



## SAFETY INVESTIGATION REPORT

202309/008

REPORT NO.: 13/2024

September 2024

The Merchant Shipping (Accident and Incident Safety Investigation) Regulations, 2011 prescribe that the sole objective of marine safety investigations carried out in accordance with the regulations, including analysis, conclusions, and recommendations, which either result from them or are part of the process thereof, shall be the prevention of future marine accidents and incidents through the ascertainment of causes, contributing factors and circumstances.

Moreover, it is not the purpose of marine safety investigations carried out in accordance with these regulations to apportion blame or determine civil and criminal liabilities.

### NOTE

This report is not written with litigation in mind and pursuant to Regulation 13(7) of the Merchant Shipping (Accident and Incident Safety Investigation) Regulations, 2011, shall be inadmissible in any judicial proceedings whose purpose or one of whose purposes is to attribute or apportion liability or blame, unless, under prescribed conditions, a Court determines otherwise.

The report may therefore be misleading if used for purposes other than the promulgation of safety lessons.

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This safety investigation has been conducted with the assistance and cooperation of the Transport Safety Investigation Center, Türkiye.

### **MV *Drawsko*** **Fatality of a crew member on deck** **while rigging a portable cargo hold light** **at Iskenderun, Türkiye,** **on 08 September 2023**

### SUMMARY

On 08 September 2023, *Drawsko* was loading a cargo of grain, at the port of Iskenderun, Türkiye. During that night, the duty ordinary seafarer was tasked with rigging up portable lights in cargo hold no. 1. Several minutes later, however, the duty officer found the ordinary seafarer lying unconscious on deck, clutching a portable light.

Attempts to revive the ordinary seafarer, by the crew members as well as paramedics, were unsuccessful.

The autopsy result revealed that the ordinary seafarer had died of cardiac arrest due to electrocution.

The safety investigation determined that the portable light's power plug had been incorrectly wired, resulting in the electrocution of the ordinary seafarer when he picked up the metal frame of the portable light.

The MSIU has issued three recommendations to the Company, designed to enhance safety when handling portable lights.



## FACTUAL INFORMATION

### The vessel

*Drawsko* was a 20,603 gt, Maltese-registered bulk carrier. The vessel was built in 2010 at the Nantong Mingde Heavy Industry Stock, China. *Drawsko* was owned by Erato Two Shipping Ltd., and was managed by Polska Żegluga Morska P.P., Poland (the Company). *Drawsko* was classed with Det Norske Veritas (DNV), which also acted as its recognised organisation in terms of the International Safety Management (ISM) Code.

The vessel had an overall length of 190.00 m, a moulded breadth of 23.60 m, and moulded depth of 14.65 m. It had a summer draught of 10.22 m, which corresponded to a summer deadweight of 30,487 metric tonnes (mt).

Propulsive power was provided by a two-stroke, Sulzer 6RTA48T-B, slow speed, marine diesel engine, producing 7,800 kW at 118 rpm.

The vessel had six cargo holds and was fitted with three deck cranes, each having a safe working load of 30 mt.

### Crew

The Minimum Safe Manning Certificate of *Drawsko* stipulated a crew of 14<sup>1</sup>. At the time of the occurrence, there were 21 persons on board, 12 of whom were Polish nationals, seven were Ukrainian nationals, and the remaining two were Bulgarian nationals. The working language on board was English.

During cargo operations in port, the chief officer kept a watch from 0800 to 1600, the third officer from 1600 to 2400, and the second officer from 0000 to 0800. The officers were accompanied by two deck ratings on each watch, but the ratings

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<sup>1</sup> Provided that the unmanned machinery space (UMS) and the bridge control systems were operational, and at least two deck officers held Global Maritime Distress and Safety System (GMDSS) General Operator's Certificates.

followed the traditional 4-on / 8-off watch system.

At the time of the accident, the third officer was on watch, along with the bosun and an ordinary seafarer (OS). The bosun and the OS had come on watch at 2000.

