REPUBLIC OF LIBERIA

Liberia Maritime Authority

Very Serious Marine Casualty Investigation Report
into the death of an Able Seafarer Deck on
M/V EUROSTAR (IMO 9546203)
on April 10, 2024

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All times Local Time (LT) unless otherwise noted

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It is not the purpose of the investigation, nor the function of the Administration, to assign fault or determine civil or criminal liability with respect to enhancing the litigation posture of any party. The Administration must report, or cause to be reported, the circumstances and proximate cause or causes of a marine casualty and any contributory factors. However, where it is determined that there exists evidence of criminal conduct under the Laws of the Republic of Liberia on the part of any seafarer holding a Liberian Certificate of Competency or other official document, the matter would be referred to the Ministry of Justice of the Republic of Liberia for appropriate action.

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CONTENT:

INTRODUCTION:

M/V EUROSTAR was underway in the Gulf of Thailand, proceeding from Koh Sichang, Thailand to Singapore, when the deck crew was instructed to carry out cleaning of Cargo Holds No.1 and No.2 by washing down hatch coamings to remove cargo remnants.

During this operation, the crew was divided into two teams: one team working on the port side and the other on the starboard side of Cargo Hold No.2. The Able Seafarer Deck 1 (ASD1) positioned on the starboard hatch coaming, assisted by an Ordinary Seaman (OS), fell into the hold and landed on the tank top in Cargo Hold No. 2.

Emergency response actions were immediately initiated. The injured ASD1 was lifted from the hold using a stretcher and transferred to the ship's hospital, where first aid and oxygen support were administered. The ship rendezvoused with a Royal Thai Naval vessel for additional medical care but the injured ASD1 was declared deceased.

AUTHORITY:

The investigation was conducted, and this report was made, in accordance with the Liberian Maritime Regulation 9.258(1) and IMO Resolution MSC.255 (84) adopted on May 16, 2008. Adoption of the Code of the International Standards and Recommended Practices for a Safety Investigation into a Marine Casualty or Marine Incident (Casualty Investigation Code) as amended.

The purpose of this investigation is to provide information about the casualty and to relate the sequence of events surrounding the casualty to determine its cause, if possible. Such investigations are conducted in order that the Liberian Maritime Authority may offer recommendations and take the necessary steps to reduce the danger of similar accidents/casualties in the future.

ABBREVIATIONS	
Abbreviation	**Meaning**
AFT	After Part of the ship
FWD	Forward part of the ship
ºC	Degree centigrade
FBB	Fleet Broadband: Satellite communication system
GRT / NRT	Gross / Net Registered Tonnage
LT	Local time
IMO	International Maritime Organization
ISM	International Safety Management
SMS	Safety Management System
LOA / LBP	Length overall / Length between perpendiculars
M	Meter
ME	Main Engine (ME): Primary propulsion system of the vessel.
MT	Metric Ton
P&I	Protection and Indemnity
STBD	Starboard side
P	Port side
JHA	Job Hazard Analysis
PPE	Personal Protective Equipment
RA	Risk Assessment
Abbreviation	Rank
C/O	Chief Officer
2/O	Second Officer
3/O	Third Officer
ASD	Able Seafarer Deck
O/S	Ordinary Seaman

VESSEL PARTICULARS

M/V EUROSTAR

PORT OF REGISTRY	MONROVIA
FLAG	LIBERIA
IMO NUMBER	9546203
TYPE	BULK CARRIER
GROSS / NET TONS	23,432/10,758 MT
DEADWEIGHT	33,912 MT
LENGTH	180 M
BREADTH	30 M
DEPTH	14.7 M
BUILT	2013
YARD	SAMJIN SHIPBUILDING INDUSTRIES CO.
OPERATOR	EUROTANKERS INC.
CLASS SOCIETY	BUREAU VERITAS
PROPULSION	B&W 6S50MC6
POWER	8580
STATUTORY CERTIFICATES	ALL VALID
CREW	20 (17 Filipinos, 1 Greek, 2 Ethiopians)
SEAFARER'S CERTIFICATES	ALL VALID

INVESTIGATION NARRATIVE:

The Deputy Commissioner, Liberia Maritime Authority, Republic of Liberia, appointed an Investigating Officer, pursuant to Liberian Maritime Regulation, 9.258(4), to investigate the cause of the death of the Able Seafarer Deck 1 (ASD1) on the M/V EUROSTAR on April 14, 2024.

The investigator conducted an onboard investigation at Indonesia Bulk Terminal Anchorage on April 24, 2024. This report is based on the Liberian investigator's report, evidence obtained, and other information provided to the Administration by the vessel operator.

