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GOVERNMENT OF PAKISTAN
MINISTRY OF MARITIME AFFAIRS
DIRECTORATE GENERAL PORTS & SHIPPING
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Karachi, 23rd January, 2026.

FINAL ACCIDENT INVESTIGATION REPORT

Subject : Fatal Forklift Incident Onboard MV HSC NEW LUCKY

Issued by: - **Capt. Rafaqat Hussain**, Chief Nautical Surveyor (CNS)
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Ministry of Maritime Affairs, Government of Pakistan
Date of Final Report: 23rd January 2026

Reference: Preliminary DGPS Investigation dated 25 November 2025 and Official Enquiry by Port Qasim Authority (PQA) dated 23 December 2025

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1. INTRODUCTION AND PURPOSE

This Final Accident Investigation Report is issued by the Directorate General Ports & Shipping (DGPS) in consolidation of: - The **Preliminary Accident Investigation Report dated 25 November 2025** conducted by DGPS; and - The **Official Enquiry Report issued by Port Qasim Authority (PQA).**

The purpose of this report is to: - Establish the **facts, causes, and contributing factors** of the fatal forklift incident onboard **MV HSC NEW LUCKY**; - Identify **systemic failures and responsibilities** of all involved parties; - Issue **authoritative findings and recommendations** from the Chief Nautical Surveyor, DGPS, to PQA and all stakeholders; - Enhance **port and stevedoring safety** and prevent recurrence of similar incidents.

This investigation is conducted in the interest of **safety improvement**, not to apportion criminal guilt, without prejudice to any judicial proceedings.

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2. PARTICULARS OF THE INCIDENT

- **Vessel:** MV HSC NEW LUCKY
- **Port / Berth:** Port Qasim, Berth MW-2
- **Location:** Cargo Hold No. 4
- **Date of Incident:** 16 November 2025
- **Time:** Approximately 0815 Hours (LT)
- **Operation:** Discharge of steel coils
- **Equipment Involved:** Forklift Model JS-4607
- **Deceased:** Mr. Saleh Muhammad, Forklift Operator
  (Employee of M/s Shehryar Transport – Subcontractor)

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3. DESCRIPTION OF THE ACCIDENT

On 16 November 2025, during cargo discharge operations of steel coils, a forklift (JS-4607) operating inside Hold No. 4 suffered a **catastrophic mechanical failure of its boom/jib assembly at the foundation** while lifting a steel coil. The boom collapsed rearwards onto the operator's cabin, causing fatal crush injuries to the operator.

The injured operator was extracted using the ship's crane and transported to Jinnah Hospital, where he was **pronounced dead at 0937 hours**.

The incident resulted in: - Fatality of the forklift operator; - Severe damage to the forklift; - Minor damage to one steel coil; - Hydraulic oil spillage inside the cargo hold.

4. SEQUENCE OF EVENTS (ESTABLISHED FACTS)

Time (LT)	Event
0815	Forklift boom/jib assembly catastrophically fails during lifting operation
0845	Incident reported to the Master
0847	Injured operator removed from hold
0850	Operator transferred to hospital
0937	Official time of death declared at hospital
0900	Cargo operations resumed
0915	Damaged forklift removed from hold
1000	PQA Control Tower formally informed
1230	PQA officials demand safety documentation
1730	Required documents not produced by stevedore/subcontractor

5. DISCREPANCIES IDENTIFIED DURING INVESTIGATION

The investigation identified material discrepancies between initial reports and verified facts, including: - Incorrect early reporting of time of death; - Delay of nearly **1 hour 45 minutes** in formal notification to PQA; - Initial mischaracterization of the cause as cargo movement rather than mechanical failure; - Failure to preserve the accident scene and premature resumption of cargo operations; - Inability of the stevedore and subcontractor to produce mandatory safety documentation.

These discrepancies point towards **systemic deficiencies in incident reporting and safety culture**.

6. FINDINGS OF FACT

6.1 Immediate Cause

The immediate cause of the accident was a **catastrophic mechanical failure of the forklift's jib-side lifting assembly**, resulting in uncontrolled collapse onto the operator's cabin.

6.2 Root Causes

a) M/s Shehryar Transport (Subcontractor) - Gross failure in equipment maintenance and inspection; . Absence of documented pre-operation checks; - Failure to ensure mechanical fitness of lifting equipment; - Unsafe system of work provided to the employee.

b) Interocean Cargo Services (ICS) – Principal Stevedore - Failure to vet and supervise subcontractor safety compliance; - Ineffective on-site supervision; - Deficient implementation of Safety Management System (SMS); - Premature resumption of operations after a fatal incident.

c) Port Qasim Authority (PQA) - Delayed incident response and notification; - Inadequate contractor vetting and equipment certification regime; - Failure to enforce scene preservation; - Insufficient proactive safety audits and enforcement mechanisms.

7. RESPONSIBILITY AND ACCOUNTABILITY

- **Shehryar Transport:** Direct responsibility for equipment integrity and operator safety.
- **Interocean Cargo Services (ICS):** Vicarious liability as principal employer and failure of oversight.
- **Port Qasim Authority:** Regulatory responsibility for ensuring a safe port environment.
- **Vessel / Master:** No operational responsibility for stevedore equipment; issuance of Letter of Protest noted.

8. CONCLUSIONS(CHIEF NAUTICAL SURVEYOR – DGPS)

This fatal accident was **entirely preventable**. It resulted from a combination of **mechanical equipment failure** and **systemic breakdowns in contractor management, safety oversight, and regulatory enforcement.**

The subcontractor provided a **mechanically unsafe equipment**, the principal stevedore allowed it through a **deficient safety system**, and the port authority failed to enforce its **statutory role as safety regulator**. Human life was compromised due to prioritization of operational continuity over safety.

9. RECOMMENDATIONS (DIRECTED BY DGPS)

9.1 To Port Qasim Authority (PQA)

- Establish a **mandatory equipment certification and permit-to-work system;**
- Implement a **port-wide contractor prequalification and safety audit regime;**
- Enforce immediate **work stoppage and scene preservation** after serious incidents;
- Introduce a unified **incident reporting and emergency response protocol;**
- Strengthen internal accountability through departmental reviews.

9.2 To Interocean Cargo Services (ICS)

- Suspend subcontracting until full safety compliance is demonstrated;
- Implement a robust subcontractor vetting and supervision system;
- Review and enforce Safety Management System (SMS);
- Ensure compensation and cooperation with legal proceedings.

9.3 To All Stevedores / Contractors

- Mandatory daily equipment inspections;
- Certified operator training and refresher programs;
- Enforced Stop-Work Authority for unsafe conditions.

10. DOCUMENTS / REFERENCES (BIBLIOGRAPHY)

1. DGP&S Preliminary Investigation Report dated 25 November 2025
2. Official Inquiry Report by Port Qasim Authority
3. Master's Statement and Letter of Protest – MV HSC NEW LUCKY
4. Witness Statements (Ship Staff, Stevedores, PQA Officials)
5. Hospital and Medical Reports
6. Independent Surveyor's Report
7. Applicable Pakistan Maritime, Port Safety and Labour Regulations
8. ILO Occupational Safety Guidelines
9. IAPH (International Association of Ports and Harbors) Port Safety Best Practices

11. CLOSING DIRECTIVE

Port Qasim Authority is requested to submit an **Action Taken Report** on the above recommendations **within fifteen (30) days** of receipt of this report.
Ensuring a **Safe Port Environment** is a statutory and moral responsibility.

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