The deceased ordinary seafarer was a 27-year-old Polish national. He had started his seafaring career in 2016 as a deck cadet and in May 2019, he qualified for his STCW II/4 certificate that allowed him to serve as a rating forming part of a navigational watch. He had served with the Company for almost two years as an OS and this was his third employment term. He had joined *Drawsko* on 25 July 2023, at the port of Ghent, Belgium, completing his elementary and shipboard familiarisation training on 26 July. The OS was certified as medically fit for duty following his medical examination of 14 June 2023.

### Environment

The sun had set about three hours prior to the accident. It was dark and work on board was being carried out under the vessel's fixed deck lights and the shore lights on the quay. The sky was clear, and the visibility was good. There was a light Southwesterly breeze, and the sea was calm, with no swell. The air and sea temperatures were recorded as 32 °C and 33 °C, respectively.

### Narrative<sup>2</sup>

*Drawsko* completed the discharge of soyabean meal at Bandirma, Türkiye, on 31 August 2023. The vessel then shifted to the anchorage for cargo hold cleaning, in preparation to load the next cargo. The vessel was scheduled to load different grades of wheat in cargo holds nos. 1, 4 and 6, at Iskenderun, Türkiye, for Ghent, Belgium. Thereafter, the vessel was to proceed to

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<sup>2</sup> Unless otherwise stated, all times mentioned in this safety investigation report are local (LT = UTC + 3).

Giresun, also in Türkiye, to load the remaining cargo in cargo holds nos. 2 and 3, for Newport, United Kingdom. Cargo hold no. 5 was to remain empty.

On 04 September, after completion of cargo hold cleaning, the vessel proceeded to Iskenderun anchorage, arriving at 2100 on the same day. Following an inspection on 05 September, the cargo holds were rejected for the loading of grain. The crew members, therefore, had to further clean the cargo holds. On 06 September, *Drawsko* was instructed to proceed to berth, and at 2230, the vessel was moored with its port side alongside the berth.

At 0100 on 07 September, following a re-inspection, the cargo holds were certified acceptable for loading, which commenced at 0325, on the same day. Initially, two cargo gangs were employed to load cargo holds nos. 4 and 6; the loading operations were supervised by a shore cargo superintendent.

At 0837, port State control (PSC) officers boarded the vessel for an inspection. Five deficiencies were recorded during this inspection.

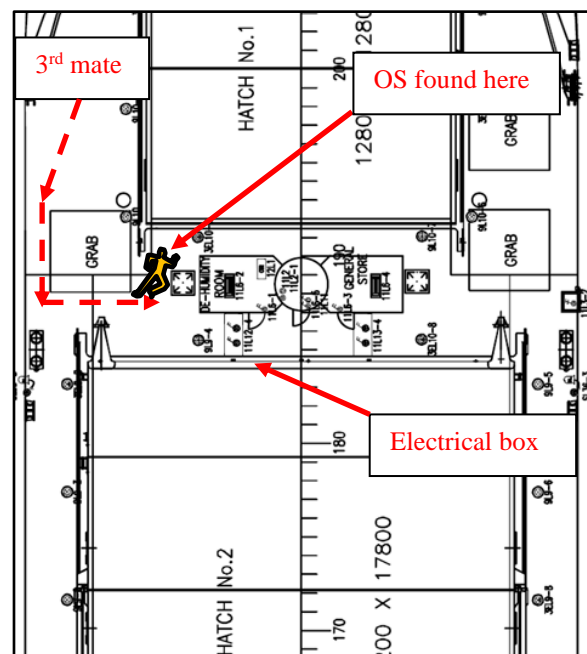
Between 1215 and 1255, the vessel was shifted 12 m ahead, to facilitate the positioning of the loading crane, in view of the limited length of the berth. Loading continued throughout the day and night, with occasional breaks for meals and shift changes.

On 08 September, at 1600, the third officer took over the deck watch from the chief officer. At 1935, loading operations were stopped in cargo holds nos. 4 and 6. The shore loading equipment was then shifted to line up with cargo hold no. 1, to load a different grade of cargo. After shifting, the loading equipment was thoroughly cleaned to avoid cargo contamination between the two different grades of cargo.