Unless otherwise mentioned, the dates and times mentioned in this report are all in local time.

FINDINGS OF FACT:

1. NARRATIVE:

On April 9, 2024, the M/V EUROSTAR departed Koh Sichang, Thailand, enroute to Singapore. The vessel was underway in the Gulf of Thailand with a moderate breeze, slight seas, and good visibility.

On April 10, 2024, the deck department, under the supervision of the Chief Officer (C/O), was instructed to clean Cargo Holds No. 1 and No. 2 by washing down the hatch coamings to remove cargo remnants. A toolbox meeting was conducted and permits for working aloft/overside were issued in accordance with the Safety Management System (SMS). The crew was divided: ASD2 on the port side and ASD1 on the starboard side of Cargo Hold No. 2.

Figure 1: Simulated position of ASD1 during hatch coaming cleaning operation on Cargo Hold No. 2.

0903 LT, ASD1 was positioned on the starboard hatch coaming, assisted by an OS. ASD1 instructed the OS to go inform ASD2 to clean both sides of the hatch coaming simultaneously. The OS informed the ASD2 accordingly and shortly thereafter, the OS returned to ASD1's location but did not find him on the cargo hatch coaming. Upon looking down into Cargo Hold No. 2, the OS observed ASD1 lying on the tank top.

The OS immediately reported the accident to the Third Officer (3/O) on the bridge via handheld radio.

Figure 2: Extension rope secured to the hatch cover pad eye following the incident.

0905 LT, 3/O announced the emergency over the Public Address system. The Master ordered the hatch fully opened, and the Second Officer (2/O), acting as the medical officer, led the rescue team into the hold. The injured ASD1 was placed on a stretcher, secured in a cargo net, and lifted by crane to the main deck. He was then transferred to the ship's hospital, where first aid and oxygen support were administered.

0920 LT, Master contacted Bangkok Radio requesting emergency medical assistance and possible airlift. The vessel altered course twice as advised by Bangkok Radio to rendezvous with the Royal Thai Navy. Throughout the transit, the crew monitored the injured ASD1's vital signs and continued oxygen support.

1440 LT, the Royal Thai Navy vessel came alongside.

1445 LT, the injured ASD1 was transferred to the naval vessel attended by medical personnel. Despite all efforts, the ASD1 was declared deceased at 1510 LT by the attending naval doctor.

2. THE VICTIM:

The ASD1 was a 28-year-old Filipino national who joined the vessel in July 2023. This was his latest assignment under the same company, where he had previously served in similar deck ratings.

On the day of the incident, records indicate that his work and rest hours were maintained in accordance with the requirements of the Maritime Labour Convention (MLC). He had completed familiarization and safety training as per the vessel's Safety Management System (SMS).

3. WITNESSES:

a. The Master was a 49-year-old Filipino national who joined the vessel on December 15, 2023. He had extensive experience in command.

ON THE DAY OF 10 APRIL 2024, I WAS ON THE BRIDGE ON THAT MORNING DOING MY ROUTINE WORKS, CHECKING /SENDING MAILS. A SUDDEN CALL HEARD FROM 3RD OFFICER HANDHELD RADIO THAT THERE IS A CREW FALLS DOWN ON THE CARGO HOLD, I ORDERED 3RD OFFICER TO ANNOUNCE THRU PUBLIC ADDRESS TO BE AWARE/ALERT ALL CREW THAT ACCCIDENT HAS HAPPENED.

IMMEDIATELY RUSHED TO THE SCENE OF ACCIDENT TO ASSESS THE SITUATION, ORDERED THE CH. OFFICER TO FULLY OPEN THE HATCH, 2ND OFFICER WITH OTHER CREW WENT DOWN TO THE CARGO HOLD TO PUT HIM ON STRECHER, PLACED HIM ON THE WOOD PALLET AND CARGO NET AND LIFTED BY CRANE INTO MAIN DECK, BROUGHT HIM IN A HOSPITAL.

MASTER ON THE BRIDGE SEEKING FOR MEDICAL ASSISTANCE UNTIL WE CONTACTED BANGKOK RADIO, REQUEST MEDICAL ASSISTANCE (AIRLIFT) AS THE CREW IS IN SERIOUS CONDITION, BANGKOK RADIO GIVES US COORDINATES (MEETING POINT) WHEREAS ROYAL THAI NAVY WILL MEET US TO GIVE MEDICAL ASSISTANCE. INFORMED EUROTANKERS OFFICE FOR THE ACCIDENT. DIVERT MY COURSE AS PER ADVISE OF BANGKOK RADIO AND PROCEED TO THE MEETING POINT.

