

MAIB Safety Bulletin 2/2008 - Fatalities in enclosed spaces

**MAIB SAFETY BULLETIN 2/2008**

Fatalities in enclosed spaces

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This document, containing urgent safety recommendations, has been produced for marine safety purposes only, on the basis of information available to date.

The Merchant Shipping (Accident Reporting and Investigation) Regulations 2005 provide for the Chief Inspector of Marine Accidents to make recommendations at any time during the course of an investigation if, in his opinion, it is necessary or desirable to do so.

This Safety Bulletin is issued to raise awareness of the unnecessary and avoidable loss of life of seafarers working in enclosed spaces and, through industry bodies and organisations, seeks to establish control measures that can be utilised to prevent such accidents in the future.

A handwritten signature in black ink, appearing to read 'Stephen Meyer', with a stylized flourish at the end.

Stephen Meyer  
Chief Inspector of Marine Accidents

**This bulletin is also available on our website: <http://www.maib.gov.uk>**

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## BACKGROUND

Since September 2007 the MAIB has started three investigations into accidents in which a total of six seafarers have died in enclosed/confined spaces:

- On 23 September 2007, three experienced seamen died inside the chain locker on board the emergency response and rescue vessel *Viking Islay*. The first two were overcome while tying off an anchor chain to prevent it from rattling in the spurling pipe. The third to die was the first rescuer who entered the chain locker wearing an Emergency Escape Breathing Device (EEBD). He was soon constrained by the device and removed its hood. All three men died as a result of the lack of oxygen inside the chain locker caused by the on-going corrosion of its steel structure and anchor chain.
- On 18 January 2008, two seamen collapsed in a store on board the general cargo ship *Sava Lake*. The chief officer entered the store to try and rescue the men but was soon forced to leave when he became short of breath and his vision narrowed. The two seamen had been asphyxiated. The store was adjacent to the vessel's forward cargo hold containing 'steel turnings'. To allow for the drainage of sea water and the removal of cargo residue, the bellows pieces on the cargo vent trunk either side of the cargo ventilation fan motor, located in the store, had been cut. This allowed a path for the air from the self-heating cargo, to enter the store. When tested, the air in the cargo hold contained only 6% oxygen.
- On 11 June 2008, an experienced seaman died on board the passenger cruise ship *Saga Rose* after he entered an almost empty ballast tank. The tank's manhole cover, which was inside a small cofferdam accessed from within the engine room, had been removed and the seaman had been instructed to confirm the tank's contents. As it was not intended for the seaman to enter the tank, no permit to work was issued. When the seaman was found to be missing, an experienced motorman was sent into the cofferdam to check on his wellbeing. He found the seaman lying at the bottom of the empty tank and raised the alarm. The motorman then entered the tank but collapsed when trying to recover the seaman. After the ship's emergency response team provided air to the stricken crew via in-line breathing apparatus, the motorman recovered and was able to leave the tank. However, the seaman never regained consciousness. He had been asphyxiated in the oxygen depleted atmosphere of the tank, which had not been inspected for several years and was heavily corroded. It is not certain why the seaman entered the tank but it is likely it was to determine whether a small amount of water in the tank bottom was salt or fresh water.

The MAIB report of its investigation of the fatalities on board *Viking Islay* was published on 9 July 2008. The MAIB will publish reports on the fatalities on board *Saga Rose* and *Sava Lake* on completion of its investigations.

Co-incident with the MAIB investigations, the Marine Accident Investigators International Forum (MAIIF) identified the large number of fatalities in the shipping industry worldwide which were related to work in confined or enclosed spaces and considered that the occurrence of such accidents was increasing. Accordingly, in October 2007, MAIIF tasked its representative from Vanuatu to research the incidence of this type of accident with a view to the submission of a paper to the International Maritime Organization (IMO). To date, responses from 18 administrations identify 120 fatalities and 123 injuries resulting from entry into confined spaces since 1991. These statistics do not include the fatalities from *Sava Lake* or *Saga Rose*.

## **SAFETY LESSONS**

There can be few aspects of personal safety on board ships that have received more attention than the importance of following the correct procedures before entering a dangerous enclosed/confined space. Tragically, it is clear that the measures which have been put into place have failed to prevent the death of many seafarers. Indeed, the data collected on behalf of MAIIF indicates that accidents in enclosed/confined spaces continues to be one of the most common causes of work-related fatalities on board ships today. This is due to:

- Complacency leading to lapses in procedure;
- Lack of knowledge;
- Potentially dangerous spaces not being identified; and,
- Would-be rescuers acting on instinct and emotion rather than knowledge and training.

It is essential that the IMO recognises the unacceptably large fatality rate in this area and takes the lead in identifying initiatives to improve this very poor safety record. It is also vital that all shipping industry bodies raise the awareness of the continuing and increasing number of deaths in enclosed spaces to show that no-one is immune to the physical effects of the lack of oxygen or harmful gases. While the holding of breath might seem a logical step to a person entering a tank 'for a few seconds' or to a would-be rescuer, it is all too frequently the last life sustaining breath he or she ever takes.

## **RECOMMENDATIONS**

**Ship owners and managers, and industry bodies and organisations** are recommended to:

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- Identify and implement measures aimed at improving the identification of all dangerous and potentially dangerous spaces and increasing compliance with the safe working practices required when working in such compartments.
- Individually and collectively raise the awareness of the continuing high incidence of fatalities of seafarers working in enclosed spaces.

**The Maritime and Coastguard Agency** is recommended to:

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Co-sponsor with the Maritime Administration of Vanuatu and other concerned administrations a submission to the IMO aimed at raising the awareness of the number of fatalities on ships which have occurred in enclosed spaces, and highlighting the need for measures to be identified which will reduce this unnecessary loss of life, such as the identification and marking of all potentially dangerous spaces.