At 2000, the bosun and the OS took over the deck watch. At about 2100, after discussions with the cargo superintendent, the chief officer advised the OS to open cargo hold no. 1 so that loading could commence as soon as the loading equipment was ready. The OS was also instructed to rig portable lights<sup>3</sup> in the cargo hold.

At about 2200, the third officer and the cargo superintendent, who were stationed at the accommodation ladder walked to cargo hold no. 1 to inspect it from the deck, before the commencement of the loading operation. They found the cargo hold satisfactory.

At about 2215, the third officer walked back towards the accommodation ladder, to find out why the portable lights had not yet been rigged. When abreast of the cross deck between cargo holds nos. 1 and 2 (**Figures 1 and 2**), he noticed the OS collapsed on deck, with the steel frame of a portable light clutched in his hands. He observed that the portable light was not illuminated.



**Figure 1: Plan view of accident site**

<sup>3</sup> The portable lights were powered by the vessel's main power supply and were used to illuminate the cargo hold. They were normally secured on the cargo hold hatch coamings.

The third officer immediately called the bosun for assistance, on the portable radio, and disconnected the portable light's plug from the socket. The master, who was awake, overheard this conversation and alerted the chief and second officers to proceed to the accident site.



**Figure 2: Location of the OS, when discovered**  
(indicated position is for illustration purposes only)

On arrival, the master found the third officer administering cardiopulmonary resuscitation (CPR) to the OS, with the assistance of the bosun. The master requested the cargo superintendent to call the port ambulance to assist. Meanwhile, the chief, second and third officers alternately took turns to resuscitate the OS, until the ambulance arrived at about 2225. The ambulance staff administered CPR for the next five minutes but as there was no positive response, they decided to shift him to the port's first aid facility.

The second officer accompanied the OS in the ambulance. At about 2325, he reported to the vessel that the OS had been pronounced deceased.

### Cause of death

The MSIU was informed that the autopsy had determined that the cause of the OS' death was cardiac and respiratory arrest due to electrocution.

A transcript of the autopsy report, which was eventually made available to the MSIU at a late stage of the safety investigation, confirmed that the death of the crew member was the result of respiratory and cardiac arrest due to electrocution.

The safety investigation was informed by its Turkish counterparts that no other injuries had been observed on the OS and that there were no definitive features that could indicate that death was due to something other than electrocution.

### The portable light

Following the accident, the portable light was seized by the Turkish authorities, as evidence for the judicial investigation. The crew members informed the safety investigation that the portable light that was being handled by the OS, had been in use for a number of months prior to the accident.

The vessel was using several other lights, of the same make and model (**Figure 3**).



**Figure 3: A portable cargo hold light used on board**

Each portable light was secured to a metal frame so that it could be easily hooked on a cargo hatch coaming. They were LED lights, rated at 100 W and operated on 230 V. Each portable light could produce 8500 LM and had an ingress protection (IP) rating of 65<sup>4</sup>.

The power cables for these lights were rated for a voltage of 0.6 kV / 1 kV and were three-core, polyvinyl chloride (PVC)-insulated copper cables, with a 1.5 mm<sup>2</sup> cross-sectional area.

Each portable light was connected (earth, live, and neutral) to one end of the power cable and the other end was connected to a rigid PVC and 'Bakelite' three-pronged, power plug, rated at 16 A and 250 V.

The plug was inserted in a socket that was rated at IP56 and protected from the elements by a weathertight casing fitted on the cargo hatch coaming (**Figure 4**). The switch had two on / off positions, which meant it could be turned either side to either switch on or off.



**Figure 4: Electrical box containing the socket**

<sup>4</sup> As per the IP rating guide, numeral 6 denotes 'dust-tight' and numeral 5 denotes 'protected against water jets'.

### **Post accident investigation**

Following the accident, the safety investigation did not have access to the portable light. However, the Turkish judicial authorities carried out a forensic examination of the seized portable light. The MSIU was informed that through testing and without energizing the light, the judicial investigation determined that there was no short circuit in the system. However, on further inspection of the cable lead, it was observed that the live wire (brown) was connected directly to the portable light's earth terminal, causing an electrical leakage.