CONTINUE MONITOR THE INJURED CREW WITH HIS VITALS, AND COORDINATE TO EUROTANKERS MARINE DEPT. (RED CROSS) FOR MEDICAL ADVICE, WITH THEIR ASSISTANCE AND INSTRUCTION WE DID OUR BEST TO KEEP THE INJURED CREW ALIVE UNTIL WE ARRIVED IN THE MEETING POINT.

PLS. SEE BELOW EVENTS ON THE ACCIDENT:

0904Lt / OS informed Bridge for the incident.
0905Lt / 3rd Officer announce in Public Address the Incident.
0915Lt / AB brought to Ship's Hospital & apply First Aid
0920Lt / Master seeking for Emergency Medical Assistance
0930Lt / Contacted Bangkok Radio and requested Medical assistance.
0945Lt / Vessel course altered to 218 degrees as per advise of Bangkok Radio
1021Lt / Vessel course altered 248 deg heading Koh Samui as per advise of Bangkok Radio
1054Lt / Call Marine Dept. (Red Cross) for Medical Advise.
1440Lt / Royal Thai Navy 270 alongside on Ship's side (Port Side)
1445Lt / Injured Crew lifted thru Royal Thai Navy Ships attended by Doctor & Nurses
1510Lt / Attending Doctor pronounce Him dead.

b. The C/O was a 47-year-old Filipino national who joined the vessel in July 2023. He was responsible for planning and supervising deck operations, including cargo hold cleaning. At the time of the incident, he was in the cargo office operating bilge systems.

c. The 2/O was a 54-year-old Filipino national who joined the vessel in July 2023. As the medical officer, he led the rescue team into Cargo Hold No. 2, administered first aid, and monitored the ASD1s vital signs until transfer to the naval vessel.

d. The 3/O was a 43-year-old Filipino national who joined the vessel in December 2023. He was the duty officer on the bridge and announced the emergency via the Public Address system after receiving the initial report from the deck.

e. The OS was a 28-year-old Filipino national who was assisting the ASD1 during the hatch coamings cleaning.

0903 – AB ordered me to tell AB that he will washed down Portside of the cargo hold and we together with AB will wash the starboard side. After our conversation I quickly went to AB who is currently on the other side of the cargo hold # 2. It took me 5-10 seconds to arrive where AB position, and I told exactly what AB said to AB

When I went back to AB , I noticed that he was not there in the starboard side of the cargo hold #2 and search for him. I check the starboard railings wondering if he is taking a pee but he is not there. When I look down at the cargo hold #2, I saw him lying behind his back at the tank top.

0904- I quickly reported to the OOW at the bridge via handheld radio what happened.

4. WORK PLANNING PRIOR TO THE EVENT:

a. The deck crew was instructed to carry out cleaning of Cargo Holds No.1 and No.2 by washing down hatch coamings to remove cargo remnants.

b. A toolbox meeting was conducted earlier in the day by the C/O to discuss the cleaning operation, associated hazards, and the use of Personal Protective Equipment (PPE). The meeting emphasized safe working practices, proper use of safety harnesses, and compliance with the company's Safety Management System (SMS).

c. A Job Hazard Analysis (JHA) and Risk Assessment (RA) were completed prior to commencement of work. A Working Aloft/Over Side Permit was issued, and all relevant documentation was verified.

d. The Deck team was instructed to clean the hatch coamings simultaneously. Safety harnesses and lifelines were required for all personnel working at height. The C/O repeated the need for continuous communication and adherence to the buddy system during the operation.

5. DAMAGE/OUTCOMES/POLLUTION/INJURIES:

- The ASD1 sustained fatal injuries as a result of a fall from height into Cargo Hold No.2.
- No pollution resulted from the incident.
- The vessel's equipment, machinery, and structure sustained no damage, and all cargo handling gear was reported to be in good working condition.

6. SUBSEQUENT EVENTS / RESULT:

On April 10, 2024 at 1440 LT, the Royal Thai Navy vessel came alongside.
1445 LT, medical personnel boarded and the ASD1 was transferred to the naval vessel for advanced care.
1510 LT, despite sustained resuscitative efforts, the ASD1 was declared deceased by attending medical personnel on board the naval vessel.

