly after the Fitter started to exit, the ASD (who was facing away from the Australian ladder) reported hearing a bang and turned around to see the Fitter lying on the tank top. The ASD reported that he did not hear the Fitter shout or make any other noise prior to falling.



12. The ASD found the Fitter unresponsive and breathing with difficulty. He shouted for help over the portable radio he was carrying.
13. At about 2010, crewmembers arrived at the Fitter's location with first aid supplies and a stretcher. The Fitter was removed from the hold on the stretcher and transferred to the ship's Hospital, where his vital signs were monitored.
14. The Master contacted the closest port to request emergency medical assistance. No helicopter was available and the Master was advised that the Fitter would be evacuated from the ship by boat within two hours.
15. At about 2030, the Fitter had no pulse and was not breathing. CPR was started immediately.
16. Based on the advice from shoreside medical personnel, CPR was stopped at 2230 on 8 July 2018 and the Fitter was pronounced deceased by the Master.
17. At about 2245, the assistance boat arrived at OURANIA LUCK's location, but was released because the Fitter was deceased.
18. A postmortem examination determined that the cause of the Fitter's death was numerous physical injuries caused by "a hit to hard and solid matter."

#### ***Manning and Rest Hours***

19. OURANIA LUCK's crew consisted of 23 officers and ratings, more than required by the Minimum Safe Manning Certificate issued by the Administrator. All the officers and ratings held valid Republic of the Marshall Islands issued seafarer documentation.
20. The Administrator did not find any indication that any crewmembers involved with this incident did not receive the amount of rest mandated by the International Maritime Organization's Seafarers Training, Certification and Watchkeeping (STCW) Code, Section A-VIII/1, paragraphs 2 and 3 and the International Labour Organization's Maritime Labour Convention, 2006 (MLC, 2006), regulation 2.3.
21. The Fitter joined OURANIA LUCK on 16 October 2017. He completed initial shipboard familiarization training on 21 October 2017, which included the Company's safe work practice requirements.
22. The Fitter's last physical examination was on 29 September 2017. He was found fit for duty without restrictions.
23. Following the incident, crewmembers reported that the Fitter appeared to be in good health and while on board had not complained of any medical issues, nor was he given any medical treatment.
24. The Fitter was scheduled to be off on the day of the incident. It is reported that he conducted no other work before opening the manhole cover.

## PART 3: ANALYSIS

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The following Analysis is based on the above Findings of Fact.

It cannot be determined why the Fitter fell from the ladder while exiting Cargo Hold No. 5 as there were no witnesses. Presumably, he lost his balance while on the straight ladder leading from the tank top to the platform at the beginning of the Australian ladder, or while transitioning from the straight ladder to the platform. It is unlikely that he fell from the Australian ladder since fall protection railings were provided along its entire length. The injuries reported during the postmortem examination were consistent with a fall from a ladder.

On the day of the incident, the Fitter was not scheduled to work. The opening of the manhole cover was reported to be the first work done that day by the Fitter. Further, the Fitter's work and rest hours complied with the STCW Code requirements. It is not believed that fatigue was a causal factor in this incident.

On 8 July 2018, the sea state was reported to be calm with little or no pitching or rolling of the ship. In addition, crewmembers were scheduled for a rest period during the hottest part of the day with work resuming in the evening to avoid exposure to the high temperatures. As such, the weather and the sea state are not considered to be causative factors in this incident.

Although the Fitter was reported to be healthy with no reported medical conditions, it cannot be ruled out that a medical event may have caused him to fall from the ladder. However, this could not be confirmed based on the postmortem examination results.

## PART 4: CONCLUSION

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This Conclusion is based on the above Findings of Fact and Analysis and shall in no way create a presumption of blame or apportion liability.

1. The causal factors which contributed to the Fitter's fall cannot be definitively determined. However, it is presumed that the Fitter fell while climbing the straight ladder or while transitioning onto the platform at the base of the Australian ladder.

## PART 5: PREVENTIVE ACTIONS

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In response to this very serious marine casualty, the Company has taken the following Preventive Actions.

1. The Company's pre-joining medical examination requirements were broadened to better ensure seafarers can carry out their likely assigned tasks while on board.
2. The Company's policy regarding working hours during times of elevated temperatures was reviewed to ensure it was adequate to reduce increased fatigue.

3. All crew serving on board ships in the Company's managed fleet underwent refresher training on the proper procedures and safety precautions to be taken while working in cargo holds.
4. A safety bulletin, which discussed the incident and the lessons learned, was sent to all ships in the Company's managed fleet.

## **PART 6: RECOMMENDATION**

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Based on the above Conclusion and in consideration of the Preventive Actions taken by the Company, the Administrator has no further recommendations.

The Administrator's marine safety investigation is closed. It will be reopened if additional information is received that would warrant further review.