The Company informed the safety investigation that the vessel had inspected the socket to which the plug was connected and could not find any fault in the connections. The circuits for the light sockets were not fitted with a residual current circuit breaker (RCCB) but had a main circuit breaker (MCB) which, according to the information provided by the crew members, had not tripped. Furthermore, the vessel's earth system had not alarmed when the accident took place.

At a very late stage of the safety investigation process, the MSIU was informed that prior to the arrival of its representative on board, the Turkish authorities had elevated a roll of black insulation tape and a knife from the area. The MSIU had not been made aware of this detail. The MSIU sought confirmation from the local authorities, and it was confirmed that the experts appointed by the judicial investigation in Türkiye had indeed elevated, *inter alia*, a roll of black insulation tape and a knife with a blue-black handle and a metallic tip (in a black plastic sheath).

### **Health condition of the OS, prior to the occurrence**

The vessel's medical log indicated that on 07 September, at 1115, the OS had

complained of colic<sup>5</sup>. His blood pressure was found to be 116 / 76. 10 minutes later, the pain subsided, and the OS was sent to his cabin to rest until his night watch. He was recommended to keep himself hydrated. The OS' condition was checked again at 2000 and was found to be good. His blood pressure at this time was recorded as 119 / 81.

At 0800, on the next day (the day of the occurrence), the OS' condition was once again checked and again, found good. His blood pressure this time was recorded as 122 / 84. The OS was reminded to keep himself hydrated due to the warm weather conditions.

## **ANALYSIS**

### **Aim**

The purpose of a marine safety investigation is to determine the circumstances and safety factors of the accident as a basis for making recommendations, and to prevent further marine casualties or incidents from occurring in the future.

### **Cause of the accident**

The MSIU was informed that there were no witnesses to the accident and therefore, the safety investigation relied on the crew members' recollection of events, and the findings of the Turkish authorities' forensic examination of the portable light.

Since there were a number of possibilities as to why the accident may have occurred, the safety investigation analysed various possibilities, including whether the OS' medical episode, on the previous day, had contributed to his demise. However, the medical log entries indicated that on the three occasions when his blood pressure was checked, the readings were normal. The

second officer, who was designated as the vessel's medical officer, had determined that the OS was not feeling well because of dehydration, given that the ambient temperature was approximately 32 °C. Moreover, the second officer stated that at 0800 on 08 September, the OS had advised him that he was feeling better. Therefore, this hypothesis was not considered any further.

The third officer found the OS lying with the portable light clutched by both hands. Although he found the light unlit, he was unable to recollect whether the switch was on or off when he disconnected the plug. Since the portable light was incorrectly wired, when plugged in and switched on, it would not have worked. However, due to electrical leakage, if the unit's metallic sections were touched by any person, it would have exposed them to electrocution.

Therefore, the following scenarios were considered:

- i. the OS had positioned the portable light on the cargo hatch coaming and then gone to insert the plug in the socket and switched it on. When he went back to check if the light was lit, he found it off, picked it up to examine it, and was electrocuted;
- ii. he had first inserted the plug in the socket, switched it on and was electrocuted when he picked the portable light to place it on the hatch coaming. However, if this was the case, he should have been found near cargo hold no. 2 instead of cargo hold no. 1;
- iii. he placed the portable light on the nearby cargo hold access hatch and then went to insert the plug in the socket and switched it on. When he came back to check if the light was on, he found it off, so he picked up the light and was electrocuted. However, if this was the case, he should have been found near the cargo hold access hatch; or

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<sup>5</sup> Colic is abdominal pain that comes and goes in waves. It occurs from the contraction of a hollow organ, such as the bowel, gall bladder or urinary tract.

- iv. he placed the light on the deck near the hatch coaming and then proceeded to insert the plug in the socket and switch it on. He then came back to position the light on the hatch coaming, found that it was off, and was electrocuted when he picked it up to examine it.