BARRIER ANALYSIS:

Hazard	Existing Barrier	Missing or Weak Barriers	Potential Consequence
Working at height on hatch coaming adjacent to a partially open cargo hold	Toolbox meeting conducted; JHA/RA completed; Working Aloft/Over Side permit issued; PPE (safety harness) assigned	No on-scene officer or supervision at the moment of the fall; no secondary/backup safety line during connection /disconnection.	A fall from height into the cargo hold, leading to severe trauma and fatality

Hazard	Existing Barrier	Missing or Weak Barriers	Potential Consequence
Dynamic vessel motion and wet surfaces during cleaning	PPE use, slip/trip prevention; teams organized port and starboard	Inadequate control of footing on hatch coaming; insufficient use of additional support/working platforms	Loss of balance, slip, and fall from height
Communication during multi-team operation	Handheld radios	Buddy separation (OS sent away) created an unobserved interval; no continuous watch on ASD1 while working at height	Incident unwitnessed; delayed recognition
Equipment integrity (harness and attachment system)	Harness worn	Pre-use inspection of harness/straps not evidenced; disposal of involved harness prevented forensic verification; securing points/approved slings not verified	Ineffective fall protection; inability to determine equipment contribution

SUMMARY:

- The vessel was underway from Koh Sichang to Singapore. The deck department planned and authorized hatch coaming cleaning on Cargo Holds No. 1 and No. 2 under the C/O supervision.

- A toolbox meeting, JHA, RA, and Working Aloft/Over Side permit were completed per the SMS.

- The deck crew operated in two teams (port and starboard). While cleaning the starboard coaming of Cargo Hold No. 2, the ASD1 fell into the cargo hold. The incident was not witnessed at the time of occurrence.

- The 3/O initiated the emergency arrangements via the Public Address system. The Master ordered full hatch opening and the 2/O led the rescue, first aid, and oxygen support efforts.

- The vessel coordinated with Bangkok Radio, altered course, and rendezvoused with the Royal Thai Navy. The ASD1 was transferred to the naval vessel for additional care but was declared deceased by naval medical personnel.

CONCLUSION:

Contributory Factors

a. Working at height exposure on a hatch coaming adjacent to a partially open cargo hold.
b. Absence of continuous supervision and on-scene officer at the time of the fall.
c. Buddy system interruption when the OS was sent to communicate with the port-side team, leaving the ASD1 momentarily unobserved.
d. No secondary/backup fall-arrest line during connection/disconnection of the harness to the securing point.
e. Equipment integrity uncertainty where there were indications of worn/frayed strap and reliance on an extension rope rather than a verified approved sling/anchorage, coupled with the disposal of the harness post-incident.
f. Wet surfaces and vessel motion during cleaning, increasing slip risk.
g. Execution gap between documented SMS controls (permits, RA, Tool Box Talk) and actual practice on deck.

Probable Cause:

The probable cause of the casualty was a fall from height into Cargo Hold No. 2 by the ASD1 while working on the starboard hatch coaming, likely occurring during attachment or repositioning of the safety harness without a backup safety line, in conditions with wet surfaces and insufficient on-scene supervision.

Recommendations:

a. Working-at-Height Controls

- Mandate two-point fall protection: primary harness and independent backup lifeline whenever connecting/disconnecting at height.
- Prohibit reliance on non-certified extension ropes; require approved slings/anchorage devices rated for fall arrest.
- Eliminate standing on hatch coamings where practicable; employ work platforms, guard-rails, bosun's chairs/cradles, or alternative cleaning methods that remove the exposure.

b. Equipment Integrity & Evidence Retention

- Implement documented pre-use inspection of harnesses, shock absorbers, connectors, and anchorage points; tag-out defective gear.
- Establish a no-disposal rule for equipment involved in casualties until investigation closure; preserve, photograph, and catalogue evidence.

c. Supervision & Buddy System

- Require continuous on-scene officer supervision for high-risk tasks; officers not to engage in task work that compromises oversight.
- Enforce an unbroken buddy system: no worker at height left unobserved; maintain line-of-sight and radio contact.

d. Procedural Assurance

- Strengthen SMS execution checks: permit to work activation and stop-work authority reminders before commencing.
- Include environmental controls (slip resistance, weather checks, vessel motion assessment) in the RA for cleaning tasks.

e. Training & Fleet Learning

- Deliver targeted training on fall-arrest systems (correct attachment, anchor selection, secondary lifeline use, retrieval plans).
- Circulate a fleet safety alert summarizing the event, barriers, and controls; conduct reflective learning sessions onboard with verification by the Designated Person Ashore (DPA).
- Integrate case-based scenarios into recurrent training and drills.

This report was prepared based on the report and findings from the investigation conducted by the Liberian Investigator, and review of additional documentary evidence, and reports compiled during their attendance on board the vessel M/V EUROSTAR, and the additional guidance provided in this report from the Liberia Maritime Authority.

All the evidence collected for this flag state investigation was gathered on board the M/V EUROSTAR, which includes but is not limited to documents, photographs, and witness interviews, which were all used as materials to develop the Commissioner's Decision and this report of investigation into this tragic incident. The content contained therein was reported without prejudice and with regard to all known facts provided.