On the basis of the information that the portable light was incorrectly wired (*i.e.*, the live wire was connected to the earth terminal), it was considered very unlikely that it would have lit up when switched on, but it now meant that anyone touching either the metallic parts of the portable light, or its mounting frame, was vulnerable to electrocution. Therefore, when the OS had picked up the portable light, there would have been an electrical current leakage, which would have caused electrocution, and which in turn, may have caused him to clutch at the portable light due to involuntary contraction of the muscles of his hands.

Taking into consideration the recollections obtained, and the information on the incorrectly wired plug, the safety investigation surmised that it was more likely that the OS died of electrocution when he picked up the portable light, after switching it on.

### Industry Guidance

The rigging and working with portable lighting are fairly routine tasks on board cargo ships and in most cases, it is a safe operation, provided all precautions are taken. Occasionally, however, accidents do happen as in the case of a similar occurrence where an able seafarer died of electrocution during cargo hold cleaning<sup>6</sup>.

The safety investigation was not aware of any extensive industry guidance on the use of portable deck and hold lighting. Bulk Carrier Practice<sup>7</sup>, published by The Nautical Institute, advises that portable lighting is usually required in any port for cargo operations and also for security purposes.

Isbester (2023) further explained that a vessel should carry at least four portable lights for each cargo hold, two to light the cargo hold, and two to shine over the ship's side to illuminate the jetty or craft alongside. Before reaching each port, the portable lights should be tested, cables inspected for damage, and repaired as necessary.

Similarly, the Code of Safe Working Practices for Merchant Seafarers (COSWOP)<sup>8</sup> also provides advice in that:

- portable electrical appliances, lights, *etc.*, should be visually inspected before every use and should be isolated from their source of electrical supply after use. Measurement of insulation resistance prior to first use and repeated on a regular basis should be considered depending on the location of use / risk of damage (Section 5.3.5); and
- where portable or temporary lighting has to be used, fittings and leads should be suitable and safe for the intended usage. To avoid risks of electric shock from mains voltage, the portable lamps used in damp or humid conditions should be either of low voltage (preferably 12 volts), or other suitable precautions should be taken (Section 11.5.8).

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<sup>6</sup> The Hong Kong Special Administrative Region Marine Department - Marine Accident Investigation Section. (2023). *Report of investigation into a fatal electrocution accident onboard the Hong Kong registered bulk carrier "COSCO WUYISHAN" at sea on 15 August 2022.* [https://www.mardep.gov.hk/en/publication/publications/reports/pdf/mai220815\\_f.pdf](https://www.mardep.gov.hk/en/publication/publications/reports/pdf/mai220815_f.pdf)

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<sup>7</sup> Isbester, J. (2023). *Bulk carrier practice* (Third ed.). The Nautical Institute.

<sup>8</sup> Maritime and Coastguard Agency. (2022). *Code of Safe Working Practices for Merchant Seafarers* (2015 - Amendment 7 ed.). TSO. [https://assets.publishing.service.gov.uk/media/6377ba338fa8f5771cd8de61/Code\\_of\\_safe\\_working\\_practices\\_for\\_merchant\\_seafarers\\_COSWP\\_amendment\\_7\\_2022.pdf](https://assets.publishing.service.gov.uk/media/6377ba338fa8f5771cd8de61/Code_of_safe_working_practices_for_merchant_seafarers_COSWP_amendment_7_2022.pdf)

### Planned maintenance system

In compliance with the ISM Code, the vessel did have a planned maintenance system in place. According to the records, the following work on “General Light” was required:

*“Light Check – functioning, casing, markings, insulation, earthing IW.”*

These tasks had to be carried out on a weekly basis. Records indicated that the last time they had been undertaken was on 02 September 2023, *i.e.*, six days before the occurrence. However, the safety investigation established that the crew members were unaware of how many portable lights were on board and when was the last time they had been inspected. There was no routine examination of these portable lights and only when a light was found to be faulty by the deck crew, it was brought to the attention of the electrician on board.

The safety investigation believes that the absence of a systematic, routine examination, even if required by the Company procedures, was suggestive of an on-board context, which could not support this requirement. What is imperative to highlight is not the fact that procedures were not followed, but the potential multiple factors, which seafarers experienced on board, leading to a situation where potentially, the procedure could not be adhered to.

Even more, it did not appear that this ‘lack of procedure adherence’ had been brought to the attention of the Company – thereby creating a job perception gap (*i.e.*, what the Company believed was being done *vs.* what was actually being done on board) which, *per se*, prohibited the matter from being addressed at the organisational level.

It would appear that an informal system had been developed on board. External to the vessel, such an approach may be deemed as procedural violation; for those on board, however, it was a coping strategy to mitigate factors, the nature of which remained

unknown to the Company and hence, yet to be identified.

What seems to be clear, is that whereas this procedure was designed to detail and guarantee the safety of using portable lighting, the crew members were expected to adhere to it, in conjunction with their day-to-day tasks.

### Wiring the power plug

In determining how the accident occurred, two hypotheses were developed.

- a. the crew members’ recollection of the portable light being previously used was not correct, and therefore this was the first time that the portable light had been used after being wired incorrectly; or
- b. the portable light was used safely before but this time someone, for whatever reason, felt the need to open the plug and eventually box it up again (incorrectly).

Following confirmation by the relevant authorities of the coastal State that the cable was wired incorrectly, the safety investigation spent significant time analysing the matter. The colours of the wires inside the sheathed cable were brown, black, and grey (**Figure 5**).



**Figure 5: The dismantled plug and wires**



It was reported that the portable light's earth terminal was connected to a live wire rather than grounded. However, the possible explanation for that to happen was less clear and perhaps more intricate. Although the safety investigation did not have information from where the cable had been procured (and when), the matter was considered in detail.

The MSIU did not come across standards which regulate the colours of cable extensions used on board vessels. For instance, whilst it is acknowledged that standards vary in different countries, the traditional green/yellow cable, which one would expect to serve as an earth cable, was not present.

It was not excluded that the use of this cable with wire insulation coloured brown, black and grey may have directly contributed to the incorrect wiring of the live wire into the earth terminal<sup>9</sup>.

The power outlets on the main deck, where portable lights could be plugged in, did not have a residual current device (RCD) at the switchboard. An RCD acts like a safety barrier in that it quickly disconnects the supply when there is an imbalance between the live and the neutral (say, someone touches the live terminal of the cable).

### **Possibility of repairs to the portable light**

The reference to the black electrical tape led to claims of potential repairs by the OS, prior to the accident. As already explained,

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<sup>9</sup> Whilst clarifying that the MSIU was unable to establish these considerations as facts, it is worth mentioning that in terms of the behaviour of humans forming part of a socio-technical system, the MSIU has come across situations in its daily investigations, where contextual factors contributed directly to several outcomes, some of which were not necessarily desirable *e.g.*, distraction. Moreover, in several of these cases, the persons involved were unable to recover the situation, even because the consequence of such an outcome would have not been immediate.

throughout the safety investigation process, the MSIU had no information on this.

Although the hypotheses of opening the plug for whatever reason has been mentioned in the previous section of this safety investigation report, and **Figure 5** showed black insulation tape on the three wires, it was not possible for the MSIU to determine when the insulation tape had been applied, and by whom. Moreover, there was no information to indicate whether any other tools had been found on site<sup>10</sup>.

Although it is acknowledged that more details on the accident dynamics could have provided clarity on the way the accident dynamics had evolved, the true objective of safety investigations is learning rather than blaming. Identifying the person who connected the plug in the way it was connected, becomes secondary to the MSIU; that task would fall within the competence of a judicial investigation, for purposes which are of no interest to this safety investigation.

What was rather critical for the safety investigation to identify was that a three-core cable was wrongly connected, and that there appeared to be neither preventive barrier systems to avoid this erroneous action, nor protective barriers to divert / minimise the potential consequences which, regretfully, resulted in the death of a young seafarer. It was clear for the safety investigation that these factors had not been identified before it became an event.

### **Glove protection**

It was not reported that the OS was wearing any gloves when he was handling the portable light<sup>11</sup>. However, it has to be

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<sup>10</sup> It was assumed that a screwdriver would have been required to open the plug and / or disconnect the wires to apply the insulation tape.

<sup>11</sup> It has to be stated that leather gloves are not considered to provide adequate protection against electric shocks. It is advisable that voltage-rated gloves are worn underneath leather gloves when

remarked that the OS had no reason to wear such protective equipment – he would not have been expected to wear voltage-rated gloves simply to handle a portable light. Moreover, even if he had to opt for the leather gloves only, the warm weather would have likely caused his hands to sweat, creating a humid environment inside the glove and offering no insulation against the electric current.

## CONCLUSIONS

1. The safety investigation concluded that the ordinary seaman died from cardiac and respiratory arrest due to electrocution when he picked up the portable light.
2. The portable light's plug was incorrectly wired; the live wire was connected to its earth terminal.
3. The colours of the wires in the portable light's cabling are considered to have likely contributed to the light being incorrectly wired.
4. The portable lights were not part of a robust planned maintenance system where they would have been regularly checked.

## SAFETY ACTIONS TAKEN DURING THE COURSE OF THE SAFETY INVESTIGATION<sup>12</sup>

During the safety investigation, the Company has taken the following actions:

- All portable floodlights have been removed from service and checked by the ship's electrician. Floodlights with

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working with electricity. The leather gloves are only intended to provide mechanical protection against abrasion, cuts, and puncture of the rubber gloves, thereby compromising the protection.

<sup>12</sup> **Safety actions and recommendations shall not create a presumption of blame and / or liability.**

no issues have been returned for service;

- Training on commitment to safety, work planning, risk assessment and scope of duties has been offered on board;
- The operation and conditions of the cable and casing, insulation and earthing have been incorporated in the planned maintenance system on all vessels within the fleet;
- All Company vessels have been directed to check the condition of all the portable floodlights' condition and tightness of the cable connections. Vessels were also instructed to withdraw from service any floodlights which were not satisfactory and to discuss the outcome at the first safety meeting on board;
- An electrical installation inspection was carried out by the ETO (no malfunction detected);
- The Company's SMS manuals have been updated to include the maintenance of the portable floodlights;
- A Company Safety Flash has been prepared and distributed among the Company's fleet.

## RECOMMENDATIONS

Polska Żegluga Morska P.P., (Polish Steamship Company) is recommended to:

**13/2024\_R1** – circulate the findings of this safety investigation to its managed and owned fleet.

**13/2024\_R2** – investigate the possibility of fitting RCD to vulnerable switch boards.

**13/2024\_R3** – consider the use of low voltage portable lights.

## SHIP PARTICULARS

Vessel Name:	<i>Drawsko</i>
Flag:	Malta
Classification Society:	Det Norske Veritas (DNV)
IMO Number:	9393450
Type:	Bulk Carrier
Registered Owner:	Erato Two Shipping Ltd.
Managers:	Polska Zegluga Morska P.P.
Construction:	Steel (Single Hull)
Length Overall:	190.00 m
Registered Length:	182.60 m
Gross Tonnage:	20,603
Minimum Safe Manning:	14
Authorised Cargo:	Dry cargo in bulk

## VOYAGE PARTICULARS

Port of Departure:	Bandirma, Türkiye
Port of Arrival:	Iskenderun, Türkiye
Type of Voyage:	International
Cargo Information:	Loading wheat in bulk
Manning:	21

## MARINE OCCURRENCE INFORMATION

Date and Time:	08 September 2023, at about 2215 (LT)
Classification of Occurrence:	Very Serious Marine Casualty
Location of Occurrence:	Iskenderun, Türkiye
Place on Board	Main deck – aft of cargo hold no. 1
Injuries / Fatalities:	One fatality
Damage / Environmental Impact:	None reported
Ship Operation:	Normal service – Moored; Loading – shore-to-ship
Voyage Segment:	Alongside
External & Internal Environment:	Dark, partly cloudy and a Southwesterly gentle to moderate breeze
Persons on board:	21 crew members and a shore cargo superintendent